



Careers in Crisis

How Black Women in the United States' Largest Industry Were Left Behind in the COVID-19 Pandemic

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IERE

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Introduction

Since the beginning of the COVID-19 pandemic, essential workers continuously put themselves in harm's way to keep the United States running. We are deeply grateful for the labor of all essential workers over the past year, and recognize that their contributions kept so many other Americans safe, fed, and healthy. These contributions, and the short- and long-term consequences of the sacrifices that essential workers made during the COVID-19 pandemic differed by race, gender, industry, and occupation.

This report examines employment trends for essential workers over 12 months, beginning at the start of the pandemic. In particular, we highlight racial and gender inequities in the healthcare workforce and the experiences of Black women. Key findings include:

- While all essential workers suffered through the pandemic, Black women faced higher unemployment and lower wages than almost every other group.
- In health care, the occupations with a larger proportion of Black women had the highest unemployment and the lowest wages.
- While white healthcare workers were able to see rewards from their work through career advancement, Black women's career standing more often stagnated or fell.

Essential work encompasses jobs in health care, energy, retail, transportation, and many other sectors. Between and within industry sectors, wages, job quality and advancement opportunities can vary greatly by occupation and type of workplace. Speaking about essential work in light of an equitable recovery requires us not only to examine the overall trends within the labor market, but also to analyze trends within sectors.

Health care is a particularly important sector to examine in the light of COVID-19. In just 30 years, the healthcare workforce has more than doubled, supplanting first manufacturing and then retail as the largest employer in the United States.ⁱ Registered Nurses and Nursing Assistants make up the first and second largest occupations in health care respectively with an annual wage gap of over \$45,000 between the two.^{ii,iii} The industry also suffers from a great deal of occupational segregation, with workers in the highest paying, high-level jobs primarily being white and those in lower paying, entry-level jobs primarily being women of color.^{iv}

Findings suggest a troubling, magnifying effect of COVID-19 on pre-existing inequities in labor markets, illustrated by a year of stagnate career progress and job loss for Black women in health care. The story the data tell makes a case that equitable career pathways are an essential ingredient in policymaking to ensure an equitable recovery.

COVID-19 and the Devastation of Low-Wage Workers

In April 2020, one month after the first states enacted stay-at-home policies, the U.S. economy experienced unprecedented losses in hospitality, retail, tourism, business, and related industries. The leisure and hospitality industry shed 47% of its jobs, the most impacted sector at the height of the pandemic, followed by the health care and education, and the professional and business services industries, which all lost over 2 million jobs.^v

By the end of 2020, 15.8 million people were unemployed or underemployed.^{vi} As of February 2021, the unemployment rate was 6.2%. This rises to 11.1% if we count workers that are unemployed or marginally attached to the labor force.^{vii} For white workers, the unemployment rate in February dropped to 5.6%; however, Black and Latinx workers experienced rates of 9.9% and 8.5% respectively.^{viii} Women have also been disproportionately affected in certain sectors: the government sector lost 45,000 jobs in just one month, with women accounting for 91.1% of those losses while making up only 57.5% of the government workforce.^{ix} The unemployment rate for all women is in line with all men as of February, but when examined in concert with race, trends are extremely worrying. Overall, employment for Black women was 9.7% lower than it was one year ago and employment for Latinx women was 8.6% lower. Comparatively, employment for the U.S. workforce in general was down 5.4% over the course of the year.^x

Employment rates for Black and Latinx women are nearly 10% lower than they were pre-pandemic.

1.4 million healthcare workers lost their jobs in April 2020.

Despite being categorized as essential workers, 1.4 million healthcare workers lost their jobs in the first months of COVID.^{xi} This is in part due to budget shortfalls in healthcare facilities. Hospitals for instance, traditionally seen as one of the more stable workplaces in health care, saw the number of patients seeking care drop approximately 50%, causing monthly budget shortfalls as high as \$60 billion.^{xii} While these shortfalls were in clear recovery prior to the second surge of infections that began in late November 2020, some analysts predict that patient volumes may remain 5-10% lower than before pre-pandemic levels.^{xiii} While these figures have leveled off in the months since the initial surge, unemployment remains a real issue for many workers in essential industries, and the racial and gender gaps in unemployment that grew show little sign of shrinking.^{xiv}

The largest numbers of jobs lost since April were in low-wage industries,^{xv} suggesting that workers at the margins were the hardest hit. Many families had no margin in the first place.

