Path Toward Economic Resilience for Family Caregivers: Mitigating Household Deprivation and the Health Care Talent Shortage at the Same Time

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Abstract

Rising costs and a workforce talent shortage are two of the health care industry's most pressing challenges. In particular, serious illnesses often impose significant costs on individuals and their families, which can place families at an increased risk for multigenerational economic deprivation or even an illness–poverty trap. At the same time, family caregivers often acquire a wide variety of health care skills that neither these caregivers nor the health care industry typically use. As these skills are marketable and could be paired with many existing medical certifications, this article describes a possible "path toward economic resilience" (PER) through a program whereby family caregivers could find meaningful employment using their new skills. The proposed program would identify ideal program candidates, assess and supplement their competencies, and connect them to the health care industry. We provide a set of practical steps and recommended tools for implementation, discuss pilot data on the program's appeal and feasibility, and raise several considerations for program development and future research. Our analysis suggests that this PER program could appeal to family caregivers and the health care industry alike, possibly helping to address two of our health care system's most pressing challenges with one solution.

Key words: Economics, economic resilience, low-income populations, workforce issues, caregiving—informal, education and training

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It is nearly axiomatic in public health that illness can threaten people's finances even as it threatens their health (Covinsky et al., 1994; National Institute on Aging, 2007; Sachs, 2001). The capacity to minimize impact and maximize recovery can be summarized in one term: resilience. The economic resilience of a household is the household's ability to recover its preillness economic state (Briguglio, Cordina, Bugeja, & Farrugia, 2005). Economic resilience can help prevent households from falling into poverty in the face of illness and/or help break an illness–poverty cycle already under way.

One source of economic difficulty is the fact that most chronically or terminally ill patients, especially those with low income, rely on family members to act as informal caregivers. In these home settings, family members provide a large proportion of caregiving. Family caregivers who return to full-time employment after caregiving are more likely to earn lower wages, have a "benefit-poor" job, and receive reduced retirement benefits (Dettinger & Clarkberg, 2002). The lower a family's income, the more significant these obstacles become (McIntyre, Thiede, Dahlgren, & Whitehead, 2006; NAC & AARP, 2009). Thus, a recent AARP (American Association of Retired Persons) report indicated that caregivers suffer significant economic hardship stemming from decreasing income, increasing out-of-pocket expenses, and conflicts between work and family responsibilities (Feinberg, Reinhard, Houser, & Choula, 2011).

Informal caregiving also has significant macroeconomic consequences. Based on a conservative estimate of 42.1 million caregivers in the United States, the AARP report placed a value of $450 billion on family caregiving in 2009 (Feinberg et al., 2011), exceeding the sum of both federal and state spending on Medicaid ($361 billion) that same year. As the population ages and chronic and serious illnesses increase in number, these problems are likely to grow (Centers for Disease Control and Prevention, 2003).

At the same time, the health care industry faces a critical shortage of diverse, experienced, and skilled home health aides that match the current and growing need (Bureau of Labor Statistics, 2012a; Smith, Cowan, Heffler, & Catlin, 2006). The demand for home health aides is expected to increase by 69% within the current decade, almost five times the total projected employment growth for all occupations (Bureau of Labor Statistics, 2012a). The shortage stems from two sources: a growing, increasingly diverse population requiring caregiving and a dearth of institutions to build the pipeline of skilled and motivated caregivers. Thus, the health care industry faces a need to find people with the very skills that family caregivers already have.

Yet, research on how to best support and train caregivers has not yet linked family caregiving to training and employment for the purpose of economic resilience. We believe that a program that offers a "path toward economic resilience" (PER) for family caregivers in the United States, especially those experiencing economic hardship, begins to provide a viable approach. The proposed program has two distinctive goals. The first is to help reverse the trend of household economic deprivation due to illness, by providing family caregivers with career opportunities

that leverage caregiving skills. The second feature of this program relates to the needs of the health care industry itself. Together, these dual imperatives create the foundation for this type of PER program for family caregivers to succeed. Although some countries have begun to provide limited avenues to become a paid caregiver (National Health Service [NHS], 2012), we know of no article to date that has detailed from a multidimensional perspective what it would take to start a specific PER program in the United States—particularly for low-income, working-aged family caregivers who stand to benefit the most.

