

OREGON'S CARE ECONOMY

THE CASE FOR PUBLIC CARE INVESTMENT

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ABSTRACT

In this paper we make the case for a comprehensive public policy approach to addressing Oregon's care gap by enabling family members to care for loved ones without economic penalty and ensuring paid caregivers are able to provide high quality care without compromising their own well-being, while all people receive care who need it. We describe Oregon's care economy; outline the serious weaknesses of our current care infrastructure for children, seniors and people living with disabilities; provide evidence of the high economic returns to public care investments; and point out that the most successful care investment programs simultaneously address the needs of over-burdened unpaid care providers, the high cost and uneven quality of paid care, and significantly increase the care workers' wages.

ACKNOWLEDGEMENTS

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TABLE OF CONTENTS

1	EXECUTIVE SUMMARY
7	SEEING THE INVISIBLE, VALUING CARE
9	OREGON'S CARE ECONOMY
20	STRESS EVIDENT IN THE CARE ECONOMY
27	THE ECONOMIC CASE FOR GREATER PUBLIC CARE INVESTMENT
33	TOWARD A STRONGER CARE ECONOMY: WHAT NEXT
34	TECHNICAL NOTES
36	REFERENCES
39	ENDNOTES

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EXECUTIVE SUMMARY



SEEING THE INVISIBLE, VALUING CARE

The Oregon care economy is largely unseen and underinvested, creating a weaker, less inclusive economy; insufficient care; and hardship for Oregonian families and caregivers. **Oregon's care economy includes all care labor, both paid and unpaid. That includes all of the work involved in taking care of children and seniors, as well as care and support for people living with physical, intellectual and developmental disabilities,** whether by unpaid caregivers, or paid caregivers in public, private and non-profit contexts.

The care economy **includes all public investment in and support for care.** Programs aimed at supporting families in their provision of unpaid care, such as paid family leave, training and education for caregivers, respite care and stipends to mitigate hardships for people providing intensive care for family members with disabilities in their home, are all elements of the care economy.

It **includes all public and private investment in direct care provision,** such as Head Start child care, and public subsidies for child care and Employment Related Daycare (ERDC), adult day programs, residential and homecare care for seniors and people with disabilities, as well as accommodations and support for care offered by employers, such as nursing rooms, on-site child care, care referral, and paid days off for family care. **It includes Oregon's families' resources of time and money** invested in purchasing and/or providing care and support.

Oregon's current care economy is vast and largely invisible. Currently underinvested, it creates and exacerbates poverty and inequality, while a strong care infrastructure would reduce poverty and inequality. We are missing the opportunity to invest adequately in the care economy in order to build a stronger, more inclusive economy and better life for us all.



In Home Health Services (working for agencies)

\$10.93/hr
median wage

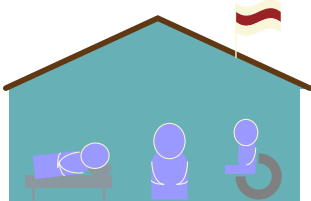
37%
have health insurance through work



In Private Household Services (working directly for clients)

\$9.34/hr
median wage

30.7%
have health insurance through work



In Long Term Care (nursing homes & residential care facilities)

\$10.81/hr
median wage

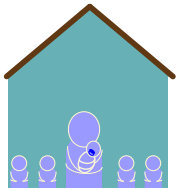
48.9%
have health insurance through work



Child Care Workers (providing care in clients' homes, ie. 'nannies')

\$9.77/hr
median wage

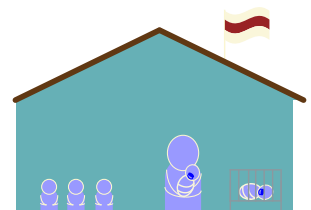
30.5%
have health insurance through work



Family Child Care Providers (care for children brought to provider's home)

\$5.58/hr
median wage

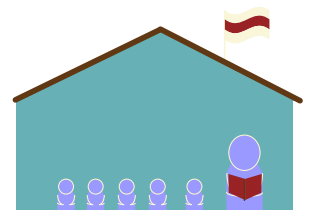
27.5%
have health insurance through work



Child Care Workers (at child care centers)

\$9.30/hr
median wage

45.3%
have health insurance through work



Preschool Teachers (in child care centers, does not include schools)

\$11.07/hr
median wage

59.9%
have health insurance through work

Source: 2014 data, see Table 2, page 13

OREGON'S CARE ECONOMY

This report seeks to bring care work into view. Our definition of care is inclusive and broad, drawing together arenas that are often thought of separately, when they are thought of at all. **HERE, THE CARE ECONOMY REFERS TO ALL LABOR IN THE SUPPORT AND CARE OF OTHERS INCLUDING CARE WORKERS WORKING WHO ARE PAID AND FAMILY MEMBERS WHO ARE NOT.**

Our definition includes the care needed in the very first days of life and that required by those in their waning years. We extend our definition from nurturing and education at the start of life to support for a secure quality of life of those with chronic conditions or different abilities, and also to the intimate care required by those who can no longer decide what care they need.

Oregon's paid care workforce consists of more than 70,000 at any one moment in time, and is expected to grow rapidly as our population ages. This is likely a conservative measure of paid work in care, as census figures may not capture the entire care workforce.

Earning roughly \$10 per hour, paid caregivers—nearly all women and disproportionately women of color—are seriously underpaid for the essential work that they do and the skills they bring. Far too many must rely on public benefits like food stamps just to make ends meet.

Most in-home, paid care workers have recently gained minimal labor rights and protections in Oregon and a few other states, but some people providing in-home elder care remain uncovered by basic labor law. The very highest workplace injury rate reported by the US Bureau of Labor Statistics is for state-run nursing and residential care facilities workers and injury rates may be even higher for in-home elder care positions.

Alongside this substantial and poorly compensated paid care workforce is a legion of unpaid care workers. A very conservative **measure suggests that unpaid care generates the equivalent of 167,000 full-time care jobs a year inside families in Oregon.** That's time spent caring mostly for young children, without accounting for activities categorized as cooking or cleaning that are part of caring, or on-call supervision. Even when very narrowly defined, women appear to provide at least twice as much unpaid care as men do. Low-income caregivers, women, people of color, people caring for their spouses/partners, and older caregivers are working particularly long, unpaid hours providing elder care.

STRESS EVIDENT IN THE CARE ECONOMY: HIGH CARE COSTS, HIGH WORKFORCE TURNOVER, UNMET NEEDS

The cost of care is extremely high. The median annual price of toddler care in an Oregon child care center was \$11,976 in 2014. Child Care Aware America found Oregon to have the second least-affordable

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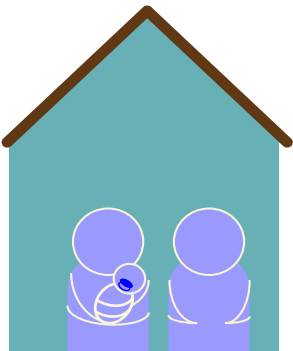
\$14,000

price per year for infant care in Oregon (2014), which means...



51%

of median income for the average single parent family needed for infant care costs



15%

of median income for the average two-parent family needed for infant care costs

center-based infant care of any state, and fifth least affordable center-based care for four-year-olds.

Full-time, center-based infant care for one child cost 51 percent of median income for single parent Oregon families for 2014, and 15 percent of median income for married-couple families, in stark contrast to the federal benchmark for “affordable” child care of 10 percent of family income.

The private market for long-term care for seniors and people living with disabilities or chronic health conditions can also be prohibitively expensive. Medicaid provides almost half of the non-family funding for long-term care, but only to those who have exhausted their assets and income.

High costs of all types of care have pushed many into lower cost, and often lower quality, alternatives. Many households piece together sometimes unreliable family or neighbor care, or simply drop paid work hours altogether. **TOO MANY GO WITHOUT CARE AT ALL. MORE THAN ONE IN TEN US CHILDREN AGED 5 TO 14 TAKE CARE OF THEMSELVES REGULARLY** during the week, including 5 percent of kids aged 5- 11, for an average of 5 hours a week. Of the world’s wealthiest countries, the 40 OECD nations, 32 have a markedly higher proportion of 3-5 year-olds enrolled in formal care or preschool than the US.