At the start of the pandemic, 80% of American workers were living paycheck to paycheck; 14% of white households, 28% of Black households, and 24% of Latinx households had zero or negative wealth.^{xvi} Even now, several months into economic recovery, approximately 60% of households have difficulties covering usual household expenses, with that rising to 77% for both Black and Latinx households.^{xvii} Meanwhile, the country's 664 billionaires saw their wealth increase by 44% or \$1.3 trillion during the pandemic.^{xviii}

77% of Black and Latinx households report having difficulty covering usual household expenses.

One year after the worst of the pandemic's economic effects, virtually every American has seen their life altered in some way by the pandemic and/or subsequent policies designed to balance economic stability and safety. Nearly every occupational sector is operating from a new normal. Work has been transformed for all but front-line essential workers, industries are adapting to meet consumers' new realities, and policymakers are focused on recovery. But these transformations impact Americans differently because of underlying racial and gender inequities in labor markets, neighborhood resources, health care, education, policing systems, and more.

For example, Black, Latinx, and Indigenous families are 2.7 times more likely to die of COVID when adjusting for age.^{xix} While communities of color are experiencing greater fatalities related to the virus, they may also be experiencing losses from police brutality or immigration enforcement, and unemployment at higher rates. During the pandemic, food insecurity grew among all racial and ethnic groups, but while around 30% of white households were food-insecure during COVID-19, approximately 50% of Black and Latinx households were food insecure.^{xx} Moreover, people of color were less confident about their food security than white people. The longstanding

In 2020, 50% of Black and Latinx households struggled with food insecurity.

racial wealth gap in the country means that white families are more likely to have resources to put food on the table if they become unemployed. They are also more likely to be employed in higher quality jobs that enable them to work from home, care for family members, or even advance in their careers during this global public health crisis.

To analyze labor market trends over the course of 2020, in the following analysis of the essential workforce, we pair the Center for Economic and Policy Research's (CEPR) list of frontline workers,^{xxi} which is based on the NYC Comptroller's Office's report, with the Economic Policy Institute's list,^{xxii} which also includes essential workers in non-essential industries, in order to identify essential workers in the Census Bureau's Current Population Survey. This report uses the Basic Monthly Current Population Survey (CPS) and the merged Outgoing Rotation Group (ORG) data. Please see **Page 17** for a detailed methodology.

Who is essential?

On March 19th, 2020, the Cybersecurity and Infrastructure Security Agency developed a list of 16 sectors “that are considered so vital to the United States that their incapacitation or destruction would have a debilitating effect on security, national economic security, national public health or safety, or any combination thereof.”^{xiii} This list became the basis for general definitions of essential work and an essential worker. The essential workforce is not cleanly defined by this, however. For example, cafeteria staff in nursing homes are considered essential workers in a non-essential sector. While food service as a sector is considered non-essential, the specific occupation (cafeteria staff) is considered essential. The Economic Policy Institute developed a list of such occupations, which we have used as a basis for our analysis.

Half of essential workers work either in health care or food and agriculture.^{xxii}

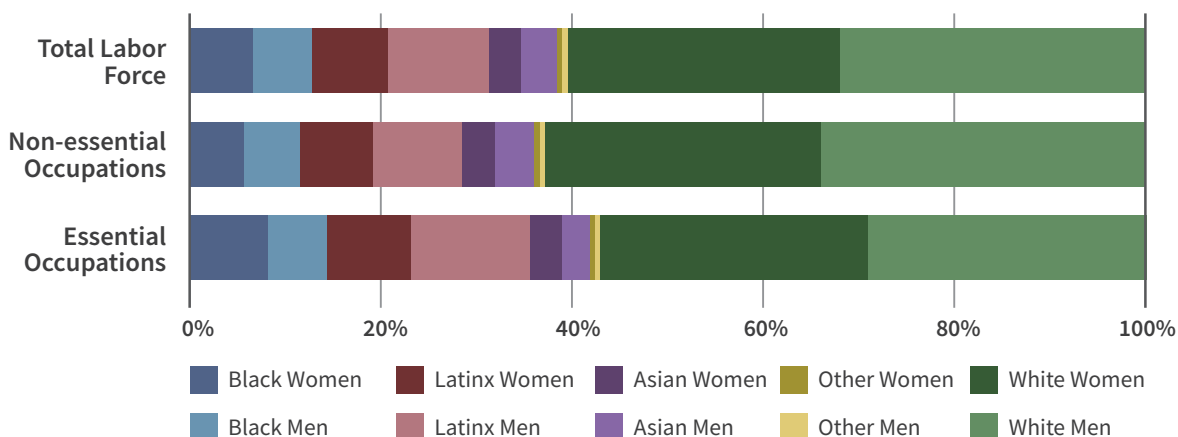


30%
work in
Health Care



20%
work in Food
& Agriculture

Figure 1: Black and Latinx workers are overrepresented in essential work.



