Thirty years from now, the U.S. health care industry and its workforce will be transformed. The forces that will transform this industry, which accounts for nearly one-fifth of the nation's total product, go beyond the market and technological forces that will reshape all industries. Health care is so closely tied to the public good that it stands as much more than simply a sector of employment. The sector's most important output – good health, at the individual and community level – is a major component of the national standard of living. And rather than directly responding to unfettered forces of supply and demand, markets in health care are defined by and tied to constraints and incentives created by public policy. The policy impact is obvious and pervasive -- from the profound impact of the Affordable Care Act (ACA), to regulation of drugs and the patent protections that reward their development, to systems of training and licensure (some would say protection) at nearly every level of employment. And health care – decent, equitable health care for all – will be a central component of any compelling vision of the future of this nation.

How we provide health care 30 years from now will say a lot about the direction this nation takes on essential questions of equity and quality of life, of government’s role in private markets, of redistributive taxation, of the very value of care and relationships. These questions may loom larger for the industry and its workers than the question of technology or even specific existing policies – as essential as these questions are.

Because of health care's complexity and the central – and uncertain – role of public policy, regulation, and funding, writing about the future of health care is an attempt to discern patterns in a very cloudy crystal ball. A few trends can be confidently predicted:

- Demand for health care will increase as the population ages. The aging of the baby boomers will necessarily transform our approach to the end of life – for both cost and quality-of-life reasons.

- Increasing longevity and attendant increases in chronic conditions will also challenge the industry, in the United States and indeed the world.¹

- Integration of systems to support more preventive and patient-centered care will continue to transform work – requiring more coordination and communication across workers and care settings.

¹ As summarized by the Institute for Healthcare Improvement: “Aging populations and increased longevity, coupled with chronic health problems, have become a global challenge, putting new demands on medical and social services.” From http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
• Cost pressures will continue to push care towards the least expensive point of provision – often meaning care in peoples’ homes.

• Less health care will be delivered in institutions (hospitals and nursing homes) and more in will be delivered in diverse settings including primary care clinics and homes. Health care will also increasingly be delivered in diverse and non-traditional settings like retail stores, community centers, and health clubs. Technology will increase the capacity to deliver health care when and where you need it – whether through mobile provision of services or internet- or phone-based interactions with professionals.

• Information and analytic systems on costs and patient outcomes will support reduction of the inefficiencies and cost/price variability in the current health care market. Systems that can identify and eliminate dramatic regional differences in procedure prices which have no relationship to health outcomes will be one target. The capacity to identify high-cost patients and provide stronger preventive care for them is another area of innovation already underway in Center for Medicare and Medicaid Services (CMMS) research pilots.

In dramatic contrast to the preceding decade, the last five years have been marked by slow growth in health care costs: in 2013, the increase in health care costs was the lowest on record. This health care cost slowdown has provided important relief to projected budgets in the public and private sector. But no one knows whether the trajectory will be maintained. The extent to which the slowdown can be credited to new health care practices and policies vs. overall weakness of the economy will continue to be debated.

The Triple Aim Framework

The health care industry and private and public stakeholders have begun to embrace a framework that may shape future industry and care directions for years to come. The framework also has the potential to promote improvements in health care job quality. The Institute for Healthcare Improvement (IHI) developed this “Triple Aim” framework in response to the fact that the United States has the most expensive health care system in the world, but is outperformed by many other nations. The Triple Aim framework calls for any new health-care design or strategy to pursue all three of the following priorities simultaneously:

• Improving the patient experience of care (including quality and satisfaction);
• Improving the health of populations; and
• Reducing the per capita cost of health care.

2 http://content.healthaffairs.org/content/early/2014/11/25/hlthaff.2014.1107
3 IHI Triple Aim framework was developed by the Institute for Healthcare Improvement, Cambridge, MA (www.ihi.org).
The question for the future of work in health care: what is the role of decent jobs in the Triple Aim? Will workers with decent and secure jobs be recognized as the foundation of providing the strong system of high quality/low cost care? Or will a short-sighted pursuit of lower per capita costs push labor standards and skills down in the sector, in a way that could ultimately be counter-productive?

