HARD LABOR

Women and Work in the Post-Welfare Era

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CONTENTS

Foreword
Daniel J.B. Mitchell  vii

Preface  ix

1. Low-Wage Work "As We Know It": What's Wrong/What Can Be Done
Joel F. Handler  3

Mark Greenberg  24

3. Barriers to Finding and Maintaining Jobs: The Perspectives of Workers and Employers in the Low-Wage Labor Market
Julia R. Henly  48

4. Self-Employment: Possibilities and Problems
Susan R. Jones  76

5. Shaping Regional Economies to Sustain Quality Work: The Cooperative Health Care Network
Peter Pitgoff  96

6. Quality Child Care for Low-Income Families: Despair, Impasse, Improvisation
Lucie White  116

7. The Health Care Puzzle: Creating Coverage for Low-Wage Workers and Their Families
Louise G. Trubek  143
8. Unemployment Insurance and Low-Wage Work
   *Lucy A. Williams*

9. Community-Based, Employment-Related Services for Low-Wage Workers
   *Joel F. Handler and Yeheskel Hasenfeld*

10. The Perils of Advocacy: Listening, Labeling, Appropriating
    *Kathleen A. Sullivan*

11. Afterword: What's the Globe Got to Do With It?
    *Fran Ansley*

About the Editors and Contributors

Index
The Cooperative Health Care Network

As stock offerings go, this was no standard Wall Street fare. The offerees were home health care aides—workers, and now shareholders as well, at Cooperative Home Care of Boston, Inc. (CHCB). Their employer is the offeror, a home health care company founded in 1995 in inner-city Boston. CHCB has provided its employees with focused training, quality jobs, ongoing support, and, in the summer of 1997, an ownership stake and further control over their work lives.

Eventually, as the business grows and achieves sufficient stability, the worker-owners will increase their role in governance and elect a majority of the company’s board of directors. Profits, although quite limited, will continue to be reinvested to ensure decent pay and benefits and will be allocated among the workers when possible. This focus on the quality of work is in sharp contrast to typical home care jobs, characterized by inadequate wages and benefits, inconsistent hours, no job security, and too little respect.

The home health care workforce typifies the world of low-wage labor markets, where so-called welfare reform in the late 1990s promises to make a difficult situation even worse. While experiencing daily the stress and turmoil of living at the economic margin, many of CHCB’s employees are working hard to distance themselves from welfare. Yet, unlike many others among the working poor or unemployed, they work in an institution that provides them a relatively safe and supportive space for the ongoing transition—or transitions—from welfare to work.

This chapter chronicles a creative response to social retrenchment, a saga of strategic deployment of accessible resources and a reshaping of regional economic forces for the benefit of targeted labor markets. While charting its own course, CHCB is part of a mutually supportive network of health care employers and trainers, including successful home care companies in Philadelphia and the South Bronx. Together, these three corporations form the core of the Cooperative Health Care Network and employ over 500 home health aides. About 80 percent of the employees were formerly dependent on public assistance. The network reflects a worker-centered model of enterprise development and employment training, offering sustained job opportunities for a predominantly female workforce, most of whom are African American or Latina. The model expressly links the quality of health care services with the quality of paraprofessional home care work—where a stable work force strengthens the enterprise in the health care market and better jobs are created in a growing low-wage labor market.

The network strategy involves women in the transition from welfare to work and provides them with ongoing training, counseling, career upgrading, and an opportunity for participation in ownership and governance of the home health care enterprises. An inspiring case study in its own right, the home care example gives rise to lessons for employers, low-wage workers, advocates, and federal and state policymakers at a fluid moment in welfare policy. The network experience is not easily replicated, certainly not in its entirety, and may be of limited relevance to strategies for the most distressed and least employable populations. But for the working poor and for unemployed people seeking work, it is an evolving strategy that will help inform public policy and private initiatives in the years to come.

One clear lesson from the home care experience is that the successful transition from welfare to work, rather than a single event, is a complex process that occurs over a period of time and that requires carefully crafted systems for ongoing support. Employers of low-wage workers can adapt selected elements of the network’s employment and training model to their own industries. Over time, government policies can reinforce these successful elements through effective public support to low-wage workers in transition from welfare. With respect to home health care workers, in particular, wage and benefit standards can be tied to a public health care finance system that has helped to create and maintain effective demand for a low-paid home care workforce.

Integration of sophisticated economic development and corporate finance with an underlying strategy to bolster a targeted labor market distinguishes the Cooperative Health Care Network from most welfare-to-work initiatives. As social entrepreneurs, theirs is a sectoral approach, aiming to upgrade the status of the home care workforce and achieving a leadership role as employers in regional markets for the home health care industry. That employer role and stature contributes to their credibility with businesses and policymakers and their ability to affect industry practice beyond their own enterprises. Add to this mix the worker ownership of network affiliates and the central role their employees play in corporate decision making, and the network’s collective voice includes the critical perspective of former welfare recipients and low-wage women workers.