This article describes a PER program that could facilitate the economic recovery of low-income families suffering heavy economic burdens from a devastating chronic or terminal illness. The program aims to leverage the skills learned during family caregiving to place informal caregivers into health care careers, broadly defined to include jobs that directly and indirectly involve caregiving. The proposed program would optimally target working-aged individuals who (a) have recently provided or who are currently providing care to an ill family member; (b) have incurred financial burden because of the family member's illness but have little or no economic reserve to mitigate it; and (c) have a general interest in changing careers or a specific interest in the health care industry. Subsequently, we describe the program, discuss its underlying rationale, and provide a set of practical steps and recommended tools for implementation. In addition, we outline strategies for targeting ideal program candidates; assessing and supplementing required knowledge, skills, and abilities; and connecting candidates to the health care industry.

Theoretical Rationale, Dual Imperatives, and the Potential of a PER Program

Illness and Poverty

Illness can take a heavy economic toll. In countries with widespread health insurance, much of the economic impact of illness stems from the lost work income of the patient and family caregiver, especially if either was a breadwinner who had to exit the workplace (Gold, Siegel, Russell, & Weinstein, 1996; Hayman et al., 2001). Statistically, high caregiving burden and financial hardship due to family illness are most prevalent in households with less than $50,000 in yearly income. In the United States, an estimated 39% of those who care for adult family members have a household income of less than $50,000, whereas 20% of caregivers have a household income of less than $30,000. Approximately 69% of caregivers experience some negative impact on their work (NAC & AARP, 2009). Indeed, average caregivers aged 50 or older who leave the workforce to care for a family member suffer mean income and benefit losses of about $283,716 for men and $324,044 for women (MetLife Mature Market Institute, 2011). Even among employed, higher socioeconomic households with financial reserves and health insurance, lost assets can take more than 6 years to recoup, often through bankruptcy (Emanuel et al., 2011; Woolhandler, Campbell, & Himmelstein, 2003). This financial fallout makes a growing segment of the population vulnerable to the economic hardship caused by costs of a devastating illness.

Illness and poverty tend to reinforce one another. At a high level, many families reach a social and economic threshold beyond which household economic recovery becomes difficult or impossible (Kundu, Reitschuler-Cross, & Emanuel, 2010). The direct and indirect costs of illness can lead to poverty, poverty can harm health, and poor health can deepen poverty, thereby repeating the downward cycle. Moreover, individual costs often adversely affect the economic

condition of the entire household (Whitehead, Dahlgren, & Evans, 2001). These links between illness and economics can make family economic resilience difficult.

More specifically, household income often drops significantly when an earning member falls ill, even in the short term, and especially if multiple family members must take time off to care for the patient (Menon, Wawer, Konde-Lule, Sewankambo, & Junliothers, 1998). In addition, the need to cover immediate health care costs can often lead to risky activities, like selling important assets, which eventually contribute further to indebtedness and poverty (Emanuel et al., 2010). As households allocate an increasingly large share of decreasing income toward the patient's care, many families may fall ever deeper into poverty. Collectively, these factors may trickle down to subsequent generations, as children drop out of school to meet the immediate economic needs of their families. Thus, poverty borne of illness may become multigenerational, predisposing the current generation to poor living conditions and future generations to poor educational opportunities (Emanuel et al., 2010; Kundu et al., 2010; Whitehead et al., 2001).