The stronger and more direct is the connection between job quality and each of the goals of the Triple Aim, the stronger is the argument for supporting and improving quality jobs as health care reform and technological transformation take place. If job quality is shown to be and understood as the fourth corner, or a co-determinant, or predecessor, of the Triple Aim, the health care workforce will be set firmly on the high road.

Jobs in the Health Care Future: Where and What?4

Whatever the progress of tele-medicine, robot-assisted care, and computer-assisted self-medicine 30 years from now, there can be little doubt that many of the most essential aspects of care will require human interaction between patients and health care providers. The myriad pressures changing the industry will, no doubt, restructure and alter that interaction in ways both predictable (a dramatic increase in e-mail and video phone interaction between patient and primary care providers is nearly certain, indeed already underway) and surprising. But whatever changes there are some tasks will continue to involve a health care workforce.

Career advice to young and displaced workers since at least the late 1990s has consistently held out the promise of opportunities in health care. And indeed, the sector has far outpaced economy-wide job growth and, in the last years, proven itself practically recession proof. The strong past and projected employment future of the sector is evident in the figure below. Over 2002-12, employment in the health care sector grew by 22 percent while the balance of the national jobs base barely budged. Looking forward – a notoriously messy business, to be sure, but using DOL’s standard projection methods – health care is projected to add another 27 percent to its total employment in 10 years, a rate of job growth nearly three times faster than that for all other sectors.

4 BLS data in this section is taken from a presentation by Patricia Pittman at the H-CAP/COWS convening on training and the health care workforce.
The health care sector is comprised of everything from hospitals to home health. The fastest growth in health care shown is concentrated in generally lower-wage segments within the industry. The figure below shows employment changes over the last 10 years and DOL projections for different health care settings. Every single sub-sector grew and is projected to grow more rapidly than the U.S. economy. But the home health subsector added jobs and is projected to continue growing at a much faster rate than any other. Hospital employment growth has been and will likely continue to be significant but much more muted.

These projections show that health care will continue to evolve, with employment shifting from hospitals – the setting with the largest work sites, the highest union density and some of the strongest training and job quality systems – toward clinics. And long-term care will continue its evolution away from the larger institutions – nursing homes – toward caring in homes.

Job growth by segment depends not only on the rate of growth but on the base level of employment before growth. As a result, the offices of health practitioners which deliver primary care will add the most jobs, more than one million, over the next 10 years. Hospitals, while growing by only 14 percent, will add just over 825,000 jobs. Home health services, with a 60 percent job growth projection, will add just over 700,000 jobs.
Important along with shifting employment are the increasing incentives for connection and linkages among these different settings. The simultaneous movement towards prevention and patient-centered care requires much greater coordination between primary care (offices), acute settings (hospitals), and home health. Some of the most expensive patients in the system need to be supported in their homes in order to avoid costs that would be generated in hospitals. The new logic of payment and reward of the Affordable Care Act (ACA) emphasizes this connection.

Another critical bottom line here is that care is increasingly shifting away from the places that have been organized (by labor among other forces), studied, regulated and understood and towards more diffuse and diverse settings. This is a time of flux and innovation. We are witnessing the emergence of new service delivery models and settings. Entirely new occupations are being forged, in fits and starts and, in the case of community health workers with some commonalities and many distinctions, across the country. The rich potential of increasingly available health cost and outcome data is becoming clearer.