This chapter begins with a brief examination of the home health care labor market, particularly in the context of welfare reform and work initiatives. It then describes the Cooperative Health Care Network as an employer-based strategy for employment training, job creation, and strategic intervention to reshape a wider economic sector. The chapter concludes with lessons learned from the
network experience and their applicability to other employer initiatives or to broader public policy.

Home Health Care Workers

As growing numbers of the elderly and disabled depend on paid workers for daily assistance, home health aides battle at the front line of health care delivery. They are paraprofessionals who operate near the bottom of a service hierarchy of physicians, nurses, social workers, and therapists. Most home health aides are women, many of them minorities, working for low wages and few benefits—contingent workers with no job security and few career opportunities. At the same time, they constitute a critical component of the expanding home health care industry.¹

Paraprofessional home care services are fragmented among a variety of job categories, including personal care workers and home attendants, as well as homemakers who receive little training and provide nonmedical services such as cleaning, cooking, and laundry. The network’s focus is instead on home health aides, who are required in most states to complete between 75 and 120 hours of training and to work under a nurse’s supervision. Home health aides provide, in addition to homemaker services, certain medical services defined by Medicare, such as bathing, wound dressing, monitoring of vital signs, and assistance with patient mobility. Much of the clientele is elderly, with acute or chronic care needs that can be addressed at home.²

As a strategic matter, the Cooperative Health Care Network works to organize within and transform a targeted labor market of home health aides, one of the fastest-growing groups of low-wage workers. In an expanding home health care industry, home care aides constitute the largest group of workers, and despite variations among different local labor markets, the overall number of home care workers is projected to increase substantially in the coming years.³ Moreover, in many urban areas, home health care is one of the few sources of paid work available to women with limited schooling or job experience.

A number of factors have led to an increased demand for home health care services, including the growing elderly population, the AIDS epidemic, increasing limitations on families’ ability to provide informal care to family members, and advances in technology. A leading factor is the rapidly escalating expense of institutional health care, driving hospitals to release patients as early as possible to reduce in-patient costs. Substantial government support for health care also helps to drive the industry. Public financing, especially through the Medicare system, accounts for roughly half of all expenditures for home health care services.⁴ The growth in home health care is attributable in part to revision of Medicare coverage guidelines following the 1988 federal court decision in Duggan v. Bowen,⁵ which resulted in Medicare payments for part-time or daily home health services for as long as an eligible patient requires such care.

Yet, such massive public subsidy for home health care has not generally translated into good jobs for home care workers. The typical home care aide is poorly paid and ineligible for employee benefits, such as health insurance. The work is often part-time and episodic, as many home care employers act as temporary help agencies, contracting with individuals from a pool of available aides and preferring flexible workers who can adapt to changing client caseloads. The work force is further atomized by the nature of the work, with individual aides traveling to patients’ homes and apartments and spending minimal time at the employer agency. Limited contact with co-workers, nurses, and service coordinators can lead to a sense of isolation, compounded by the physical and emotional strain of the work. These factors, combined with few opportunities for career advancement, contribute to high turnover and inconsistent quality of service in the home care industry. Clearly, from a managerial perspective, many home care employers have an interest in work-life improvements that would alleviate recruitment and retention problems, and “quality of work life programs” have been documented in a number of home health care companies.⁶ But, the structure of the political economy and underlying societal values reinforce the marginal status of the home care work force.

Our society views home health care as women’s work, and most home care workers are women. As in other gender-segregated labor markets, such as child care, employment growth at the bottom of the occupational hierarchy has channeled women into caregiving jobs deemed unskilled and underpaid. Yet, with circular reasoning, the “unskilled” label is often applied to such employment because of the predominance of women in the field—work that in fact requires skill and demands responsibility.⁷

The worker-centered companies in the Cooperative Health Care Network provide a direct challenge to society’s marginal view of gendered work. Rather than accepting caregiving as marginal, the network enterprises place home health care workers at the center of sophisticated economic activity. Not only does this approach help to make women’s traditionally invisible work visible, but it bolsters the stability and status of home health aides and the quality of their collaborative enterprise. Despite all the characteristics of home care work that typify low-wage labor markets, home care can be a motivating job as well. When coupled with an adequate support system, the upside of isolation can be autonomy, and the flip side of the emotional strain can be personal involvement and immediate feedback on the job. The network enterprises reinforce these motivating job characteristics with better pay, benefits, career opportunities, communication, and organizational support, along with worker involvement in decision making—all contributing to respect and a valued status for home care workers.

The network experience suggests expanded possibilities for poor women in transition from welfare to work and also counters common stereotypes of welfare recipients. The myth that welfare policies caused female-headed households to remain poor ignores real barriers to ongoing employment of the working poor. In
the rush to welfare reform, the assumption that dismantling the federal welfare system would lead to personal responsibility and work opportunity failed to account for lack of available jobs with adequate pay and benefits, huge gaps in health insurance and child care assistance, transportation barriers, continuing challenges of domestic turmoil, and other realities of life at the economic margin.

