



**Testimony of Candace Inagi
before the
House Energy & Commerce
Subcommittee on Health
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Good morning Chairman Deal, Ranking Member Brown and other Members of the House Energy and Commerce Subcommittee on Health. My name is Candace Inagi. I am Assistant to the President for Government and Community Relations for Local 775 of the Service Employees International Union. SEIU represents 1.8 million workers nationally and is the nation's largest health care union. Local 775, based in Washington State, represents 28,000 home care and nursing home workers, including many family caregivers who are caring for Medicaid beneficiaries participating in the state's program of consumer-directed care.

We face a national shortage of direct care workers; at least 35 states currently report serious shortages of caregivers. For individuals with chronic care needs, often the biggest barrier is finding an available home care worker.

It would be a mistake to think the shortage of long term care workers is a temporary phenomenon – a function of the current business cycle. It is important to see the labor shortage for what it really is: a rational response of people to a labor market that often pays lousy wages and no benefits. The national average wage for a direct care worker is \$8.18, but average annual income for home care workers ranges from \$7,000 to \$12,000 per year since few can find full-time work.

We can expect the current shortage to get worse. The traditional long term care worker — women between the ages of 25 and 45 — have more economic alternatives. BLS estimates that we will need an estimated 5 million additional direct care workers to fill current vacancies and meet the demand for additional services.

Who will care for those with long term care needs? We must support informal caregivers and make it easier for friends and family to help with household activities, transportation and other chores that make it possible for those with disabilities to stay out of institutions. Home care and other kinds of non-medical assistance often require more patience, strength and sensitivity than technical skill. Because long term care is often the most intimate of hands-on care, many people are more comfortable having family members provide those services.

But informal caregiving is not the silver bullet to the workforce shortage. Trends like smaller families and greater economic mobility among families impact the supply of informal care.

We cannot meet the demand for long term care solely through informal care. Our dysfunctional health care system already puts too much responsibility for long term care services on the family. Medicaid and Medicare are enormously successful at helping low-income and disabled individuals access health care but neither program is designed to address the long term care needs of millions of middle-class Americans. Medicare provides health insurance for seniors and the disabled but

benefits are time-limited and the program excludes social supports. Medicaid addresses the long term care needs of low-income Americans, but the income eligibility requirements make it a program of last resort. Many states have used federal waivers to create home and community based programs that substantially improve the spectrum of long term care choices available, but in most states, the program has yet to shake the institutional bias completely.

Unpaid or “informal” care complements paid or “formal” care since most consumers receive a mix of both over time. Paid care is an important source of respite for family members; paid care can also supplement the efforts of family members during work hours. Paid care can substitute for unpaid care when individuals with multiple disabilities are physically and emotionally too much for family members to handle or when families burn-out.

I would like to shift gears for a moment and mention the effort by several states to address the workforce shortage through the creation of Medicaid consumer-directed care. This arrangement, in which individual beneficiaries are allowed to select, manage and if necessary dismiss workers, offers beneficiaries greater autonomy and more choice. Beneficiaries that take advantage of consumer-directed care often have greater consumer satisfaction because they get the type of care they want, when they want it. No longer are they stuck in bed until an agency decides to provide assistance.

Consumer-directed programs can be problematic too. Because the Medicaid beneficiary is the employer — not the state that actually pays for services — workers are in an impossible position, unable to increase wages or improve benefits because their “employer” is indigent and lacks the resources to make caregiving a sustainable job.

SEIU has worked with governors and policymakers in states like Washington to develop a solution that allows for expansion of consumer-directed care: creating a public agency (often called a public authority or a home care commission) that can serve as a co-employer for the purposes of determining wages and benefits. Consumers retain the right to hire, train, and terminate a personal care provider. Care is provided when and in the manner determined by the beneficiary. But workers have a co-employer -- the state -- with resources to provide an adequate wage and health insurance. SEIU, representing the workers, is able to negotiate with the state acting as the co-employer for adequate wages and decent health care coverage. In California, Oregon, and Washington, the result has been a significant expansion of the labor market for direct care workers.

On behalf of SEIU, we appreciate this opportunity to express the concerns of caregivers struggling to improve the care and the quality of life for their disabled clients.