Even though the cost of care is high, the quality of care jobs is low. Care workers earn extremely low wages and many rely on public benefits to make ends meet. Low job quality generates high turnover in care jobs, which undermines the quality of care. Indeed, low employee turnover is a

widely accepted proxy for quality in care work. One in five child care workers left the field in 2012. Turnover of long-term care workers on average was over 60 percent annually in 2013, 90 percent for caregivers of adults with developmental disabilities.

These problems of affordability and job and care quality will not solve themselves. The need for care is projected to grow substantially in the near future. Oregon's Office of Economic Analysis predicts that the population 65 and older will grow by half by 2020, as compared to 2011. According to a recent Oregon Department of Human Services report, it will be difficult to recruit and retain the paid care workers needed for elder care if wages and working conditions are not improved.

THE ECONOMIC CASE FOR GREATER PUBLIC CARE INVESTMENTS

There is a strong, well-documented, economic case for systematic and significant public investment in care. Care investments generate stronger economic growth; strengthen families and communities; and promote equity.

CARE INVESTMENTS PROMOTE GENDER EQUITY. Women provide far more unpaid care than men do, hurting their overall lifetime earnings, increasing their poverty rate and poverty among families supported by women, and creating high rates of poverty among women in old age. Not only do parents – especially mothers – work fewer hours as a result of their caregiving responsibilities, but employers assume that they might work fewer hours, and therefore promote men over comparably or better qualified women. Stronger care infrastructure would help reduce gender disparities.

CARE INVESTMENTS PROMOTE RACIAL EQUITY AND SUPPORT LOW-INCOME FAMILIES. Women of color are disproportionately represented in poorly paid care work so improving their jobs closes the wage gap. People in low-income households – disproportionately women and people of color – too often go without care they need, receive care of poor quality, and live in families particularly burdened by both unpaid care and care expenditures disproportionate to their incomes. Improving care infrastructure would support and strengthen these families.

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Securing a decent standard of care requires fundamentally and dramatically reshaping our understanding of what care work is, what it is worth, and how to pay for it.



CARE INVESTMENTS PROMOTE ECONOMIC

GROWTH by increasing labor force participation of unpaid caregivers, boosting earnings, lifetime incomes, reducing poverty, and increasing tax revenues. More and better care for seniors and people living with disabilities reduces emergency room visits and health care expenditures.

THERE'S A SIGNIFICANT LONG-TERM PAYOFF TO HIGH QUALITY, EARLY CHILDHOOD CARE.

Children who receive high quality care have been shown to do better in school, earn more and require less social assistance later in life.

Securing a decent standard of care requires fundamentally and dramatically reshaping our understanding of what care work is, what it is worth, and how to pay for it. The workers providing care must be valued, not venerated as saintly or ignored as servants, but prized as workers who serve the public interest. Families need to be supported in their caring – able to provide care at critical moments, able to afford care for loved ones, secure in the quality of the care. All of that will require serious, and public, investment.

TO CHANGE THE CARE ECONOMY, THE STATE OF OREGON MUST INVEST RESOURCES DIRECTLY

INTO IT. For that investment to pay the highest returns economically and socially, it should be through comprehensive programs that support unpaid caregivers; make paid care more available, accessible, affordable, and culturally appropriate; and employ paid caregivers with wages and working conditions that allow for dignity, comfort and access to care themselves. With significant and smart investment, Oregon can build a stronger care economy.

SEEING THE INVISIBLE, VALUING CARE

Care work is essential and invisible, private and public, paid and unpaid, denigrated and revered.

It is essential because it makes decent life possible for those who need hands beyond their own to thrive. It is the most fundamental underpinning of society, community, and family.

Even so, care is often invisible because the gritty labor of helping, supporting, and nurturing those who need it is intimate, personal, and ongoing. Care is invisible to many during the parts of their lives when they do not need or provide it. But for many others, care is invisible because they are constantly at it, needing or providing care in every waking moment.

As structured in the United States, care work is intensely private, provided in intimate and personal spaces, and paid for by individuals in private markets. At the same time, the substantial public interest and investment in the sector is pervasive and evident. Care is not just a private event but a public good, which benefits the entire community rather than simply the individuals involved.

PUBLIC INVESTMENT IN CARE IN THE US IS GENERALLY INDIRECT, COMPLEX, AND ENTIRELY INADEQUATE IN SCALE. Most of the work is done by family members “for free,” and yet the US family policy is uniquely weak among developed nations, with no national paid family and medical leave program to support families with new additions or other intense care demands, meager public nursing support for newborns, very little publicly provided child care, inadequate health care for part-time employees, and only partial support for the elderly and people with disabilities.

When care work is paid it is performed by a disregarded workforce—nearly all women, and disproportionately women of color—employed in some of the fastest growing and lowest paying jobs in the economy. Their “priceless” work, of such critical importance to families, rarely offers more than miserable wages and poor benefits.

This report seeks to bring care work into view. Our definition of care is inclusive and broad, drawing together arenas that are often thought of separately, when they are thought of at all. Here, the care economy refers to all labor in the support and care of others including care workers working who are paid and family members who are not. Our definition includes the care needed in the very first days of life and that required by those in their waning years. We extend our definition from support to secure quality of life of those with chronic conditions or different abilities and the intimate care required by those who can no longer decide what care they need.

*To change the care economy,
the state of Oregon must
invest resources directly into it.*



It's unwieldy, perhaps, to embrace so much diversity: care paid and unpaid, care for the young and old, and care and support spanning all levels of health and ability, **BUT CARE IS A BIG, COMPLEX PART OF OUR ECONOMY, SOCIETY AND LIVES, AND A HOLISTIC APPROACH IS NEEDED TO CONCEIVE A COMPREHENSIVE POLICY PROGRAM. ALL OF US REQUIRED AND RECEIVED CARE AS CHILDREN. NEARLY ALL OF US WILL NEED IT AT SOME POINT AGAIN, WHETHER DURING ILLNESS, DISABILITY OR OLD AGE.** And nearly all of us have provided or will provide care, and worry about the kind of care and support our loved ones are able to secure. This care economy is essential to the very foundation of our families, our relationships, and security and prosperity in Oregon. By bringing it all together, we intend to make it visible, which is a critical step toward valuing it, and investing in those values.

Securing a decent standard of care requires fundamentally and dramatically reshaping our understanding of what care work is, what it is worth, and how to pay for it. The workers providing care must be valued, not venerated as saintly or ignored as servants, but prized as workers who serve the public interest. Families need to be supported in their caring – able to provide care at critical moments, able to afford care for loved ones, secure in the quality of the care. All of that will require serious, and public, investment.

To change the care economy, the state of Oregon must invest resources directly into it. For that investment to pay the highest returns economically and socially, it should be a comprehensive program that supports unpaid caregivers; makes paid care more available, accessible, affordable and culturally appropriate; and employs paid caregivers with wages and working conditions that allow for dignity, comfort and access to care themselves.

OREGON'S CARE ECONOMY

Defining the care economy is no simple task. Care work – paid and unpaid – is often invisible, or in the shadows of formal structures. What is not seen is rarely counted. Even so, we use the best data we can to help bring care into focus. We use an inclusive definition of the care economy embracing both paid and unpaid care work at all ages and levels of ability in those who are cared for, educated, and supported.

IN OREGON'S PAID CARE ECONOMY, WE ARE REFERRING TO ORGANIZATIONS, INCLUDING GOVERNMENT AGENCIES, AND FACILITIES PROVIDING CARE, AND THE SUBSTANTIAL WORKFORCE OF HEALTH AND CHILD CARE PROVIDERS DOING HANDS-ON CARE WORK. We include those workers who provide direct care and support for seniors, whether in their own homes or in residential facilities such as nursing homes. We also include those workers who support the independence of those with physical, intellectual and developmental disabilities. And we include the entire child care workforce providing care to babies, toddlers, preschoolers and school-age children in the state.