Changes in the welfare system, including new work requirements, will continue to strain already overcrowded low-wage labor markets. A flood of new workers competing for limited jobs, combined with workfare programs that place welfare recipients in jobs as a quid pro quo for their public assistance, creates downward pressure on wages and increased vulnerability of low-wage workers to economic downturns. The resulting demand for creative welfare-to-work solutions is giving rise to a wide range of private sector and nonprofit initiatives in employment training and placement. The most successful of these programs involve support services and extended involvement with participants beyond initial training and are closely coordinated with industries that hire low-wage workers. Evolving federal and state policies provide financial support for these programs, and with encouragement from the Clinton administration a number of large private employers have announced plans for hiring welfare recipients.

But despite notable successes, many efforts are unfocused and ineffective at placing people in decent and lasting employment. A counterproductive ramification of the 1996 changes in federal welfare law is a disincentive for state governments to support effective training programs. With pressure to reduce their welfare rolls, the incentive for states is to push as many public assistance recipients as possible, as quickly as possible, into quick-fix positions—workfare, work readiness courses, and part-time jobs at minimum wage—instead of more in-depth training programs that might lead to stable jobs. It is in this context that the network example sounds a useful counterpoint, with elements that could be instructive for public policy and private industry.

The Network and Enterprise Development

The Cooperative Health Care Network stands out as an unusually successful welfare-to-work initiative. As an employer-based strategy, the network’s approach combines sophisticated economic development with express social goals of creating quality jobs for workers and providing quality home health care for clients. The network currently consists of a nonprofit training and development corporation, three worker cooperative home health care companies, and a new managed care organization at a formative stage.

The network enterprises are profitable businesses that were carefully planned and developed with strong management, targeted market demand, and long-term equity capital. This alone is a concrete measure of success, particularly in the competitive and fluid health care market environment. From the outset, though, the business success was explicitly a vehicle to create better and more stable jobs in a growing low-wage labor market—to build a career ladder that enabled inner-city women to climb, rung by rung, from poverty to job training to a stable job and ultimately to lasting employment at a livable wage. The ladder extends even further, beyond the reach of most home care aides elsewhere, with the option of employee ownership and the potential for work in training, management, or other skilled jobs in health care. The network’s success in sustaining employment is built in part on a careful process of screening and training, consistent standards for worker performance, a substantial investment in ongoing support, and a worker-centered organizational culture.

The initial member enterprise, Cooperative Home Care Associates, Inc. (CHCA), began operations in the South Bronx in 1985. As a licensed paraprofessional home health care company, CHCA positioned itself in the market as a subcontractor of services to Medicare-certified home health agencies. It was founded as a community economic development project of the Community Service Society (CSS), a large nonprofit social service organization in New York City. CSS played an entrepreneurial role in the difficult start-up years, providing needed equity and management expertise. Two former CSS employees who conceived of the home care enterprise strategy stepped into key management roles early on, became employees and members of CHCA, and today help to lead a work force of over 350.

In terms of bridging welfare and work, one CHCA innovation was to place the training program at the site of the employer, offering industry-specific training to women on public assistance and the promise of a job to successful graduates. This on-site training model enables CHCA, as the employer, to control a structured process of recruitment, selection, and training—critical for building its desired work force, although clearly screening out many potential workers who cannot meet threshold standards for becoming quality caregivers. The training program, typically 4–6 weeks in length, embodies goals and expectations that are consistent with the host enterprise, and also contributes to a continuing corporate culture that provides in-service training and ongoing support to its employees.

In 1991, CHCA strengthened its training component by spinning off the Para- professional Healthcare Institute, Inc., a nonprofit organization that focused initially on CHCA’s entry-level training program. In short order, the institute supplemented this internal role with an external initiative to replicate CHCA’s success with start-ups in other urban areas. This led to the start-up of Home Care Associates of Philadelphia, Inc. (HCA) in 1993 and Cooperative Home Care of Boston, Inc. (CHCB) in 1995, both now operating as successful worker-cooperative enterprises and providing over 150 jobs for former welfare recipients. With foundation support, the institute acted as initial sponsor and developer in both start-ups—guiding local entrepreneurs in feasibility assessment, business planning, management recruitment and orientation, equity investment, and support for work force training. It continues to consult nationally to other home health care enterprises, some of which will join the network in years to come.
The institute, later renamed the Paraprofessional Healthcare Institute, Inc. (PHI), also serves as a site for exchange of ideas and mutual support among the three core home care enterprises, each operating in a different market and all of which are represented on the PHI's governing board. PHI will continue to nurture the emerging Cooperative Health Care Network as a broader association of home care companies, welfare-to-work trainers, and public policy advocates who share the goal of quality work for paraprofessionals in the health care industry.

The network's success at enterprise development distinguishes it from many other efforts at job training or at promoting transition from welfare to work. It has integrated its training program with a capacity to create and sustain employment opportunities and its social goals with savvy business planning and management skills. In terms of finance, the network has combined philanthropic support for its charitable and educational work with more conventional health care financing and revenue for its component business operations. The health care context was an early and strategic choice, not simply because of a growing low-wage labor market but also due to the huge cash flow of federal Medicare expenditures and the opportunity to apply those funds to worker and community development. The philanthropic support is in part a factor of the policy potential of such an innovative approach.