In addition to individual- and household-level effects, the combination of illness and poverty can have important macroeconomic effects. For example, sustained poverty and reduced human capital in households can contribute to increased mortality, low labor productivity, and a suboptimal investment-savings path at the societal level, all of which can hinder economic growth (Bell, Devarajan, & Gersbach, 2004; Haacker, 2004). This may help to explain the strong, cross-national correlation among poverty, poor health, and low human capital accumulation (United Nations, 2004). The high cost of care, then, can take a macro and micro toll.

Our proposed PER program for family caregivers potentially offers one way to mitigate poverty and facilitate economic recovery at the household and societal level. Though not a panacea for such a pressing set of problems, we believe that this program leverages the inbuilt investment of human capital and begins to address the close relationship between illness and poverty in a straightforward and self-sustaining way (Cross & Emanuel, 2008). As detailed, this program aims to mitigate the economic impact of illness by putting affected family members back to work, should they desire employment in the health care industry.

The Health Care Talent Shortage

At the same time that health care costs impov erish many families, the health care industry faces a critical shortage of experienced and skilled home health aides who represent the vast cultural and linguistic makeup of the changing U.S. population (Bureau of Labor Statistics, 2012a; Smith et al., 2006). Although many U.S. industries face a talent shortage (Deloitte LLP, 2011), the health care talent shortage is particularly acute because of the industry's sheer size (16% of GDP in 2004), projected growth (faster than any other industry from 2008 to 2018), and reliance on specialized skills and technology (Bureau of Labor Statistics, 2012a; Smith et al., 2006). Complicating matters considerably, the percentage of people aged 18–64 is expected to decline as the population ages, shrinking the size of the workforce as the size of the population needing medical care grows. General population growth and an increase in the prevalence of chronic diseases further contributes to the growing demand for medical care, threatening to deepen the health care talent shortage (Ryan, Smith, Antonucci, & Jackson, 2011). By 2020, the health care industry is projected to lack 1.1 million direct care workers (Zywiak, 2010).

In addition to a shortage of employees in general, the health care workforce is likely to face a shortage of employees with the diversity required to serve an increasingly heterogeneous society. Indeed, the caregiving sector is already substantially less diverse than the U.S. population at large (Dodge & Huang, 2008; Institute of Medicine, 2008). For example, the population of home health aides is estimated to be 50% white and 33% African American, and less than 10% is of Hispanic ethnicity (Khatutsky et al., 2011). In contrast, the U.S. population is now approximately 64% non-Hispanic white, 12% African American, and 16% Hispanic—and rapidly diversifying. The Hispanic population grew 43% in the last decade, whereas the non-Hispanic white population grew only 5% (U.S. Census Bureau, 2011). As the population diversifies, the caregiving workforce will need an ever broader set of cultural and linguistic skills to respond to patient needs (Hughes, Rammohan, & Emanuel, 2003; Wynia, Latham, Kao, Berg, & Emanuel, 1999). Unless the industry can diversify in accord with the population, the formally employed caregiving workforce may find effective health care communication and delivery increasingly difficult (Castillo & Guo, 2011; Taylor & Lurie, 2004). By appealing to a set of people who might not otherwise consider a career in health care—any family caregiver at economic risk—the proposed PER program could possibly help to diversify the face of the workforce.

Gender diversity is another important dimension needed in the health care workforce. An estimated 95% of home health aides are women (Bercovitz et al., 2011), whereas 59%–75% of family caregivers are women (Family Caregiver Alliance, 2012). Women tend to assume a greater burden of caregiving for aging parents than men do (Brody, 1981; Horowitz, 1985; Stoller, 1983), but explanations for this gender difference remain unclear and do not strictly

follow gender role theories (Finley, 1989). Although gender-specific roles still predominate, particularly with regard to labor market behavior, it is clear that caregivers are not a homogenous group (Finley, 1989). Thus, the literature provides few a priori reasons to believe that women are inherently more and men are less suited to caregiving.