Essential Work in 2020

While jobs in the 16 sectors were deemed essential to society, workers in them tend to earn much less than those in jobs categorized as non-essential, and the earnings gap between essential and non-essential workers grew during the pandemic. Conversely, non-essential workers were hit harder by unemployment than essential workers, though essential workers still faced a high level of unemployment. This gap reached its peak in April of 2020, when unemployment for non-essential workers grew to 16%, and unemployment for essential workers reached just below 12%.

Figure 2: The weekly wage gap between essential and non-essential workers grew.

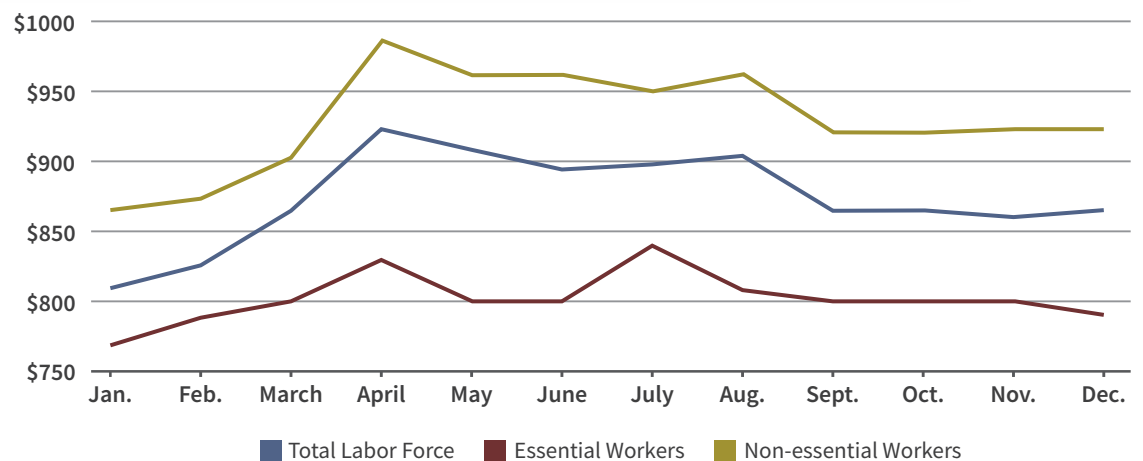
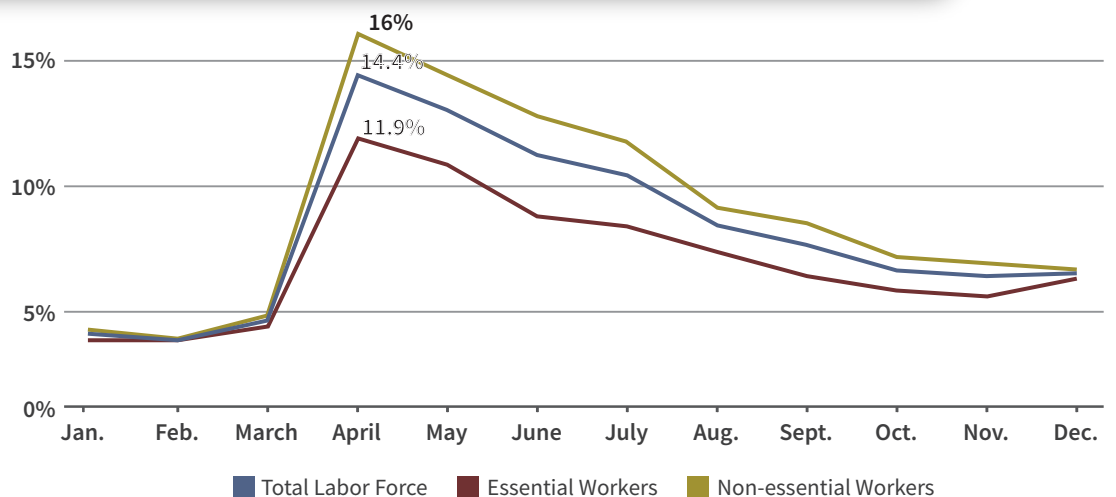


Figure 3: Non-essential workers were hit with higher levels of unemployment.