The network's sectoral employment strategy and labor-based model represent advances beyond conventional approaches to community-based economic development. In recent decades, much of the economic activity of community development corporations has concentrated on creating affordable housing, with substantial subsidized financing available. Community efforts to create employment for the urban poor have tended toward neighborhood-based resource-delivery strategies—channeling finance and other resources into a narrowly defined geographic area and among a variety of industries and small businesses. In contrast, the network's approach identifies the problem of urban joblessness not simply as a lack of resources but as the absence of marketplace relationships as well. Thus, with sophisticated business planning and management expertise, it has penetrated deeply within a single industry, selected in terms of a regionally defined labor market rather than a narrow geographic neighborhood.

This sectoral strategy has targeted a particular labor market that employs many low-wage women, with the concrete objective of reshaping that market in selected regions. In order to influence the quality of entry-level jobs accessible to inner-city women, the network's enterprises have intervened as employers inside the home care industry, competing on the basis of quality and helping to raise employment standards in local markets. Characterizing themselves as "yardstick corporations" against which other companies can measure their employment practices, the network enterprises provide better pay and benefits than most of their competitors and have achieved a rate of employee turnover that is roughly half the 40 percent industry average. The companies' "investment" in the front line work force, rather than weakening their competitive position, has contributed to a reputation for high-quality service. They have nurtured a worker-centered corporate culture, instead of viewing workers as fungible employees, and thus have equated better working conditions with an improved bottom line. By building on the connection between the quality of work for home care aides and the quality of care for their clients, the network enterprises have translated individual responsibility and self-worth into organizational strengths.

A critical component of this sectoral approach is that each of the core enterprises is engaged in a web of regional relationships, in the marketplace as well as the political arena. Early on, for instance, CHCB staff conducted orientation presentations to caseworkers at all six Boston welfare offices, stressing job opportunities and high selection standards. The company continues to work with these public agencies and with community-based organizations, both for recruitment and as advocates for employees in transition from welfare to work. Similarly, CHCA leadership worked with historically antagonistic players in the New York home care industry—other providers, unions, legislators, regulatory authorities, and consumer advocates—to boost Medicaid reimbursement rates in 1989, arguing and demonstrating that better work conditions can lead to greater reliability and quality of care. A year later, this unlikely coalition produced a report calling for standardized job titles for home care workers, uniform training and certification, reforms in government oversight, and a client complaint system.

This external strategy, defined with reference to a selected low-wage labor market, is complemented by a worker-centered internal culture and legal structure. Each of the three network home care companies is a worker cooperative, a for-profit corporation owned and controlled by its employees. In a worker cooperative corporation, each worker has the opportunity to obtain a membership share for an affordable fee, ordinarily paid in modest installments after completion of an initial trial period of employment. Share ownership gives each member the right to one vote in shareholder voting, including election of the board of directors, and a right to a portion of corporate profits allocated to members on the basis of their work in the cooperative. When a member leaves the job for whatever reason, the company redeems her membership share in exchange for her original fee, plus any accrued but unpaid dividends and, in some cases, reduced by corporate losses allocated to equity shares.

The worker-elected board makes organizational policy decisions and oversees management. Senior managers retain substantial discretion to make day-to-day operational and personnel decisions, and to guide the board in longer-term planning. But, the worker participation in governance helps to reinforce a corporate culture that respects all workers, wherever they may be in the management hierarchy. It encourages greater psychological ownership and job commitment and creates a safer space for the difficult transition from welfare to work. This worker-centered organizational culture includes a range of informal or ad hoc supports—a supervisor helping an employee resolve a problem with her welfare caseworker,
peer group encouragement to maintain work standards, constructive responses to breakdowns in child care or transportation, and so on.

The network affiliation provides some shelter from the harsh market environment for health care enterprise. The Paraprofessional Healthcare Institute, systematizing the entrepreneurial function, was the controlling owner of the Philadelphia and Boston home care companies during the difficult start-up years, playing much the same role as the Community Service Society played a decade earlier in start-up of the Bronx cooperative. This trusteeship period allows the institute to take much of the financial investment risk in the early years, extending ownership to the workers after the enterprise has achieved some stability and value in the home care market. Majority control shifts to the worker-owners over the course of several years, after which the institute retains a minority equity stake and continues to participate in governance.

This balance between enterprise self-management and mutual support among network affiliates has enabled the enterprises to build on their common experience while responding to different local market conditions. Health care finance is substantially subsidized through Medicare for the elderly, and the network's collective experience has helped to build relatively stable enterprises within this finance and regulatory system. At the same time, the regulatory environment and the health care industry are changing rapidly and driving many health care providers toward managed care, including mergers and consolidations of numerous institutions. Medicare cuts and other regulatory changes, combined with private sector adjustments to managed care, are causing upheaval in home health care labor markets. The near-term result is growth in some regional markets and no growth or even shrinkage in others. Bureaucratic changes associated with welfare reform, meanwhile, have disrupted recruitment networks for home care workers. Each of the three network cooperatives has responded to these changes, with strategies tailored to its local market.