Though working in long-term care is quite different than working in a child care, we group these positions together here, as researchers are increasingly doing, to highlight what these jobs share: these jobs are essentially human and interactive. They require compassion and skill, and are physically and emotionally demanding. The care families need from these providers often surpasses what many families can afford, and yet the people doing the work are compensated with very low wages and benefits. To close the gap between affordability and job quality in these fields, public investment is critical – but has so far been inadequate to meet the needs of both providers and consumers.

On the unpaid side, we include the care that happens every day within families when family members take care of loved ones. This includes the care involved in raising children from the intense early years and on. We also mean to include the work that many do taking care of and supporting the independence of ill, elderly or disabled relatives and friends. This care is not often counted as “work”, but it is – and provides great economic benefit to our communities when done well.

It is important to note that data on care are imperfect. Even on the paid side, where jobs are defined and more federal survey data are available, there are reasons to suspect that care work is undercounted. The more informal the work, the less likely it is to be reported in standard surveys on work. We know this is a sector with a range of formality and more gray market edges than many.

To close the gap between affordability and job quality in these fields, public investment is critical – but has so far been inadequate to meet the needs of both providers and consumers.

For this reason, the estimates of the size of the paid care workforce are conservative estimates of the size of the sector. On the unpaid side, the data questions are even more evident and precise measures unavailable at the state level. We present here the best approach to the best data available.

PAID CARE WORKERS IN OREGON

There are about 70,000 workers providing care in different sectors to hundreds of thousands of residents in the state of Oregon. Roughly 36,000 work for institutions and agencies that provide health care services to the elderly in facilities and homes. The state supports another 20,000 workers who work directly for clients' in their homes. Another 14,000 workers provide child care and early education to thousands of babies, toddlers and other preschoolers across the state.

HANDS-ON HEALTH CARE WORKERS: The state of Oregon has more than 57,000 workers providing frontline, hands-on health care. In 2014, the Oregon Department of Human Services (DHS) found 36,000 care workers employed by institutions and agencies.¹ Key sectors for this workforce include nursing facilities (with 7800 workers), residential care facilities (with 9500 workers), adult foster care homes (6100 workers), assisted living facilities (4600 workers), and health care agencies providing in-home care (4700 workers).² An additional 20,000 home care workers are paid by the state to work directly with clients in their homes. According to September 2014 data from the state DHS, that direct pay workforce of 20,000 was made up of 7688 personal support workers and an additional 12,682 home care workers.

CHILD CARE WORKERS: Child care employs some 14,000 Oregonians. This group consists of about 9000 child care workers in centers and in homes and roughly 5000 preschool teachers and assistant teachers (see below for further distinctions between family child care providers, workers employed at child care centers and child care providers working at clients' homes).



Table 1

EMPLOYMENT AND WAGES OF CARE WORKERS, OREGON, 2004 - 2014

Care Work Sector	Care Work Occupation	# of Workers 2004	# of Workers 2014	Median Hourly Wage 2004 (2015 dollars)	Median Hourly Wage 2014
Child care	Child Care (excluding preschool teachers and assistant teachers)	4,805	8,895	\$10.39	\$10.90
	Preschool teachers	4,753	5,199	13.20	13.50
Hands-on health Care	Home health Aides	7,492	5,151	11.52	11.09
	Personal care aides	5,331	19,347	11.49	11.19

Source: Occupation Profiles provided by State of Oregon Employment Department. See technical note for details.

Table 1 shows the official statistics provided by the State of Oregon Employment Department for a subset of these care jobs in 2004 and 2014. While these occupational data do not encompass the complete care workforce, given the turnover in the care workforce and the informal nature of some paid care arrangements, these data makes a few things clear. First, these jobs are growing. Note especially the strong growth of the personal care aides, an occupation which nearly quadrupled over 2004-14 and is among Oregon’s top ten jobs for projected increases in the coming ten years.³ And second, note that wages in these sectors were very low ten years ago and, taking inflation into account, remain very low today.

JOB CHARACTERISTICS AND WAGES OF CARE WORKERS

Care workers in Oregon receive wages that are close to the floor of the labor market, just barely above the state minimum wage. To get a sense of wages and demographics of the Oregon care workforce, we turn to the American Community Survey data from the federal Census Bureau. Table 2 shows that hourly wages for care workers fall in the \$9 to \$11 per hour range.

Family child care providers are the exception here. Their wages are substantially lower with a median wage of around \$5.60 an hour for the work in their own homes caring for children other than their own. These wages are below the minimum wage, but this is possible (and, in fact, common across the country) as in-home providers are running businesses and hence not “employees” that must be paid at least the minimum wage. However, the State is an important actor in this market, both as a regulator and source of subsidies, and bears some responsibility for low pay in it.

The median wage for care occupations in all settings taken together is just \$10.29 per hour, or \$20,580 annually if people are able to work full-time for 50 weeks a year.

The median wage for care occupations in all settings taken together is just \$10.29 per hour, or \$20,580 annually if people are able to work full-time for 50 weeks a year. In 2014, Oregon's minimum wage was \$9.10 per hour, so care workers in Oregon earn at or just above the state's wage floor. Only three occupations—preschool teachers in child care centers, in-home health aides, and health aides (including nursing aides, etc.) in long-term care facilities—have averages above \$10 per hour. Generally speaking, care work done inside homes pays less than care in institutional or center type settings.

One bright spot in Oregon that should become more evident in the data in future years is the rising wages of in-home care providers as a result of unionization. The contract in 2014 provided a wage of \$13 per hour and benefits for the in-home workforce of home care and personal support workers. As noted in the literature, unionization can improve wages and working conditions for in-home care workers and for family daycare providers, particularly where the State serves as “the employer of record.”⁴

“I recently left one of the most highly regarded child care centers where I had been working for several years. I started out as a student and over time advanced in position. I was eventually offered a permanent job. Unfortunately, even though I'd hoped early childhood development was the career path for me, I had to turn the offer down because I would not have made enough money to support myself. Every other staff member that I knew there needed a second income to be able to support their family. If we expect to have well trained professionals coming in to this field then we need to make it a more desirable field including decent compensation. This is not babysitting. We need to change the mindset to understand quality childcare is curriculum based, intentional education. Improving pay for childcare providers would go a long way toward creating greater stability for the workers and for the families they serve.”

- Lindsay

Table 2

WAGES AND JOB CHARACTERISTICS FOR OREGON CARE WORKERS, 2014

Care Work Sector	Industry/Site of Care Work	# of workers	Median Wage (2015 dollars)	% with health insurance through work	% who worked 50 weeks or more in past 12 months	Median hrs/week worked ALL workers in industry
Hands-on Health Care Workers	<i>In Home Health Services (i.e., home health and personal care aides working for agencies, etc.)</i>	5,364	\$10.93	37.0	68.1	35
	<i>In private household services (i.e., home health and personal care aides working directly for clients)</i>	2,341	9.34	30.7	73.1	30
	<i>In Long Term Care (i.e., in nursing homes, residential care facilities)</i>	16,909	10.81	48.9	69.8	38
Child Care	<i>Child care workers providing care in clients' homes (i.e., "nannies")</i>	1,960	9.77	30.5	47.8	30
	<i>Family child care providers (care for children brought to provider's home)</i>	1,072	5.58	27.5	87.2	40
	<i>"Child care workers" at child care centers</i>	6,908	9.30	45.3	52.4	30
	<i>"Preschool Teachers" in child care centers (does NOT include those in schools)</i>	4,779	11.07	59.9	66.6	38
All Care Workers Combined		39,333	10.29	45.4	65.7	36
All Workers in Oregon		1,646,210	17.29	64.4	74.6	40

Source: Author's calculations using 2010-2014 American Community Survey (5-year estimates). Working population considered is civilian, non-institutionalized labor force ages 18-64. See technical note for details.

Wages paid to care workers are so low that they are far more likely than US workers as a group to be eligible for public benefits, even when they work full-time.



Steady work can be hard to secure in care sectors. Family child care providers are the only subsector where a large share of the workers (87 percent) work for 50 weeks or more during the year. For all other subsectors, the share of workers with year round work falls around 70 percent or lower, and, in the case of child care workers providing care at clients' homes, much lower (48 percent). Positions in child care may be for the school year only; in-home care workers piece together work for multiple agencies or employers, requiring time-consuming, unpaid commutes between jobs and work that's intermittent, rather than year-round. This means that these jobs can provide only low incomes, not only because wages are low but also because hours and weeks of work may be low as well. For those who work year-round, however, weekly hours of work are also close to full time (40 hours).