Paving the Low Road: Strongest Growth in Sector with Lowest Job Quality

The last section made clear one trend that is crystal clear: the strongest employment growth in health care is in the lowest-quality jobs in the field – home health and personal care work. And the projections suggest a disturbing continuity of growth at the bottom.
The National Landscape of Personal Care Aide Training Standards\(^5\) summarizes the shift in the field this way:

> While 15 years ago 75% of Medicaid spending on long-term care supports and services was directed to institutional care, now nearly half is spent on home and community-based services and this percentage is growing. Nationally, the number of home and community-based workers will outnumber facility-based workers by more than 2:1 by 2022. In many states, this ratio is even more dramatic: in California, three-quarters of the direct-care workforce is employed in home care settings. The increasing reliance on home and community-based delivery systems is reflected in the projected demand for personal care aides, who provide the majority of non-medical home and community-based long-term care services and supports. By 2022 more than 1.75 million PCAs will be employed in the U.S.

As the Paraprofessional Healthcare Institute (PHI) has shown,\(^6\) these fast-growing jobs pay poverty level wages, offer irregular hours, and are held by a workforce dominated by women and people of color. Perhaps most important, federal policies regulate and pay for most health-care services for elderly and frail clients. This is a tax-funded industry. The wages it offers are low and disturbingly stagnant: the 2013 median wage in the jobs, $9.76, was actually five percent lower than the 2000 value, correcting for inflation.\(^7\)

This aspect of the recent past – that the strongest growth has occurred in the lowest paying jobs and that the wages in these jobs are actually lower today than 10 years ago -- stands as a serious challenge as we look ahead to a future for the health care industry. A high road in health care is possible and practiced across the nation (more on this below). But there are systematic forces that have paved the low-road as well. They are likely to continue pushing in this direction in the future.

**Toward the High Road in Health Care**

The feasibility of a high road or good jobs strategy in health care is well established – of high-performance organizational models that value workers at all levels, engage workers in quality care and system improvement, and secure strong health care outcomes and efficient delivery of care. Evidence comes partly from health care jobs in other countries, as documented in *Low-Wage Work in the Wealthy World*, a Russell Sage volume that included contributions from five participants in the EARN Future of Work project (Gautier and


Schmitt 2009, chapter 8). There is evidence in the United States as well, with longstanding projects and new experiments proving the possibility and promise of the high road in health care. As far back as 1997, Keystone Research Center documented the existence of exemplary nursing homes delivering quality care founded on quality jobs (Eaton 1997). The examples profiled helped give rise to the Pioneer Network (https://www.pioneernetwork.net/) and a national movement for person-centered care. Evidence on the viability of the high road in hospitals comes, for example, from research on Magnet Hospitals. These certified institutions recognize nurses as the lynchpin of communication and cooperation in acute care, and provide them with support, respect, and good jobs, enjoying improved patient outcomes as a result.

Many good jobs examples in health care come from union-represented worksites. COWs (the Center on Wisconsin Strategy), one of the state EARN groups, has helped document some of these union examples though a project in which it provides research and technical assistance to the Healthcare Career Advancement Project (or H-CAP) network. H-CAP brings together the Service Employees International Union (SEIU) and leading national health care employers, and provides a hub for 15 labor/management affiliates and labor-based training organizations in 13 states. The network reaches more than 900 healthcare providers that employ nearly 600,000 workers who have access to training benefits or services. This work across the country provides a treasure trove of examples where quality jobs, quality training, and quality care are being supported and built.

The H-CAP examples are diverse and impressive. Across the nation, training has engaged workers in the process of transforming and improving health care at every level of the organization. In some hospitals, training and engaging environmental service workers has improved actual measures of room cleanliness and patient perception of it. Building skills for workers to advance or to improve in their current jobs, creating a context for discussion and embrace of new strategies of care delivery, and engaging workers’ voices in the project are the consistent strengths of such programs.

Even at the very bottom of the health care job quality ladder, unions have been working and developing real models. Unions have helped bring home health workers out of the shadows in many states (including CA, OR, WA, IL, MA, and NY). Wages and working conditions are strengthened in the process. And training standards and supports in many of these states have become stronger as well. The result has been higher care quality for the frail and elderly and reduced turnover among the workforce.