In Boston, for instance, saturation of the inner-city market suggests that CHCB might need to expand its regional base in order to continue its growth and job creation. This presents a challenge to the cooperative culture of the organization, as CHCB explores affiliation with other home care providers and faces a more scattered work force from neighboring cities. CHCB is also exploring diversification of its training component—training health care paraprofessionals other than home health aides, such as certified nursing assistants, and coordinating the placement of these successful trainees in jobs at hospitals and nursing homes. In planning, CHCB is drawing in part from the Philadelphia experience of HCA, which already has established an external placement program.

In response to home care market limitations in Philadelphia, HCA diversified its services to include training and placement of some workers at other institutions. Its Trial Placement Program combines up-front job training with job placement that includes three months of intensive job coaching. Trainees must complete an eight-week job-readiness program focused on workplace comportment, problem-solving skills, and job-specific health and clinical skills, resulting in certification as home health aides or certified nurse assistants. Successful trainees are then placed temporarily in full-time positions at a mental health facility, nursing home, hospital, or clinic. The first three months of employment are a trial period during which the worker is employed by HCA, with HCA in turn paid by the host company and the worker receiving intensive job coaching and guidance from HCA. After the trial period, either the host company makes a permanent job offer or HCA places the worker at another company or back at HCA as a home health aide. As in Boston, this program has the potential to disperse the workers and thus undermine the cooperative culture of HCA, but it has increased the company's ability to promise decent jobs for its trainees.

In the Bronx, CHCA and the institute are confronting the health care industry changes head-on by forming a specialized managed care organization for chronic and severely disabled residents of New York City. The broader health care market is in an unprecedented period of turmoil and restructuring, with health care providers attempting to reduce costs through consolidation and new managed care groupings. Government budget cutting and changes in Medicaid and Medicare funding are helping to accelerate the rush to managed care, a model that enables providers to contain their risk of open-ended and costly services.

Massive consolidation in the industry is placing far greater power into far fewer hands and buffeting the less powerful players who are unable to join forces and compete. With the shape of managed care networks driven by hospitals, physicians, health maintenance organizations, national service providers, the Federal Health Care Finance Agency, and private insurance plans, home health care providers stand on shifting ground and face an uncertain future. In response, many home health care organizations are consolidating or forming alliances to gain leverage in negotiating larger volume contracts, and mergers and acquisitions in the home care industry reached record numbers in 1996.12

The newest network affiliate, Independence Care System, Inc. (ICS),13 takes that response a step further by shaping the home care market environment more directly and essentially building an institution that assures a flow of quality work for CHCA. ICS is a managed care group, with a management team assembled by the institute and core participation by three New York-area health care organizations—the Institute for Urban Family Health as the lead provider for primary care physicians, the Visiting Nurse Service of New York as the provider of professional home nursing, and CHCA as the paraprofessional home care service provider. Additional organizational relationships will strengthen and expand the capacity of ICS—Concepts of Independence assisting clients in consumer-directed personal care planning, five major hospitals (Montefiore, Bronx Lebanon, Beth Israel, Mt. Sinai, and Lenox Hill) available for in-patient services, a number of social work organizations (including the Independent Living Centers, the Brookdale Center on the Aging, and the International Center for the Disabled).
providing specialized services, and other service providers for such matters as substance abuse treatment, dental care, pharmacy, and adult day care.

This vertical integration will increase stability of CHCA's home care enterprise at such a fluid moment in the health care industry, securing a market for a projected 1,000 home health aides. In a comprehensive and flexible manner, ICS intends to integrate the full range of primary care, specialty care, hospital care, nursing home care, home care, and social support services for a targeted clientele with severe disabilities throughout New York City. With paraprofessional home care aides in a central role, ICS furthers the goal of redefining the relationship of home care workers with other health care professionals, particularly with doctors and nurses. The result will be a managed care initiative that values the paraprofessional role and presents more career advancement opportunities for low-income women. This stands in dramatic contrast to the relatively weak position of home care providers that contract with integrated vertical systems organized by hospitals, with physician groups, or with national companies emerging in the new era of managed care.

Policy Implications

The network's move into managed care signals a bold strategic turn and a new phase of an inspiring saga. Yet, since its inception in 1985, Cooperative Home Care Associates and its progeny have appeared in profiles and reports as somehow unattainable or inapplicable to other community development settings. The elements of success—visionary leadership, skilled business management, institutional and philanthropic support, a burgeoning and federally subsidized labor market, democratic worker ownership, a worker-centered organizational culture, a mutually supportive network, and intense collaborative work for over a decade—presumably would all need to be part of a successful replication. Transposing particular elements of the enterprise model without others arguably would have limited results in different circumstances. One of the founders likened CHCA in the past to a gem, significantly valuable while intact but of considerably less value in smaller pieces chipped away.

But context is critical, and the convergence of welfare reform and health care reform has made the network experience more relevant to other employers and more timely with respect to public policy than ever before. Moreover, the network enterprises have evolved as respected and seasoned employers in the home health care industry. They can draw valuable lessons from their experience, for welfare-to-work policies and for employers of low-wage workers.