Finally, as with most low-wage jobs, care jobs come with weak benefits. The lack of health insurance through employment is evident in Table 2. Benefits for the care workforce in homes are rare: less than 37 percent of in-home workers gets health insurance through their work. For workers in child care centers benefits are more common, but only 60 percent get health insurance through employment. In long-term care, only half of workers get health insurance through their job.

Wages paid to care workers are so low that they are far more likely than US workers as a group to be eligible for public benefits, even when they work full-time. Child care workers nationally were nearly twice as likely as the US workforce as a whole to be in households enrolled in the federal Earned Income Tax Credit (EITC), the Children's Health Insurance Program (CHIP), food stamps or the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). Nearly two-thirds of child care workers in families receiving benefits worked full-time.⁵

DEMOGRAPHICS OF CARE WORKERS

Care work is women’s work in Oregon as in the nation, as shown in Table 3. More than nine of every 10 workers in child care are women. Women hold more than 80 percent of hands-on health care positions as well.

In some subsectors, care work is disproportionately the work of women of color. Almost three of every 10 family child care providers and almost one in five child care workers employed at child care centers in Oregon are Hispanic. Nearly 15 percent of health care providers at long-term care facilities are Hispanic as well. In these sectors, Hispanics’ share of jobs exceeds their statewide

Table 3

DEMOGRAPHIC CHARACTERISTICS OF CARE WORKERS IN OREGON, 2014

Care Work Sector	Industry/Site of Care Work	Female (%)	Hispanic (%)	Black, non-Hispanic (%)	Non-citizen (%)	High School (%)	Some college (%)	AA or more (%)
Hands-on Health Care Workers	In Home Health Services (i.e., home health and personal care aides working for agencies, etc.)	87.1	9.1	3.9	6.9	34.2	37.8	18.4
	In private household services (i.e., home health and personal care aides working directly for clients)	81.8	7.0	2.6	3.4	35.8	33.9	19.4
	In Long Term Care (i.e., in nursing homes, residential care facilities)	85.5	14.7	4.5	9.3	32.8	39.8	15.7
Child Care	Child care workers providing care in clients’ homes (i.e., “nannies”)	97.5	8.4	0.0	8.4	22.0	45.7	23.1
	Family child care providers (care for children brought to provider’s home)	98.3	27.8	0.0	8.0	31.5	28.8	21.1
	“Child care workers” at child care centers	90.9	19.5	5.2	10.6	30.4	35.7	25.8
	“Preschool Teachers” in child care centers (does NOT include those in schools)	96.7	15.3	2.2	8.4	11.7	33.1	50.1
All Care Workers Combined		88.7	14.4	3.8	8.7	29.6	37.6	22.8
All Workers in Oregon		47.7	11.8	1.6	8.0	22.5	28.9	40.0

Source: Author’s calculations using 2010-2014 American Community Survey (5-year estimates). Working population considered is civilian, non-institutionalized labor force ages 18-64. See technical note for details.

Key Finding: Oregon’s care workforce—including child care workers and direct care workers supporting seniors and people with physical and developmental disabilities—numbers 50,000 and is growing rapidly. Earning roughly \$10 per hour, these workers—nearly all women and disproportionately women of color—are seriously underpaid for the essential work that they do. Only a substantial public commitment to these workers and a significant public investment in their jobs will make decent care and decent jobs a reality.

share of jobs (12 percent). The proportion of African American workers in the state is significantly smaller, but African Americans are over-represented in care work as well.

The longstanding occupational segregation of this work and its ongoing connection to “free” labor provided by women in the unpaid sector is one factor that keeps wages down. Discrimination these workers face—for reasons of race, gender, and ethnicity—means that care workers may have fewer external options.⁶ In these ways, the demographics of the workforce are intimately linked to its low wages.

The legacy of centuries of sexism and racism lives on in the devaluation of caregiving work due to its association with women, especially women of color. Care providers and other domestic workers, as well as retail, service and agricultural laborers, were explicitly left “uncovered” by the 1938 Fair Labor Standards Act forfeiting for them the right to be paid the minimum wage or overtime, participate in Social Security, and be subject to limitations on minimum and maximum hours.⁷

Remedial action in states like Oregon and recent federal executive orders have brought an end to most, but not all, of these exclusions, yet the history of weak labor standards for care workers is still evident in low wages and few non-mandatory benefits. Oregon’s *Domestic Workers’ Bill of Rights* just went into effect in January, 2016, requiring overtime for caregivers working in their employers’ homes.⁸

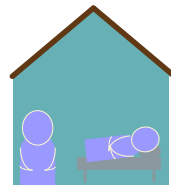
However, there is more to be done. People employed directly by households are still considered to be “companions” for the elderly or people with disabilities, and in this status remain outside the protection of labor law to enforce standards on minimum wage, overtime pay, and rest breaks and sleep time.⁹

Given the very low wages of care jobs, one might expect the education level of the workforce to be low, as earnings rise with education levels, on average.¹⁰ This is not the case. Overall, more than one-in-five care workers has completed post-secondary degree (at the Associates level or higher). Most notably, half of Oregon’s preschool teachers, hold an AA or more, a level of education that exceeds the state workforce. In spite of greater education in this occupation, preschool teachers receive a median wage of \$11.07 per hour compared to more than \$17 per hour for the overall workforce.

These jobs are also frequently very demanding, mentally, emotionally and physically. Few people realize that the injury rates for workers in state-run nursing and residential care facilities are by far the highest of any industry in either the public or private sector.¹¹ “Home care workers employed through state governments have an astronomically high incidence of injury...more than fifty times the national average for all workers,” though injuries sustained from lifting adults without the help of a second person or a mechanical lift can be reduced by training.¹²

UNPAID CARE IN OREGON’S CARE ECONOMY

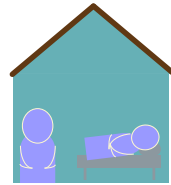
Turning now to the unpaid side of Oregon’s care economy, data and definition problems are much more substantial. There are no standard sources to count unpaid caregivers or hours of unpaid care provided at the state level. Indeed, the exact boundaries of what should count as “care” in the unpaid sector are simply hard to draw. The most evident care is the time spent by parents raising and nurturing children



In Home Health Services (working for agencies)

\$10.93/hr
median wage

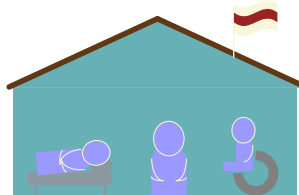
37%
have health insurance through work



In Private Household Services (working directly for clients)

\$9.34/hr
median wage

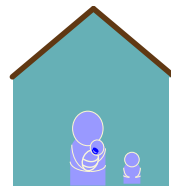
30.7%
have health insurance through work



In Long Term Care (nursing homes & residential care facilities)

\$10.81/hr
median wage

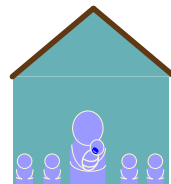
48.9%
have health insurance through work



Child Care Workers (providing care in clients’ homes, ie. ‘nannies’)

\$9.77/hr
median wage

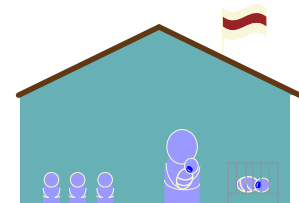
30.5%
have health insurance through work



Family Child Care Providers (care for children brought to provider’s home)

\$5.58/hr
median wage

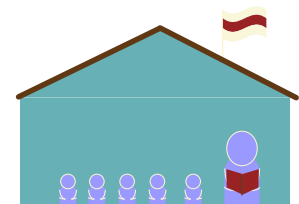
27.5%
have health insurance through work



Child Care Workers (at child care centers)

\$9.30/hr
median wage

45.3%
have health insurance through work



Preschool Teachers (in child care centers, does not include schools)

\$11.07/hr
median wage

59.9%
have health insurance through work

Source: 2014 data, see Table 2, page 13

Over the course of a year, unpaid care in Oregon accounts for nearly one-half a billion hours of work. This unpaid care work is equivalent to the hours of work provided by 167,000 full time jobs.



from their earliest days. Grandparents, siblings, and other relatives are also a part of the picture of uncompensated care for children. But if a parent cooks or goes shopping with a young daughter, is that care or a household chore? Is all “awake time” spent with an infant “care”? What about time checking in on an elderly relative or taking him out for a meal? In part because it is hard to define exact boundaries of unpaid care and also because data series are inattentive to unpaid care, we simply do not have good state level data about what care is going on.