The presence of labor unions to negotiate for wages and job quality is, of course, an essential contribution. But beyond that, leveraging worker voice and securing density in specific areas, labor unions in health care deliver two components that may be essential to achieving broad diffusion of high-road strategies by the 2040s.

First, by securing and amplifying worker voice within health care, unions change the very context and impact of workforce training and service delivery innovations. Workers’ engaged in the project of improving their work, in order to honor their own commitment to quality, is a hallmark of the high road, and a realization of the dignity of work. In a recent
presentation to an H-CAP gathering, Marie Monrad a Vice President in the Kaiser Permanente Health System in California, brought to life the potential of worker voice linked to systemic implementation of high-road organizational approaches. Monrad discussed the proliferation of team-based problem solving and its impact on health outcomes at Kaiser. She noted that teams, organized to solve specific and measurable problems in pursuit of the triple aim, are having a significant impact on system costs. She also stressed that engagement requires worker buy-in, and strategies and supports for engagement and ownership of problem-solving at all levels of the organization. Her examples provided anecdotal evidence of the ways that workers in decent jobs, with significant voice and support in the project of improving health care delivery, can be the fourth corner of the Triple Aim.

Second, where unions achieve density across large health care networks in a region, they can establish network- and area-wide wage and benefit standards. They can also secure significant investments in training, and leverage over training systems for health care professions. Without unions or policies that establish regional standards, the temptation to use the shift to community based and home care as an opportunity to lower wages and benefits may be too great. This could limit the diffusion of high-road strategies in non-institutional settings and short-circuit the potential to combine good jobs, high skills, and devolution of more health-care delivery to these settings. The short-run attraction of the low road could impede the long run potential of health-care system-wide high road.

Looking forward three decades, progressives must seek to support, prove, and demonstrate the positive impact of decent jobs for all health-care workers on the Triple Aim. And we must support unions in their work in the health care sector, demonstrating the connection directly from unions to the kind of worker engagement and job quality for workers that can directly lead to the Triple Aim as well.

Of course, even if the argument in favor of good jobs for all is compelling – while it needs further demonstration and support – the high road is far from given. Cost pressures will continue to squeeze workers across the health care spectrum with especially negative impact for workers at the bottom of the ladder. We must be prepared to support workers in the industry, to build their skills, to strengthen their voices, and to pursue an equitable health care transformation that extends good quality care to all populations, and decent work with dignity to the workers who perform this critical work.

**Thirty Years Forward: Caring Matters**

Health care is not simply another industry in the American economy. It is an essential public good, a right. It is not simply a measure of the quality of our lives, but a generator of it. Quality care for all can mitigate the ever-increasing inequities generated by our economy. Or we can pile the injury of greater health disparity on top of other inequities. Our approach in this sector will be defined in a greater way than most sectors by the American approach to government, taxation, inequality over the next 30 years. The interests of health care workers 30 years from now, and the interests of health care
consumers, and the interests of the lowest-wage workers in this industry can come together and forge a coalition to support quality jobs, quality care, and equity in health and beyond. But any strategy around decent jobs in health care must be attentive to the broader politics and context. The high road here is about more than just a different way of doing business. The high road in health care is something that must be chosen politically.

Such a choice will also require, over the next 30 years, a revolution in the way we think about care work. That these jobs have so long been so poorly paid and so little respected owes directly to a societal denigration of care work: “mom did it for free, so it can't be worth much.” For elders and others in need of support and service to stay in their homes, our programs consistently aimed at dignity and independence. But dignity and independence has rarely been afforded to the very workers who help them maintain their own. And that contradiction – extending dignity to elders on the backs of a poverty-wage workforce, providing for independent living with workers who must consistently rely on state supports like Food Stamps in order to make ends meet – must finally be overcome by a surge in social support for these workers. Broad social support may be more likely to come in response to demands from those workers than out of any other enlightenment. But whatever the reason, we need to systematically revalue care work and elevate its monetary rewards and social standing.