Indeed, economic theorizing and research suggest that anyone could benefit from a caregiving career. It is nearly axiomatic in economics that individuals, regardless of their gender, tend to change jobs when they expect a future job to yield more utility than their current job (Anderson & Meyer, 1994; Schneider, Trukeschitz, Muhlmann, & Ponocny, 2012). Similarly, they leave the workforce if neither their current job nor a prospective job affords as much utility as staying home, which can happen when people derive utility from nonpecuniary sources like spending time with their families. This implies that both men and women could be attracted to a caregiving career if it afforded sufficient utility. By providing people with a career option that they would not otherwise have had, the proposed PER program may offer some individuals a higher utility alternative than exiting the workforce or continuing in a dead-end job. If so, more men and women alike may decide to become caregivers.

Knowledge, Skills, and Abilities Gained While Caregiving

Taking care of a chronically or terminally ill family member usually provides the caregiver with skills that are otherwise confined to trained professionals and medical aides in health care clinics and institutions. Although those skills can vary, they range from assisting with daily living or medication administration, as would a nurse's aide; to performing dressing, intravenous tubing, or dialysis bag changes, as would a registered nurse (RN); to providing spiritual support, as

would a chaplain for a terminally ill patient. Many family members acquire these skills directly, learning from trained providers who visit the home (Eisai Inc, 2000). In economic terms, these skills represent an infusion of human capital in the form of training. Those who leave school or college to care for a patient, though sustaining an educational loss, gain a valuable set of skills. Those who leave the workplace, though sustaining a professional loss, could also gain a new career option in the health care industry.

Yet, neither family caregivers nor the health care industry typically harnesses this human capital investment; instead, acquired skills typically fall by the wayside once the family caregiver's assistance is no longer needed. We see this as an opportunity to help both the caregiver and the health care industry. In doing so, we recognize that not all caregivers or health care providers would want to pursue this path, but we believe that many would and will, and the pilot data presented subsequently lends support to this belief.

In designing a system to catalyze the transition from family caregivers to health care employees, it is important to know what skills family caregivers have acquired and how they might fit into a new health care career. In many health care settings, providers teach family caregivers medical skills on a "need-to-know" basis. For example, when a patient becomes at risk for developing or actually develops a bedsore, a nurse trains the family caregiver to prevent and possibly treat the wound. This informal instruction results in a population of family caregivers who have a highly variable set of skills that depend on the nature of the family member's disease and degree of care involvement. In addition, a given set of skills may be spread among family members. Finally, skills may vary depending on whether the family member was chronically or terminally ill.

Despite this variance in skills, it is important to note that the families of those enrolled in hospice and palliative care participate in patient care activities to a greater extent than the families of those receiving other health care services. Family members involved in hospice care, for example, often learn skills otherwise performed exclusively by clinicians—, how to move the patient safely; administer medications; use sterile techniques for syringes, pumps, and intravenous equipment; change wound dressings; and manage bodily fluids with universal precautions. Hospice and palliative family caregivers may also learn how to adapt to loss and help others do so (Knight & Emanuel, 2007). From a social worker, they may gain administrative knowledge like how to manage insurance requirements and government entitlements, as well as how to navigate the health care system. Home hospice generally affords this training, overtly or through the process of care, and other palliative care service arrangements like inpatient or ambulatory care, which often precede home hospice, typically provide some of it (Cross & Emanuel, 2008).

In other words, most family caregivers who have cared for a seriously ill family member possess a set of skills ranging from technical to interpersonal. Table 1, based on the literature, interviews with experts in geriatrics and palliative care, and research provided by the National Family Caregivers Association, lists the skills that we believe most family caregivers have acquired to some extent (Eisai Inc, 2000; Lau et al., 2009). This core set of skills offers a useful foundation for family caregivers to build upon in pursuing a health care career. The fact that few family caregivers currently do so offers all the more impetus for a new PER program.