To get a sense of the scale of unpaid care in Oregon, we turn to the American Time Use Survey. This allows for a conservative estimate for total time spent by families providing unpaid care for children or other relatives in the state. The survey asks about time spent in different sorts of care. We take respondents’ reports of time spent providing care to children or other relatives and estimate time spent in Oregon on the basis of national care estimates. Reported time spent caring for the young or for other household adults are the two categories of care we look into.

THESE CARE TIME ESTIMATES ARE DEFINED VERY CONSERVATIVELY. Time spent caring for children or household adults is included but not supervisory care of adults in the household, care provided while also doing chores, and chores undertaken as part of care, such as shopping or telephoning on behalf of another adult in the house who cannot perform these activities themselves. Data is based on time use reported for a single, specified day only, which may not be representative or capture activities that are not performed daily.

The scale of unpaid care is impressive, even conservatively measured. Table 4 shows that one in four women (25 percent) and fifteen percent of men engage in care for children as a primary activity each day. On average, these women spend more than 2 hours a day on care. Men spend just under 2 hours a day on care. It is no surprise, but for parents engaged in the care of children, their work is a quarter-time job in addition to their paid work.

Table 4

ESTIMATED TIME SPENT PER DAY IN UNPAID CARE WORK, OREGON, 2015

	Average percent of the population engaged in care each day	Average care hours per day for persons who care	Population 18 years and over	Number of people engaged in care	Total hours care
<i>Caring for and helping household children</i>					
Men	15.6	1.46	1,524,647	237,845	347,254
Women	25.6	2.16	1,586,877	406,241	877,480
<i>Caring for and helping household adults</i>					
Men	4.8	0.64	1,524,647	73,183	46,837
Women	6.4	0.62	1,586,877	101,560	62,967
<i>Total Oregon Hours Care/Day</i>					1.334 Million
<i>Total Hours Care/Year</i>					487.1 Million

Women are more likely to provide care and spend more time doing care work than men.

Care for other relatives inside households is both less common and less time consuming than care for children. Still, one-in-twenty adults spends some time providing care to household adults and, for those care providers, adding another 0.6 of an hour of care time. Because chores undertaken for adults who do not live in the household are captured as a care activity, men’s contributions to elder care are captured more accurately than are women’s, as men are more likely to perform chores in support of relatives who do not live in the household, which are counted as elder care, while women more often perform chores on behalf of seniors living in the household, which are not counted as elder care.¹³

Assuming that care time in Oregon reflects national time use estimates, the final columns in the table estimates the number of Oregonians engaged in care and the total hours devoted to care. Oregon households engage in more than one million hours of care every day. The vast majority of the 1.33 million hours of care work each day is with the state’s children, but substantial work caring for household adults is evident as well. **OVER THE COURSE OF A YEAR, UNPAID CARE IN OREGON ACCOUNTS FOR NEARLY ONE-HALF A BILLION HOURS OF WORK.** This unpaid care work is equivalent to the hours of work provided by 167,000 full time jobs. The Oregon unpaid care economy is greater than three times the size of the paid care economy, even by this extremely conservative estimate.

The table also shows that unpaid care is dominated by women: seven of every ten hours of unpaid care is provided by women. Notably, unpaid care is less feminized than paid; women account for 89 percent of the paid care workforce in the state.

STRESS EVIDENT IN THE CARE ECONOMY

HIGH CARE COSTS, HIGH WORKFORCE TURNOVER, UNMET NEEDS

There is evidence of significant strain in Oregon's care economy in both the paid and unpaid sectors. For families, costs of care are high, and many simply cannot afford the quality or quantity of care that they and their loved ones need. In spite of prohibitive costs, the paid care workforce suffers the stress of very low wages and benefits. Poor remuneration creates conditions that generate high levels of turnover in the care workforce, which negatively impacts both workers and those in their care. For many families, costs that are prohibitively high mean they simply go without care, leaving children and seniors who may need support, guidance, and care fending for themselves. All of this is evidence that the Oregon care economy is underfunded and underinvested. Families can't afford the quality and quantity of care that is best; workers can't afford to stay in the jobs.

HIGH CARE COSTS STRETCH FAMILY BUDGETS

The most significant evidence of stress generated by the undervalued care economy is the high cost of care. Most care is a private good in the US, meaning that families are largely on their own when it comes to the cost of care. This is especially true for the care of kids before they reach school age. And the costs of care for young children are high. Oregon families pay nearly three-quarters of the cost of supporting our state's child care system, while the federal government picks up 19 percent of the cost and the State of Oregon just 9 percent. Subsidized child care in Oregon is available only for low-income families, and only for a fraction of them.¹⁴

Until children start school, the cost of child care is prohibitive for many Oregon families. The cost of care at the 75th percentile is shown in Table 5. We show the 75th percentile because it is the state's maximum for subsidies. Even moving away from the high end to the middle of the child care market, the median price of center based toddler care is \$11,976 per year.¹⁵ Considering that cost, many families balk, seek lower-cost (and sometimes lower-quality) alternatives, piece together sometimes unreliable family or neighbor care, or simply drop paid work hours.

Table 5

OREGON CHILD CARE MONTHLY PRICES, FULL TIME CARE AT THE 75TH PERCENTILE, 2014

	Infant	Toddler	Pre-School
Center	\$1219.00	\$1200.00	\$890.00
Large Home-based	\$960.00	\$910.00	\$810.00
Small Home-based	\$600.00	\$600.00	\$550.00

Source: Deana Grobe and Roberta B. Weber. 2014. "2014 Oregon Child Care Market Price Study" Oregon State University Family Policy Program, Oregon Child Research Partnership, p.12, <https://www.oregon.gov/DHS/ASSISTANCE/CHILD-CARE/Documents/2014-Market-Rate-Study.pdf>.

The average full-time, center-based infant care for one child cost 51 percent of median income for single parent families for 2014 in Oregon. That is simply unattainable even with full-time, year round work. That cost is 15 percent of median income for married-couple families. High costs mean that the very families that could most gain from decent and stable care cannot afford it, exacerbating inequality in the state from the very first years of life.¹⁵

This problem is only growing. Nationally, the cost to households purchasing child care has risen seventy percent – after adjusting for inflation – since the Census Bureau began collecting these figures in 1985 until the most recent data available for 2011. **CHILD CARE COSTS REPRESENTED 30 PERCENT OF THE INCOME OF FAMILIES BELOW THE POVERTY LINE WHO PAID FOR CHILD CARE.**¹⁷

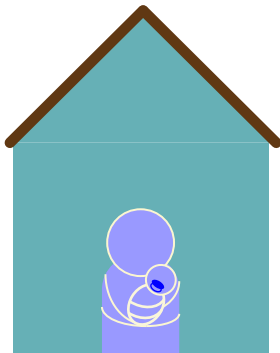
For long-term care of the elderly and disabled, public investment is more evident and accounts for a greater share of total expenditures. Still, many families find that loved ones need more care than their Medicare or Medicaid programs will allow. In these instances, families turn to the private market where costs are higher and where there are very few ways to measure and ensure quality.

Further, when needs are most intense and an elderly relative needs to move into residential long term care, families find they need to spend down all assets before a loved one can qualify for Medicaid. Only people whose income is less than 133 percent of the poverty line and whose assets are at most \$2,000 – apart from a house and car – are eligible for Medicaid-paid long-term care.

For long-term care of the elderly and disabled, public investment is more evident and accounts for a greater share of total expenditures. Still, many families find that loved ones need more care than their Medicare or Medicaid programs will allow.