Fueled by election year politics in 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act. This version of welfare reform eliminated Aid to Families with Dependent Children (AFDC), the long-standing federal guarantee of minimal cash benefits to poor families with children. The Act shifted responsibility to the states for assisting the poor by replacing AFDC with a capped block grant program known as Temporary Assistance for Needy Families (TANF). Of particular relevance to employers of low-wage workers, the Act directs states to require adult TANF recipients to work after two years on public assistance (with a five-year lifetime limit) and to meet overall work participation rates for TANF recipients—provisions likely to cause severe crowding in already strained low-wage labor markets. Nothing in the Act, however, addresses the paucity of quality jobs available to those on public assistance and the obstacles faced by the working poor in sustaining employment.14

The Cooperative Health Care Network can speak first-hand about the role that an employer plays in helping people move from welfare to work and about how to respond to increasing pressure to hire former welfare recipients.15 The network experience underscores the need for an effective welfare-to-work training program to be in a marketplace position to guarantee a decent job for successful training graduates. The training itself must be linked to job-specific skills and knowledge, while also helping people to become socialized to the world of work and to develop problem-solving and communication skills. The transition from welfare to work may require a realignment of an individual's social system, which is more likely to succeed with a cohort of peers in the workplace making that change in concert and with some training and supervision by others who have succeeded in their own similar transition. Ongoing support for employees in the network enterprises is customized by those who know first-hand what type of support is required.

The success of the network as trainers and employers also depends upon careful initial screening and high standards for training and work performance. Some of those recruited never make it past the initial interview, for reasons ranging from drug abuse problems to an inability to show up when scheduled. Others may fail the training or the initial on-the-job trial period for lack of the required sensitivity, maturity, judgment, and caring required of a good home health aide. Still others drop out of the training or the job for personal reasons or crises at home. The bottom line, then, is that only a fraction of those who express an interest in working in one of the cooperative enterprises will become permanent members. Thus, while lessons from the network experience are applicable in other settings, its model targets a particular and more employable band of the working-poor spectrum, leaving to others the question of how to craft policies and initiatives that support more distressed and troubled people.16 To survive as employers, the enterprises demand that workers continue to meet well-defined rules and standards in exchange for the guarantee of a decent job. Exceptional efforts at communication and support help to nurture an organizational culture that reinforces this exchange and where peer enforcement of standards may even be more pronounced than management dictates.

If the transition from welfare to work requires the availability of decent work, then employers are essential to any policy prescription for welfare reform. The network has demonstrated the advantage of tying training programs directly to
the ultimate employer or at least to an industry-specific intermediary in tune with the needs of employers. Thus, a public policy to move people permanently from welfare to work should reward certain employer-based transition programs—providing subsidies to companies that guarantee a decent job for all successful training participants and that maintain those jobs for a defined period of time.

A public policy for subsidies to employers dances dangerously close to the “corporate welfare” so widely criticized in other contexts. Employer subsidies for hiring low-wage workers, in fact, have been roundly criticized in recent years. The Targeted Jobs Tax Credit (TJTC) provided federal tax incentives to employers of low-wage and disadvantaged workers from its enactment in 1978 until it expired in 1994. Preceding the TJTC program’s termination, the Inspector General’s Office of the Department of Labor conducted a program audit, concluding that employers who took advantage of the tax credit in hiring low-wage workers would have hired most of these workers even without the tax incentive. Retroactive certification that employees were part of the targeted group, for instance, led many employers to identify and certify workers already on their payroll. The audit also confirmed that most jobs obtained with TJTC incentives were near minimum wage, part-time, and without benefits.

Nonetheless, after a two-year hiatus, Congress enacted the Work Opportunity Tax Credit (WOTC), essentially reinstating the expired TJTC, albeit with several significant changes designed to address problems of the prior law. Retroactive certifications are no longer permitted, with employers now required to determine in advance which newly hired employees meet the criteria for subsidies. In response to criticism that the tax credits merely created an employer windfall without leading to long-term employment, the WOTC increased the minimum employment period for subsidized employees from 90 to 180 days. Finally, compared to the prior law, eligible categories of employees were narrowed and the amount of the credit was reduced slightly. Criticism of these incentives continues, both from employers who want fewer restrictions and from employee advocates who call for narrower targeting.

In the wake of the 1996 federal welfare legislation, the WOTC was extended to eligible employees hired before July 1998 and might be extended further in the future. It is supplemented by two other tax credit incentives for hiring poor people. First, Congress enacted a Welfare-to-Work Tax Credit in 1997 for employers who hire long-term welfare recipients before May 1999. Second, the empowerment zone employment credit has been in effect since 1993. Until its expiration in 2005, the empowerment zone employment credit provides employer incentives for hiring employees who live and work in a federally designated “empowerment zone,” which is typically a distressed inner-city locale. HCA in Philadelphia is exploring the creative use of these tax credits to leverage outside investment and to encourage private-sector collaboration with their worker-centered enterprise. This strategy echoes the widespread use of low-income-housing tax credits by nonprofit developers who, over the past decade, have capitalized affordable housing construction by syndicating tax credits through limited partnership structures. With respect to the work credits, HCA would draft relationships with local governments and other community providers in a way that maximizes the utility of the tax credits, draws needed capital to the worker cooperative venture, and encourages other health care providers to collaborate with HCA.