One Approach to a Family Caregiver PER Program

As detailed earlier, people who have already gained skills by caring for a loved one represent a natural source of talent. Since family caregivers learn varying skills, however, a training program is needed for interested candidates to supplement gaps and standardize their knowledge and ability, as well as assure their competency. The proposed PER program would help recent or current low-income family caregivers capitalize on informal caregiver experiences through formal training and subsequent skill enhancement, driven by the individual's ability and motivation to complete the program and apply their experience toward a health care profession.

Specifically, the program would supplement the skills that informal caregivers already learn while caring for an ill family member, connecting these newly skilled individuals with the health care industry through either certified supplemental training or credits toward an existing program. This could help family caregivers to parlay their learned skills into a productive career, mitigating some financial fallout while also finding some fulfillment after family caregiving duties are relieved, either through the recovery or passing of a loved one.

As noted, not all family caregivers would want to enter a position in the health care industry; we recognize this group and respect their preference. Others may be open to a position in the industry but not one involving direct provision of care. Rather, these caregivers may prefer (for cultural, personal, psychological, or logistical reasons) to obtain employment in other parts of the health care sector. For example, some caregivers might be interested in working for the insurance or billing sector, and skills gained while navigating the health care system for their loved one,

combined with previous school or professional experience, could allow them to do so. Whatever their specific preference, family caregivers could offer the health care industry a pool of motivated employees who already know some of the requisite skills and inherent challenges.

In short, the proposed program may begin to offer a win-win solution to the dual imperatives stated at the outset, meeting the needs of both caregivers and the industry. From the individual caregiver perspective, the proposed PER program could leverage the positive sides of the caregiving experience to provide long-term economic and emotional resilience. From a health care industry perspective, this PER program could help to stabilize and diversify the workforce along several dimensions that would match the evolving U.S. demography.

Pilot Evidence for PER Program Feasibility

Theoretically, the individual, societal, and health care industry perspectives suggest that a PER program would stand a strong chance of succeeding. Empirically, a 2009 survey of patients, families, and health care providers in suburban Chicago identified a pool of family caregiver candidates for such a program, revealing that they and stakeholders would respond favorably to this program (Simon, Dean, O'Halloran, Hajjar, & Emanuel, 2010; Simon et al., 2010). Additionally, recent studies in India and Uganda begin to demonstrate the viability of similar options that facilitate economic resilience abroad (Emanuel et al., 2008; Gupta & Tanneberger, 2007).

We fully recognize that additional research on program feasibility is required. For illustrative purposes only, and as an initial step in that direction, we collected pilot data by surveying a

sample of working-aged adults from across the United States. The sample was provided by Amazon's web-based mTurk service, which connects researchers, among others, with a panel of respondents (Amazon neither discloses the number of respondents in the pool nor discloses how many respondents view any particular survey on mTurk. The researcher only knows how many people have chosen to complete the survey. Nevertheless, psychometric research has repeatedly shown the sample to be reliable and representative of the general population) who have agreed to participate in short online studies for minor compensation (in this case, $0.25). Psychometric research has shown that the mTurk sample is quite diverse, reliable, and representative of the working-aged population at large (Buhrmester, Kwang, & Gosling, 2011). Table 2 details the questions and results of our survey. Among a sample of the 81 respondents who agreed to complete the survey within our time frame (40.5% men; mean age 35.7, SD = 14.8), almost everyone (n = 76; 93.8%) had at some point had a family member with a serious or long-term illness. About half of these respondents (n = 35; 46.1%) had served as a family caregiver, for an average of 28.8 hours per week. Most (94.1%) of the respondents who were responsible for paying their relative's medical bills reported adjusting their financial behavior (e.g., by reducing spending, taking out a loan, assuming additional credit card debt), and 68.6% of those who served as caregivers adjusted their career (e.g., by reducing their hours, quitting their job, delaying their education). Caregivers' responses suggested that they had learned from the caregiving process, and the full sample's responses suggested a general receptivity toward the idea of leveraging that learning through a PER program.