Perhaps we can even get to the point where we both reward the hands-on, relational care work in health care and build an increasing workforce to carry out that work. Technology may enhance our independence and disconnect us from physical community. But human interaction and connection, the actual touch of a caring hand and a look directly in the eye, cannot be replaced by technology. If technology liberates us from other needed labor, perhaps we can hope it actually liberates us to be more in touch with one another. Or at least delivers a surplus to support a vast workforce of caring community outreach workers who help maintain the connection, independence, and quality of life of the isolated and lonely and ill. Technology will surely eliminate some of the work of health care industry, but if we can value caring, fund it, and deliver it, we will keep the human in our health care industry as well.

**Policy to Generalize the Health Care High Road by the 2040s**

A range of complementary policies could help universalize good jobs strategies in health care by the 2040s.

**The Quadruple Aim.** As noted, quality jobs at all levels of health care are integral to achieving the Triple Aim. To increase focus on quality jobs, and to help resist the short-run temptation to cut costs through low-quality jobs in non-institutional settings, the importance of quality jobs should be recognized and promoted. Quality jobs, strong training systems, and engaged and committed workers provide an essential foundation for pursuing the Triple Aim. A clear and consistent focus on the ways that workers are essential and valuable to all outcomes helps integrate job quality into the fabric of health care reform. Research and policy must be designed to make this connection and move
toward a framework – perhaps even the “the Quadruple Aim” – that is attentive to health care workers as essential to the reform project.

**A Healthy Wage.** Sector-specific wage standards have a long history as a tool for promoting “the high road” in particular industries. The best known U.S. examples are the prevailing wage and benefit standards that govern federally funded construction projects and similar laws that govern publicly funded construction in many states and some localities. In the construction sector with many small firms, these laws help prevent cutthroat competition that lowers wages, benefits, training investment, and safety standards. In the health-care sector, labor costs for workers paid less than $15 per hour are a small fraction of overall costs: they are dwarfed by capital costs, prescription drug costs, and the compensation of higher-paid professionals. Nonetheless, the same tendency toward very low-wage competition exists in non-institutional health care, especially home health. This undercuts care quality and continuity (the last because of high turnover) and likely forestalls cost-saving combinations of highly skilled home health care workers and advanced technology. For these reasons, a health care wage standard – a “healthy wage” – in the neighborhood of $15 per hour makes sense. A 2007 report by the Pennsylvania Department of Labor and Industry recommended exploring such a healthy wage standard as a cost-saving or at least cost neutral measure (PDL&I 2007).

**Regional Unions and Bargaining.** Region-wide collective bargaining provides a powerful tool for diffusing high-road organizational models and preventing the move to more non-institutional health care delivery from increasing reliance on low-wage jobs. Broad-based bargaining also can provide the employment security workers need to safely and creatively explore the marriage of new technology with skilled workers and cost-effective new modes of health care delivery.

**Regional/Multi-Employer Scheduling Pools.** Scheduling that matches workers’ preferences with consumer health care demands is easier with larger pools of consumers and employees. This gives large health-care systems an advantage in terms of accommodating employees and still meeting the needs of patients, as illustrated by a scheduling example featured recently in *National Journal* (Johnson 2014). Multi-employer and regional scheduling pools could make worker- and family-friendly scheduling universal.
References


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1 In addition to the conversation with the many involved in EARN regarding the future of work, this piece is the product of discussions and collaboration with colleagues across the country working in the labor/management health care context. We are particularly indebted to the staff at H-CAP, Laura Chenven, Daniel Bustillo, and Danielle Copeland, as well as to leaders throughout their network of SEIU related health care projects including Sandi Vito and Tracy Woodman. Presentations at a recent H-CAP/COWS convening by Patricia Pittman and Marie Monrad provided essential fodder for this as well.