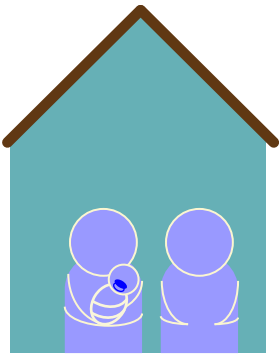
\$14,000

price per year for infant care in Oregon (2014), which means...



51%

of median income for the average single parent family needed for infant care costs



15%

of median income for the average two-parent family needed for infant care costs

States are directed to take the house to recover Medicaid expenditures after death, unless the surviving spouse or a caregiving child is living in it.¹⁸ Severe financial stress for surviving spouses has led to new Medicaid “spousal impoverishment” policies to allow people who relied on Medicaid to pay for nursing home care for their spouse to retain up to \$119,220 in assets, in 2016.¹⁹

Still, assets carefully nurtured over the course of life can disappear in the midst of stressful decisions about care needs and care quality, a particular burden for working and middle class families that reduces their ability to pass along any of their lifetime savings to their children and widens the wealth inequalities for the next generation.

LOW WAGES LEAD TO HIGH TURNOVER AND LOWER QUALITY CARE

Even while costs of care can be prohibitive, the pay for care work is so low that turnover in the sector is very high. This is true in both child care and in hands-on home and residential care.

In child care, turnover rates are significant. Some 20 percent of the 2012 workforce in regulated child care in Oregon were not working in the field in 2013. Only 53 percent of child care centers retained 75 percent or more of their teachers from 2012 to 2013.²⁰ The foundation of quality care is the stability and connection between a child and the provider of the care. Turnover rates at these levels undermine children’s ability to thrive. Children have been shown to develop better language skills, be more sociable and exhibit fewer behavior problems if they have close relationships with caregivers, which requires continuity.²¹

The problem of turnover is even more pronounced in long-term care. Long-term care providers surveyed in 2014 reported turnover of 64 percent in the care workforce: nearly two of every three workers in long-term care were replaced in a single year.²² Higher rates of turnover in residential long-term care correlate with negative care outcomes, such as increased risk of pressure sores.²³ For those who need care and support in their own homes or residential settings, these high rates of turnover in long-term care can generate anxiety and reduce stability, piling an additional source of stress on families that are often already stretched quite thin.

The quality of care – regardless of the age or ability of the consumer – is directly related to the quality of the relationship between the worker and the consumer. That relationship is disrupted (more accurately, destroyed) whenever a care worker leaves and must be replaced. Indeed, “turnover rates are often used as an indicator of quality of care.”²⁴

FOR THIS REASON, HIGH TURNOVER IN CARE WORK IS EVIDENCE OF STRESS IN THE SYSTEM: stressed workers who leave their jobs; stressed care providing employers that must refill jobs at what can seem like a revolving door; and stressed recipients of care, who must rebuild relationships in the chaos of the churn.

UNMET CARE NEEDS TODAY, GROWING DEMAND IN THE FUTURE

With private costs high and growing and family income stagnant, too many simply go without care they need. This is documented nationally with regard to children. More than one in ten US children aged 5 to 14 take care of themselves regularly during the week, including 5 percent of kids aged 5- 11, for an average of 5 hours a week.²⁵



Wages and the Quality of Care

Over twenty five years ago, the Department of Defense started to compensate some child development workers taking care of the children of service members and other military personnel, as they did other positions with similar training, experience and seniority. Pay rose by 76 percent and turnover plunged.* The result is not only better jobs, but higher quality care.†

*Whitebook, M., Phillips, D., & Howes, C. (2014). *Worthy work, STILL unlivable wages: The early childhood workforce 25 years after the National Child Care Staffing Study*. Berkeley, CA: Center for the Study of Child Care Employment, University of California, Berkeley, p.38.

†Smith, L., & Colker, L., 2001. *Making It a Reality: An Infrastructure to Attain High-Quality Child Care*. *Young Children*, 56(3), 78-85. Retrieved from <http://www.jstor.org.proxy.lib.pdx.edu/stable/42727957>

Low-income caregivers, women, people of color, people caring for their spouses/partners and others with whom they live, and older caregivers are working particularly long, unpaid hours. Half of caregivers report that they have no choice but to provide the care they do.



Further, the public investments in care in Oregon do not reach all those who qualify for them. According to the most recent data available from the Oregon Child Care Research Partnership, only 16 percent of Oregonian children eligible for child care subsidies are served (15,046 of 79,285 eligible).²⁶ Head Start programs have proven, strong positive effects on children lasting into adulthood, but the program reaches just 26 percent of Oregonian children eligible for it, including only 6 percent of those eligible for Early Head Start.²⁷

Of the world's wealthiest countries, the 40 OECD nations, 32 have a markedly higher proportion of 3-5 year olds enrolled in formal care or preschool than the US. In Belgium, France and Spain, preschool or formal child care is universal, and even in 11th-ranked Great Britain, the proportion enrolled is over ninety-three percent.²⁸

For older adults, the evidence of unmet need is similar. The AARP's most recent report on caregiving in the US found that of the nearly 20 percent of Americans over 18 provide care for adults and/or children with disabilities and spent 24 hours per week providing that care. (Three quarters of the time, those unpaid care workers are taking care of an adult over 50.) One in four of these caregivers were spending more than 40 hours a week, with significant impacts on their work, health, and finances.

Low-income caregivers, women, people of color, people caring for their spouses/partners and others with whom they live, and older caregivers are working particularly long, unpaid hours. Half of caregivers report that they have no choice but to provide the care they do. The caregivers facing a "high burden" of care (40 percent of caregivers) are helping with an average of half the tasks of activities of daily living including toileting and

bathing, three-quarters of the instrumental activities of daily living, and coordination of medical care.²⁹

The AARP reports that four-in-ten unpaid caregivers feel highly stressed by their caregiving. **NEARLY ONE-IN-FIVE, 18 PERCENT, SAY THEY ARE HIGHLY STRAINED FINANCIALLY BECAUSE OF CAREGIVING.**³⁰ MetLife estimates that employer-paid health care costs are as much as 8 percent more for employers of people providing elder care, due to the negative impact of caregiving on the health of unpaid caregivers.³¹

The need for care in the future is projected to grow substantially. The baby boom is aging and life expectancy is growing which guarantees the forecast. This “silver tsunami” will increase the proportion of American adults over 65 from one in six to one in four by 2030. The share of adults 85 and over will grow from 2.3 percent to 5.3 percent by 2050.³²

In 2012, Oregon’s Office of Economic Analysis forecast that the growth rate of the elderly population would be more than 4 percent a year for nearly ten years, so that by 2020, the cohort of people 65 and older would grow by half, compared to 2011.³³ **THE AGING AND DISABILITY CASE LOAD WAS EXPECTED TO INCREASE BY 10 PERCENT DURING THE '15-'17 BIENNIUM ALONE.³⁴ AND CARE WORK WILL GROW IN RESPONSE: OVER THE NEXT TEN YEARS, BOTH NURSES AND PERSONAL CARE AIDES ARE IN THE TOP TEN OCCUPATIONS IN PROJECTED JOB GROWTH.³⁵**



US Chamber of Commerce

Private Initiative for Elder Care

The US Chamber of Commerce Eldercare Program provides 10 days of paid leave for family illness regardless of family member’s age, and a Back-up Care program through a employer vetted vendor to provide subsidized in-home care for elderly adults at a rate of \$6 per hour for up to 20 days.*

*National Alliance for Caregiving for ReACT, “Best Practices in Workplace Eldercare,” March 2012

Families are defined by care but also frustrated by it. Many are unable to afford it and feel stretched to the breaking point trying to fill in the gaps, balance work and family needs, and feel secure in the care they do buy. Without a significant public investment in the care economy, these frustrations will only grow.

HIGH COSTS, HIGH TURNOVER, UNMET NEEDS LEADS TO HIGH FAMILY STRESS

There are substantial costs to the underinvestment in our care economy. These costs are often borne indirectly, but are quite real.