As a supplement to the work opportunity and empowerment zone tax credits, the 1997 Congressional budget agreement added some $3 billion for a new block grant program to help states build a welfare-to-work transition system for long-term welfare recipients. At the state level, a variety of “grant diversion” programs have channeled funds for individual welfare benefits to employers instead, in order to partially subsidize private sector jobs for welfare recipients. Over a dozen states experimented with such grant diversion programs prior to the 1996 federal welfare legislation, pursuant to federal waivers, and the new TANF block grants will lead to more such efforts in other states in the years to come.

The network experience suggests that employer incentives should be limited to those who provide effective training and the guarantee of a decent job for all successful training participants. Economic studies have shown that more holistic policies, combining wage subsidies with job development and training, have been somewhat successful in improving the employment and earnings of specific targeted groups. Federal and state governments should integrate disparate policies that affect low-wage workers and ensure that the transition from welfare to work is not more punishing financially than remaining on welfare. In general terms, for instance, public assistance recipients should be permitted to keep a larger portion of cash, food stamp, child care, and Medicaid assistance during the early stages of employment, with continuation of modified health coverage and other support for the working poor. Over time, an expanded Earned Income Tax Credit can continue to help make work a rational and feasible choice for the poor.

A clear policy lesson for successful welfare-to-work initiatives is that job opportunities for the poor should “make work pay,” offering employment with a livable wage and decent benefits. In addition to the minimum wage laws, federal and state laws have long governed a wide range of employer-employee relations, with baseline standards regarding work hours, health and safety, discrimination, and the right to organize. But more narrowly crafted public policies should address the current crisis of increasingly crowded low-wage labor markets, through employment standards attached to government subsidies or contracts, and through tailored public assistance to the working poor.

In Massachusetts, for example, CHCB has combined its role as an industry employer and an advocate for better work standards by joining in a strategy to secure health insurance coverage for all home health aides. With wages close to the poverty level, many home health aides already are eligible for federal Medicaid coverage for family health insurance. But as the jobs improve, with higher wages and more consistent hours, income limits for Medicaid coverage create a
pervasive incentive for home care aides and their employers to limit the number of hours worked in order to maintain Medicaid qualification. Even as Massachusetts has increased the family income limit for Medicaid coverage to 133 percent of the poverty level and has expanded coverage further for children, many home health aides continue to fall outside the Medicaid eligibility criteria.

In conjunction with the Massachusetts Council for Home Care Aide Services, an industry association, CHCB has argued that the state government should create a demonstration project that targets Medicaid coverage categorically to all home care workers. Given the large number of home care workers whose wages are directly or indirectly controlled by government reimbursement policies, such as Medicare, public dollars have helped to create and maintain this low-wage labor market. Medicaid coverage, the argument goes, should attach to this reimbursement system—to the benefit of the workers, who would receive medical insurance, and to the benefit of the employers, who would be better able to retain qualified workers without bearing the high cost of private insurance.25

On a much larger scale, the federal government can play a pivotal role in ensuring basic wage and benefit standards for home care workers. The federal government is the nation’s largest funder of health care, providing billions of dollars annually to private health care providers through Medicare and Medicaid. This public funding drives much of the home care industry, as these providers rely on government funding to hire paraprofessionals in home care agencies. Arguably, then, the federal government has unintentionally created a low-wage labor market of home health aides, consisting predominantly of women from poor communities.26

The federal role in creating and sustaining the home care labor market suggests an opportunity as well for a government role in improving the labor standards for home care workers. The federal government can attach wage and benefit standards to the receipt of public tax dollars, in this case requiring that all employers who receive Medicaid and Medicare funding comply to livable wage and benefit floors for their low-wage paraprofessional employees. Some of the direct cost could be federally supported, as through expanding Medicaid coverage or other individual public benefits to home care workers. Other costs, however, would be borne by employers who themselves profit from federal health care finance subsidies.

Several prevailing wage laws provide precedence for tying wage and benefit floors to contracts funded by the federal government. Although they share a common purpose—providing a wage floor for employees of government contractors—the two main federal prevailing wage laws apply to different sectors: the Davis-Bacon Act applies to the construction industry and the Service Contract Act (also known as the O’Hara-McNamara Services Act) applies to providers of services.27 Both use the concept of a statutory wage floor based upon the prevailing wage in a given locality, rather than an across-the-board statutory minimum wage. They also apply narrowly to particular government contracts, not more generally to Medicare or Medicaid reimbursements. Nonetheless, the long history of government regulation of labor standards of its contractors by attaching conditions to federal money provides useful precedent for advocates of wage and benefit floors in the government-funded home health care field.