Although these data are cross-sectional and not necessarily representative of the U.S. caregiving population, they provide some illustrative evidence that the proposed PER program may serve a

need among a segment of the U.S. population. Clearly, further empirical research is needed with a larger and more representative sample.

The remainder of this article offers a practical model for implementing the proposed PER program. Our goal is to provide concrete steps and actionable guidance to practitioners and executives interested in implementing the program. We detail how interested parties would identify candidates; provide certifiable knowledge, skills, and abilities; and connect candidates to the health care industry.

Family Caregiver PER Program Implementation Logistics

Given that family caregivers will vary in terms of acquired skills, especially when they have not cared for a family member in hospice, the program would need to be flexible enough to assess, identify, and address all gaps in skill sets required for a particular job. Family caregivers could make the formal transition in many conceivable ways. For example, one permutation of the proposed program would help the family caregiver complete and certify training, then assist them in securing employment as a paid home health aide or in another health care role. Another permutation might include supplementing and certifying the caregiver's training for nursing, social work, or chaplaincy. In this example, home care experience might be accepted as an entry or "fast-track" qualification. Alternatively, standard programs could accept home care experience as an entry qualification or allow test-out options for relevant courses.

Among these options, our recommendation is to create an educational program that supplements and then certifies a family caregiver's skills at the home health aide level. Doing so would

reduce the variability of skills and thereby create a more concrete role for caregivers as part of the health care team. Creating a certification program would also help to ensure that certified individuals are willing and able to perform the relevant tasks, instilling more confidence in prospective employers.

To systematically realize the potential of this investment in human capital, it is necessary to define uniform standards and assure reliable quality. Existing programs for volunteer, caregiver, and nurse's aide training provide good starting points (International Longevity Center, n.d.; Rosalyn Carter Institute for Caregiving, 2007). Certification could be provided by a national body or by private bodies with mandatory or voluntary accreditation.

Although creating a certification program is undoubtedly the most effective means to assist family caregivers in achieving later entry into the health care workforce, many logistics about who will develop and administer and how to create such a program will require further attention. These details—including the location, platform, cost, course duration, and exam administration—are issues that need to become part of a broader discussion as program developers move the proposed PER program forward. Establishing a robust certification program requires both time and resources. Overall, existing institutions offer a plethora of platforms for connecting family caregivers with the health care industry, and additional institutions and platforms could be developed if and when the program's success is documented. To address this problem in the short term, we propose several means by which institutions and organizations can, themselves, bridge the gap between the acquired and required skills in the following sections (Cross & Emanuel, 2008).

Targeting Candidates

In any successful training program, the most suitable candidates must be identified. As indicated, the proposed PER program should optimally target working aged, recent or current family caregivers who face economic risk. Specifically, we suggest that many of such individuals should (a) come from families with little to no economic reserve, (b) be motivated to complete program requirements and to apply their skills toward a health care profession, and (d) be able to realistically obtain the qualifications necessary to succeed as a caregiver in this capacity.

The Supplementary Appendix included with this article provides illustrative contents of a possible screening survey that is intended to assess the level of interest in a PER program but has not yet been tested. The intent of this survey would be to screen adult family members of those who have or recently had an illness that required the family caregiver to reduce or terminate school or employment. This survey could also be used as a self-assessment tool for interested family caregivers.

In addition, we believe that the screening survey should aim to identify the subset of candidates who demonstrate the most interest in training, and the most suitability for a career in the health care industry. Specifically, questions would focus on both interest and qualifications by querying topics like age, skills gained through caregiving, grief closure (in the case of a family member's passing), interest in a certified caregiver role, communication skills, financial knowledge, and traits and dispositions. In addition, skills possessed by the individual caregivers would be assessed via a scale to determine the level of supplemental support required.