Many Oregon families struggle to make their way forward when the care loved ones need is unaffordable or unavailable. The stress of balancing demands of heart with the cold calculus of pay and the cost of care is especially intense when babies are very young and when family members are in sudden decline. Unpaid caregivers pay the cost, with lower incomes, worse health and financial stress. Employers absorb the price of lost days and on-shift distraction of workers worried about family members. Care workers pay with economic insecurity and turbulent workplaces. Children, seniors and adults with disabilities all pay by receiving too little care and lower quality care than necessary. These costs are being paid by individual families and affect Oregon's overall economic health. A stronger system of care would require investment, but would also reduce these costs.

“My problem is when my main worker is ill, and they send another worker and they have not been trained for my daily needs or direct care I need. It makes me feel disrespected since I have to explain to them my daily needs when the company should have trained the worker according to my needs. I had to call an on-call worker and had to have someone on-call until they were able to find a new worker. “

- Sherry

THE ECONOMIC CASE FOR GREATER INVESTMENT IN CARE

The economic case for systematic and significant public investment in care in Oregon and elsewhere in the US is very strong. Care investments can promote equity, generate stronger economic growth, and strengthen families and communities. Evidence comes from international comparisons demonstrating that more developed care infrastructure supports economic equity and economic growth. Evidence also comes from innovations in child and health care models inside the US. On net, the evidence shows that care is an investment with many winners: employers, workers, parents of the young, relatives of the old, sick, infirm, or disabled, and care workers. Building a stronger care infrastructure is an effective economic stimulus even as it promotes equity and quality of life in our families, communities, and state.

“The lifetime pay disadvantage of mothers grows in settings where their child care demands are met only in private markets.”³⁶

- Peter Lindert, economist

INVESTING IN CARE FOR EQUITY

Women provide far more unpaid care than men do, hurting their overall lifetime earnings, increasing their poverty rate and poverty among families supported by women, and creating high rates of poverty among women in old age. **THE SIGNIFICANT BURDEN OF UNPAID CARE CARRIED BY CHILDREN, PARTICULARLY GIRLS, GOES ALMOST ENTIRELY UNRECOGNIZED BUT HARMS THEIR EDUCATIONAL ATTAINMENT AND OPPORTUNITIES.**

Not only do parents – especially mothers – work fewer hours as a result of their caregiving responsibilities, but employers assume that they might work fewer hours, and therefore promote men over comparably or better qualified women. In this way, the lack of care supports compound gender disparities.

“Unaffordable child care can be a serious poverty trap for low-income families.”⁴¹

*- Gosta Esping-Andersen
Academic Consultant to the EU on
Social Policies*



A strong and effective care infrastructure supports gender equity by strengthening women’s connection to the labor market and raising wages of the overwhelmingly female care workforce as well. For example, public care investments are largely responsible for the fact that a higher proportion of Scandinavian women work for pay than in any other high-income nation, and confront the lowest gender pay gaps, while the opposite is true in Southern European economies.³⁷

The World Economic Forum’s 2015 Global Gender Gap Report finds that the US ranked 51st of 145 nations in women’s labor force participation relative to men’s, and 74th in terms of wage equality for similar work.³⁸ Those low rankings are in strong contrast with the number one rankings of the US for women’s literacy and enrollment in higher education, relative to men.³⁹ The US educates women, but fails to provide the family-friendly policies and investments in care infrastructure that have blossomed abroad -- paid family and medical leave, more availability of equitable part-time work, and publicly supported child care and elder care.⁴⁰ Investments in these areas are investments not only in care, but also in gender equity.

“I signed up for a full load of college classes so I would qualify for student loans, yes, I used student loans to provide for my family when I had my son. He is now two and a half and my family is still trying to recover financially. The lack of paid family leave meant that my husband had to drop me off at our home and head right back to work because he had already taken the two days we could afford without pay.”

- Carrie

“We have struggled a lot with child care costs. My husband makes \$15/hr and with two children we pay at least \$17/hr for care. Essentially, our adjusted gross income last year was just under \$30k combined, and we will spend at least \$15k on child care this year. That’s half of our income! This is totally stressful and crazy.”

- Corey

Care investments also support racial and economic equity. Women of color are more likely to work in poorly paid care employment so improving their jobs closes the wage gap. People in low-income households – disproportionately women and people of color – are far more likely than those who are better off to go without care they need, to receive care of poor quality, and to live in families particularly burdened by both unpaid care and care expenditures disproportionate to their incomes. Single mothers particularly face an impossible task, unable to earn enough to pay for high quality child care, and unable to spend the time to provide it themselves. Children don’t get what they need, as “cognitive inequalities are strongly correlated with poverty and income inequalities more generally.”⁴² Public investment that makes high quality care more affordable for families will disproportionately help low-income families and families of color.

INVESTING IN CARE WOULD HELP REDUCE AMERICA’S SHOCKINGLY HIGH POVERTY RATES. US child poverty rates are particularly egregious, more than double the rate in countries with very similar political philosophies, such as Great Britain and New Zealand. US children are 5 times more likely to live in poverty than children in Iceland, and 3 times more likely than the children of France and Germany. Even Greece and Spain, both suffering from sustained economic depression, have child poverty rates below the rate of the US.⁴³

PUBLIC INVESTMENT IN CARE COULD MAKE AN ENORMOUS DIFFERENCE FOR FAMILIES AND CHILDREN IN POVERTY. High quality, low-cost child care can free parents to work more, reduce (or eliminate) the drag of care costs on family budget, and provide children with a solid foundation for learning and success in school and life.

High Payoff to Canadian Investment in Child Care

While child care investment is often discussed as a long-term investment, the evidence on Quebec's universal, low-fee child care program, started in 1997, has paid off much sooner. Though fees charged to parents have increased from the original \$5 a day for 4 year-olds, to a sliding scale from \$7 to \$20 a day for children from 0 to 12 year olds, the impact of investments in low-fee child care has included: a dramatic increase in women's labor force participation, related increases in tax revenues, and a significant reduction in tax credits and transfer payments to low-income families. The program is more than paying for itself; "each \$100 of daycare subsidy paid out by the Quebec government generated a return of \$104 for itself and a windfall of \$43 for the federal government."^{*}

^{*}Fortin, Pierre, Luc Godbout and Suzie St-Cerny, 2011. "Impact of Quebec's Universal Low-Fee Childcare Program on Female Labour Force Participation, Domestic Income and Governments." In French in *Interventions économiques/Papers in Political Economy, Issue 47*, 2013. In English: https://www.oise.utoronto.ca/atkinson/UserFiles/File/News/Fortin-Godbout-St_Cerny_eng.pdf.

High care needs for elders, people with disabilities, as well as for children, burden low-income families disproportionately as well, in an impossible vicious circle. Many households are low income because of care obligations: some members are unable to work and others can't both provide care and earn enough to pay for care.

Public investment in strong care infrastructure will help create a more inclusive economy, allowing people to earn enough to take care of their families financially, provide the care family members need, and contribute to the community with tax revenues, while setting their children on a path to greater success.

INVESTING IN CARE FOR GROWTH

If we invested more public dollars in care, our local, state and national economies would be more vibrant. Public spending for all kinds of care boosts economic growth by allowing family care providers to work more for pay, increasing their labor force participation, hours of work, current earnings, lifetime incomes and retirement payments.⁴⁴

According to the chief economist for the US Department of Labor, if the US had the care infrastructure of Canada or Germany, 5 million more American women between the ages of 25 and 54 would have worked for pay in 2015, increasing US GDP by more than \$500 million.⁴⁵ Beyond the impact on women's labor force participation, public investments in state supports for families also build a more inclusive economy, reducing social exclusion and broadening earning power while reducing social distress and public expenditures to fight poverty and crime.⁴⁶

Research has consistently shown that public spending on high quality, early childhood education and care – beginning at birth is as powerful an investment in state and local economic development as any other tool we have. In this way, our investment in stronger care today reaps productivity gains into the future as well.