In 1993, President Clinton’s failed attempt at health care reform occasioned a number of hearings and reports on the potential economic and employment impact of his proposals.28 Similarly, in crafting the policy rationale for attaching wage and benefit standards to federal health care finance, an interim step is to document the role that government plays in creating low-wage jobs. In other contexts, such as immigration or international trade, legislative changes have required labor impact assessments by the General Accounting Office or other federal agencies. The Department of Labor and the Department of Commerce are required, for instance, to report to Congress on the jobs impact of the North American Free Trade Agreement. On a larger scale, several failed attempts in Congress during the 1990s would have required an economic and employment impact statement for all significant federal legislation.29

Documentation of the government role in maintaining a low-wage labor market in home care would lay bare the marginal economic status of health care paraprofessionals. Assessing the impact of Medicare and Medicaid cuts and of the TANF-driven flood of low-wage workers is likely to show this low-wage labor market squeezed even further. Such documentation would be especially informative if it were sufficiently refined to measure quality—wages, benefits, hours worked, work load, and so on—in addition to overall quantity of jobs.

Illinois took a similar, although modest, step in the context of the child care industry. A 1996 law directed the state Department of Human Services to present an annual survey of average wages and benefits paid to caregivers throughout the state and recommendations for increasing wages to ensure quality care for children. With respect to chore housekeeping and homemaking services under contract with the state, Illinois requires that a set percentage of the rates is pays, and thus of any rate increases, must be allocated to direct-care workers in wages and benefits.30 In 1996, the Massachusetts legislature appropriated $14 million to fund a wage increase of up to 4 percent for direct-care workers, earning less than $20,000, employed by providers of homemaker or personal care services to the elderly or by human service providers under contract with the state.31 Modest as these policy initiatives may be, they suggest the potential for targeted work standards on a larger scale.

Conclusion

The experience of the Cooperative Health Care Network foreshadows a changing policy context, particularly the dismantling of the long-standing federal welfare system. Although public assistance to the poor will take shape at the state level, and the federal role will continue in some form, low-wage labor markets will be
defined increasingly without reference to the current welfare regime. "Transition from welfare to work" becomes a less meaningful phrase for advocates of the working poor.

The network today identifies its major pool of labor from the welfare rolls, and it has received deserved attention as an exemplary model of a welfare-to-work program. But the network's strategy maintains its integrity apart from the welfare system. It is fundamentally an economic development approach driven by social values—an employer-based sectoral strategy to create quality jobs for workers and to upgrade the status of the home health care workforce, to provide quality home health care for clients and to demonstrate the capacity of poor working women for sophisticated enterprise.

The complete story of the Cooperative Health Care Network is yet untold. Its successful track record will be severely tested in the years to come, with dwindling public support for the working poor and consolidation of managed care in the health care industry. A measure of success will be not just survival but, as a collaborative yardstick enterprise, the extent to which its lessons and values influence others in the health care industry and in the public policy area. The linkage of quality health care with quality of work for the frontline caregivers is a powerful message applicable to many segments of health care delivery and generalizable to employers in other industries. Public policies, beyond today's welfare system, can draw from the network's experience by promoting the creation of decent jobs and by crafting support systems built upon an understanding of the complex and challenging transition from poverty to lasting work.

Notes

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7. The CEO of Cooperative Home Care of Boston captures in the most personal terms the essence of the serious responsibility of home care aides. Before sending a home health aide to provide health care services to a client, he queries: "Would I trust this person to care for my mother?" For an extended discussion of caregiving work and feminism in the context of child care enterprise, see Peter Pitegoff, "Child Care Enterprise, Community Development, and Work," The Georgetown Law Journal 81 (1993): 1897, 1920-29. See also Suzanne Gordon, "Feminism and Caregiving," American Prospect (Summer 1992): 119, 120. The enormous scale of federal Medicare subsidies, maintained in part by a powerful lobby for senior citizens, enables the network to pursue an enterprise and job development strategy for home health aides that would be more difficult in the context of other caregiving industries—such as child care—that enjoy lesser public subsidies or political support.

8. Among the more successful welfare-to-work programs are the Center for Employment Training (San Jose, CA), America Works (New York, NY), Project Quest (San Antonio, TX), and Project Match (Chicago, IL). With respect to private employer welfare-to-work initiatives, see Hilary Stout, "Clinton Hopes Success of Chicago Bus Operator Will Spur More Firms to Hire Welfare Recipients," Wall Street Journal, January 10, 1997, p. A12.


18. 26 U.S.C.S. section 51. The Work Opportunity Tax Credit was enacted as section 1201 of the Small Business Job Protection Act of 1996 (the minimum wage legislation), 104 P.L. 188, 110 Stat. 1755 (1996). The amount of the employer tax credit under the WOTC is generally up to 35 percent of the first $6,000 paid to an eligible employee, or $2,100. Despite a promising introduction of the new law, many employers have expressed frustration and disappointment with its utility in sustaining jobs for former welfare recipients; see, e.g., Rochelle Sharpe, “Great Expectations: A Tax Credit Designed to Spur Hiring Seems Promising—at First,” Wall Street Journal, August 21, 1997, p. A1.