When designing this portion of the survey, program developers should determine how to surface the most accurate information about candidates' likely qualifications (e.g., direct questions vs. scenario-based questions). Program developers should be particularly aware that, for caregivers of a deceased relative, the degree of interest in program participation that a candidate expresses may be a function of the individual's grief closure. Special care should be taken when working with candidates whose caregiving experiences encompass end-of-life care. We recommend that additional questions outside of this survey also assess a given candidate's risk of exposure to poverty and their current financial situation.

Care should be used when evaluating a candidate's potential for success. Although, in some instances, the most impoverished individuals may be the most worthy candidates for the training program, these individuals may also be suffering such hardship that they could not benefit from this particular type of economic intervention. In such situations, individuals with slightly greater economic resilience may merit priority consideration, as they may be in a position to reap greater benefits and change their economic trajectory.

Connecting Candidates with the Health Care Industry

Several avenues exist through which candidates could be connected to the health care workforce. First, family caregivers could join existing programs. Caregivers could be directed to positions that require less education and thereby have a lower barrier to entry, like the occupations listed in Table 3. Certified nursing assistant (CNA) programs offer one example. These programs are administered by local community colleges and generally require 75 hours of course work

(Raymond, n.d.). The average cost of $300 is significant but probably not prohibitive to prospective caregivers, especially to those who receive a scholarship (Obeck, n.d.). A second avenue that institutions or organizations could recommend to caregivers is a technical education. Therefore, a caregiver could pursue a career in phlebotomy or another skill-based program. Phlebotomy certification programs are also available at local community colleges and cost about $1,600 on average (Keefer, n.d.). Some health care institutions interested in a program of this nature may offer loans or grants for this training.

Additional opportunities arise from the possibility of aligning the acquired skills with particular health care career paths. Such career paths could include newer careers such as patient navigator, community health worker, or peer educator. Other options include more established career paths like CNA, medical assistant, and home health aide. With further training and support, some individuals could go on to obtain their certification as a licensed practical nurse (LPN) or RN.

These career paths vary widely in earning potential, responsibilities, job availability, job location, and additional education and training required. An optimal family caregiver PER program prepares individuals for entry-level positions (CNA, medical assistant, home health aide) and also offers a path for more highly skilled and highly paid career tracks. Alternatively, new career paths specifically for those with home or long-term care training, or a new type of patient navigator, might need to be designed.

From a policy perspective, startup costs over the first few years of the proposed program should be within the range of average community education and training program grants. Ultimately, the

proposed program may have the potential to become economically self-sufficient and independent. Similar, but more involved programs might need continuing, modest support over the first few years.

Our proposal for caregiver training has some similarity with other programs that are under development or established. Caregiver training programs sometimes develop national in-home caregiver training standards (Schmieding Center for Senior Health and Education, n.d.). Some research on how to best support and train caregivers for elders also exists (EUROFAMCARE, 2006). In addition, caregiver training that parallels oncology clinician education in palliative care has begun to be developed, as part of the National Cancer Institute funded EPEC-O project (Emanuel, Ferris, von Gunten, & von Roenn, 2005). Similar initiatives have been implemented abroad. The United Kingdom's NHS provides multidimensional support for family caregivers and comprehensive resources for caregivers looking to return to the workforce. Further, NHS connects individuals interested in a health care career with appropriate industry platforms (NHS, 2012). Although independent home care agencies offer in-house training regulated by the Care and Quality Commission, no formal, public training program exists that specifically trains family caregivers for careers in the health care industry. Moreover, to our knowledge, no training program exists yet in any country that leverages family caregiver employment specifically in the health care industry for the purpose of economic resilience or mitigating the talent shortage.