Children who attend high quality early childhood programs have been shown, later in their lives, to stay in school longer, suffer less unemployment, commit fewer crimes, be less likely to have children at a young age, earn higher wages, pay more taxes and require fewer public benefits.⁴⁷ Even under relatively conservative assumptions, the return on state investment in 3 hours a day of universal pre-K care for 4 year olds is estimated to be nearly 7 percent annually.⁴⁸

That payoff is calculated based on the impact of high quality early childhood care and education on children’s future earnings in combination with the greater earning power of adults freed to devote more time to paid work and the stimulus of increased public employment. Investing in high quality child care infrastructure is also extremely progressive with rewards highest in the lowest fifth of the income distribution. Overall gains are 2.8 times the investment cost, including the benefit of increased property values tied to stronger schools.⁴⁹

PUBLIC INVESTMENT IN CARE ALSO HELPS EMPLOYERS. Workers who are also responsible for family members often struggle to balance the demands of work and family. Employees are distracted by the needs to arrange for paid care, cover for it when plans fall apart or someone is sick, or monitor the needs of those who might need care but do not have access to it, such as older children or aging parents.

According to the Metlife Study of Caregiving Costs to Working Caregivers, “the total estimated aggregate lost wages, pension, and Social Security benefits of these caregivers of parents is nearly \$3 trillion”, with individuals absorbing losses of over \$300,000 each.⁵¹



The workers providing care must be valued as workers who serve the public interest. Families need to be supported in their caring – able to provide care at critical moments, able to afford care for loved ones, secure in the quality of the care their family members receive.

The cost of caregiver stress ripples across the economy. MetLife found that “six out of ten employed caregivers had to make work-related adjustments as a result of caregiving needs.”⁵⁰ MetLife estimates that nationally employers lose \$6.6 billion annually just to replace the workers who left employment situations where caregiving was not accommodated.⁵¹

INVESTING IN CARE FOR FAMILIES AND COMMUNITIES AND THE FUTURE

When the stress of juggling work and unpaid elder care is too much, many experienced workers at the peak of their earning capacity drop to part-time status or quit working altogether to care for aging parents or loved ones with a disability. According to the MetLife Study of Caregiving Costs to Working Caregivers, “the total estimated aggregate lost wages, pension, and Social Security benefits of these caregivers of parents is nearly \$3 trillion,” with individuals absorbing losses of over \$300,000 each.⁵²

Public investment in care allows families the ability to shift their budgets toward expenditures that provide economic stability and security, through the purchase of a dependable vehicle, a house or to save for emergencies, their children’s education and retirement. Given the coming “silver tsunami” and the unsustainable price of infant care, Oregon needs to and can do better.

TOWARD A STRONGER CARE ECONOMY: WHAT NEXT

Oregon should pursue a comprehensive public policy approach to better enable family members to care for loved ones, ensure paid caregivers are able to provide high quality care without compromising their own well-being, and provide for all Oregonians who need it.

WITH SIGNIFICANT AND SMART INVESTMENTS, OREGON CAN BUILD A STRONGER CARE ECONOMY. The task is not simple. But it is essential for families in the state. For maximum impact, investments should be made with an understanding of the complexity of the care economy, the challenges faced by paid and unpaid caregivers, and should build towards a comprehensive system that truly values care of children, seniors, and people living with disabilities.

Public investments will help relieve serious stress felt by far too many families throughout the state – the financial stress of purchased care, the emotional stress of care in difficult times, and the double bind of family and work. Public investments will support economic growth and economic equity in the state.

As mentioned at the outset, securing a decent standard of care requires fundamentally and dramatically reshaping our understanding of what care work is, what it is worth, and how to pay for it. The workers providing care must be valued as workers who serve the public interest. Families need to be supported in their caring – able to provide care at critical moments, able to afford care for loved ones, secure in the quality of the care their family members receive.

To improve Oregon’s care economy, the State will need to pursue a comprehensive approach to it. Key elements of a new care economy in Oregon will certainly include:

- ✓ **PAID FAMILY AND MEDICAL LEAVE:** Supporting families by providing income so they can focus on care when needs are most intense.
- ✓ **AFFORDABILITY AND ACCESSIBILITY:** Making high quality senior care and child care truly affordable and broadly accessible.
- ✓ **QUALITY IN CARE AND IN JOBS:** Substantially improving the wages and benefits of all types of care workers, as well as supporting additional training for care providers.

These are the essential elements of a new care economy. The potential rewards of investing in the care economy are substantial but continue to be deferred. We can take a different course for families and for the Oregon economy by truly valuing care.



TECHNICAL NOTES

Data in Table 1 is based on occupational profiles provided by the State of Oregon Employment Department. The category “personal care aides” corresponds roughly to the long-term care providers in nursing homes and residential care facilities identified from the American Community Survey data. The category “home health aides” corresponds roughly to the in home health services providers identified from the American Community Survey. See below for identification of occupations from the ACS.

Numbers in Tables 2, 3 and 4 are based on microdata from the Public Use Micro Sample (PUMS) version of the 2010-2014 American Community Survey five-year estimates provided by the Census Bureau. The figures are based on the population of individuals in the sample who are between 18 and 64 years old, and who worked within the 12 months previous to the interview. The categories presented in the tables are generated in the following way:

HOME HEALTH WORKERS are those whose occupations are classified as “Nursing, psychiatric, and home health aides” (occupation code 3600) or “personal and home care aides” (occupation code 4610). Within this category, we selected workers classified within two sets of industries:

- Home health care services (industry code 8170), and
- Private households (industry code 9290).

Health Aides includes workers whose occupation is classified as “Nursing, psychiatric, and home health aides” (occupation code 3600) or “personal and home care aides” (occupation code 4610), who are

- not included in the Home Health group defined above,
- and are classified in one of the following industries:
 - Nursing care facilities (industry code 8270)
 - Residential care facilities, without nursing (industry code 8290), and
 - Other health care services (industry code 8180)
- Note that this definition excludes people working in Hospitals.

CHILD CARE WORKERS include those whose occupation is classified as “child care worker” (occupation code 4600). Workers in this group are classified in the following subgroups:

- Private household services (industry code 9290)
- Family child care providers, if workers are classified in industry “child day care services” (industry code 8470), and who are classified as “self employed.”

Child care workers other than household and family child care includes all other workers classified in occupation “child care worker” (occupation code 4600).

Preschool and Kindergarten teacher includes workers classified under occupation “Preschool and kindergarten teachers” (occupation code 2300), who work in industry “Child day care services” (industry code 8470). This excludes all teachers working in primary schools, and thus captures mostly preschool teachers. Some Kindergarten teachers might be included, but only if they are employed in child care centers.

The State of Oregon Employment Department (OED) uses the broad census occupation code in reporting their figures. For this reason, the OED numbers are slightly different compared to the estimates obtained combining occupation and industry codes from the ACS.

VARIABLES

Given the restrictions imposed by the data and variables structure in the PUMS data set, median total person’s earnings are calculated in the following way:

- Total person’s earnings in the past 12 months (variable wagp) is divided by the total number of weeks worked in the past 12 months. This generates an estimate of weekly earnings.
- Starting in 2008, the Census changed the way it reports the number of weeks worked, and now reports it as a discrete variable. The number of worked weeks is presented in discrete intervals: fewer than 14 weeks worked during the last 12 months; 14 to 26 weeks worked; 27 to 39; 40 to 47; 48 to 49; and 50 to 52 weeks worked. We impute the number of weeks worked by assigning to the worker the median value of the interval he is classified in.
- We divide our estimated weekly earnings figure by the usual number of hours worked per week in the last 12 months to generate an estimate of hourly earnings.
- Note that we use total person earnings instead of wages because many workers who are self-employed report wages that are too low or zero, while at the same time reporting non-zero earnings.

Female reports the percentage of workers in each category who are women. Percentages in this and other demographic variables are calculated using the population weights provided.

Hispanic reports the percentage of workers in each category who identify as being of Hispanic or Latino origin.

Black reports the percentage of workers in each category who report black as their race, and who are not of Hispanic origin.

Noncitizen reports the percentage of workers in each category for whom their citizenship status is classified as “Not a citizen of the US.”

High School degree or more reports the percentage of workers in each category who have completed a high school degree or greater level of education.

Insurance through an employer or union reports the percentage of workers who declare to receive health insurance “through a current or former employer or union.”

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