Why this Matters and to Whom

Spiraling health care costs, the recent financial crisis and recession, and a health care industry talent shortage seem to have created the perfect storm, threatening the viability of health care

organizations and the patients and families who depend on them. PER programs may offer one solution that begins to address these challenges. The proposed PER program for family caregivers provides a practical plan for getting family caregivers back on their feet. Consistent with the tenor of health care reform, it could begin to address the talent shortage by targeting, training, and connecting a large and new influx of diverse talent, thereby helping to stabilize the workforce. Additionally, the program could begin to address the relationship between illness and poverty by building human capital and promoting economic resilience among at-risk individuals, ultimately improving their prospects for steady employment above the minimum wage. Figure 1 depicts an integrated schematic of our proposed PER program.

As an example of the program in action, consider a family caregiver from a low-income family. For 2 years, this hypothetical caregiver has been providing care to her mother, who had cancer and just passed away. While caring for her mother, the caregiver has not worked; accordingly, she has taken out loans to pay for her mother's medical bills. Prior to her mother's illness, she worked in a school cafeteria at minimum wage. After her mother's passing, the caregiver could possibly reapply for her job in the same cafeteria. However, she has now gained new caregiving skills that—with a reasonable amount of relatively low-cost supplemental training through the PER program—could allow her to obtain certification. This certificate, in turn, could enable her to apply for a medical assistant or other caregiver position. We believe that, after a sufficient amount of grief closure, this caregiver and others like her might prefer the opportunities afforded by a PER program. If so, the health care industry would benefit from a new and experienced set of employees.

As this example suggests, the proposed PER program is grounded on the basic economic principle that individuals will generally pursue the path that maximizes their utility, broadly defined. Avoiding economic deprivation and achieving economic resilience are inherently beneficial for families suffering the fallout from an illness. The PER program is not a curative remedy; it applies only after considerable economic damage has been incurred—and often becomes feasible only after a family caregiver's duties are relieved. Additionally, it would not help those who are not interested in or qualified for health care work. Some who forgo opportunities in order to care for their loved one may have better paths to recovery. Some who provide end-of-life care may find the emotional toll too high or the responsibilities too demanding so soon after bereavement. That said, we believe that many people would find gainful employment and the opportunity to assist others, an important part of the economic and emotional recovery process.

Some clarifications and caveats should be noted. As stated, not all caregivers are eligible or want to gain employment after caring for their loved one. Rather, some are patients who, themselves, need health care support. Although this could decrease the impact of the PER program, it is also important to note another consideration that could increase its impact: the economic challenges of illness often extend to people with insurance. The vast majority of people with health insurance in the United States remain vulnerable to economic deprivation as a result of the multiple dimensions of the cost associated with illness. For example, health insurance rarely covers lost wages or foregone educational opportunities. Additionally, the current move in national policy toward preemptive versus reactive health care strategies (e.g., the Patient

Protection and Affordable Care Act) makes it increasingly important to target those who are likely to lose significant financial ground as a result of illness (e.g., the underinsured).

For these reasons, we believe that the PER program for family caregivers offers a step in the right direction. Having presented the basic outlines of a PER program, substantial future effort would be required to see our proposal to fruition. For example, future data collection on the feasibility of the PER program for caregivers from various communities around the United States, especially from distinct cultures and socioeconomic positions, would enhance the empirical evidence presented here. Likewise, in-depth, qualitative interviews with leaders from multiple health care industry sectors (e.g., hospice, health care insurance, medical centers) as well as the public sector would help to demonstrate PER feasibility from a programmatic perspective. Similarly, the input of education and training sector leaders is needed to understand the logistical and content-related requirements for a PER program. Once this information is collected and analyzed, pilot testing of different types of PER programs is needed before undertaking any full-scale implementation.

In summary, we recognize that additional research and program development is required. Nevertheless, we believe that the rationale and preliminary evidence presented here suggest that the proposed PER program could appeal to both family caregivers and the health care industry, thereby promoting economic resilience and helping to mitigate the health care talent shortage. Given the tectonic shifts currently shaking the U.S. health care system, we strongly encourage further discussion, debate, and dialogue on the development of PER programs as a step toward the future.

* End notes, references, tables, and figures available from Brian Gunia