Composition and Compensation of the Essential Workforce

People of color and women are overrepresented in the essential workforce. While people of color make up 39.5% of the labor force, they make up 43% of the essential workforce (**Figure 1**). Black women and Latinx men are particularly overrepresented. Black women work in essential occupations at a rate that is approximately 22% higher than their participation in the workforce as a whole, while Latinx men work in essential occupations at a rate that is approximately 18% higher than their participation in the workforce as a whole.

Workers in these essential occupations tend to earn much less than those in jobs categorized as non-essential. In January of 2020, essential workers had a median income of approximately \$770 per week, while non-essential workers earned around \$865, a gap of \$95 per week. This gap grew throughout the pandemic (See **Figure 2**). At the height of the pandemic's economic downturn in April 2020, essential workers made \$830 per week, while non-essential workers earned \$985, a gap of \$155 per week. The wage gap between essential and non-essential workers did not return to pre-pandemic levels in 2020, and as of December the gap was \$133 per week. Had this earnings gap remained at January levels, essential workers would have earned approximately \$19,000 more over the course of 2020.

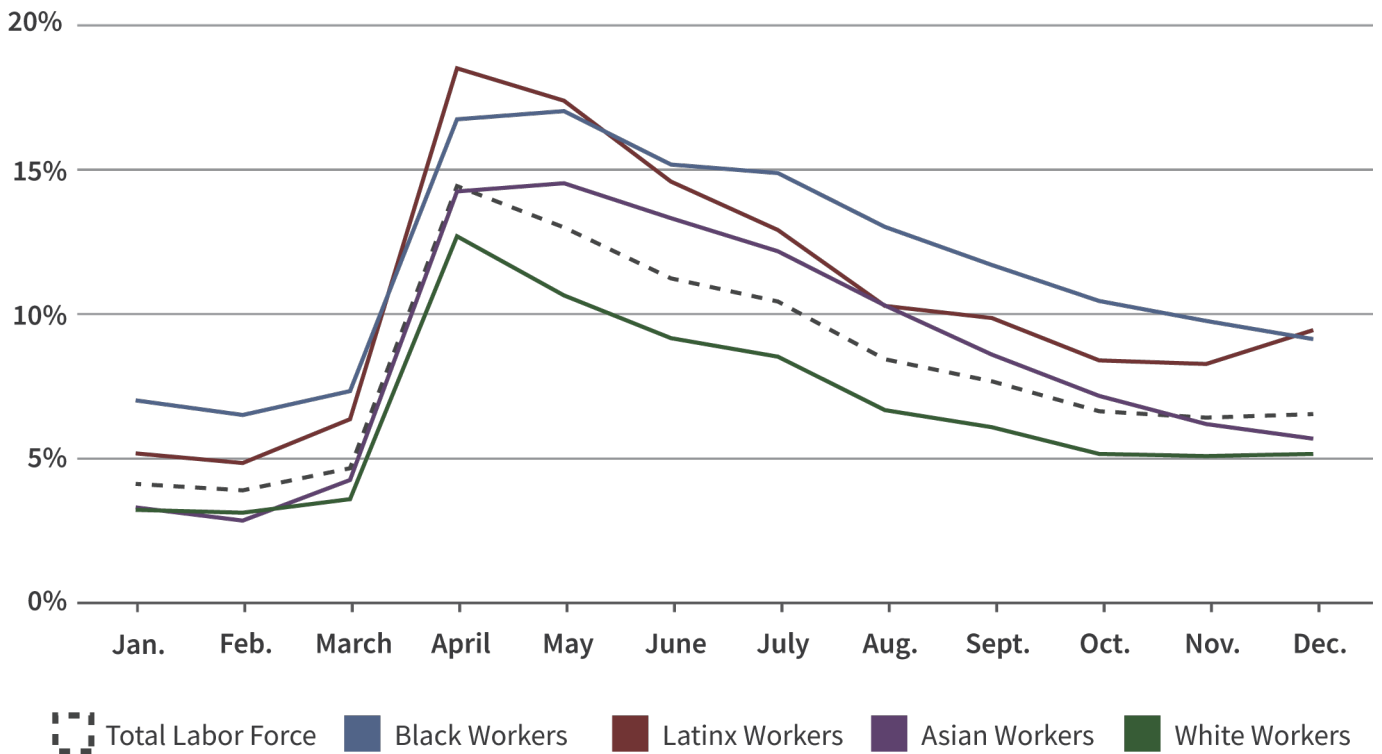
A growing earnings gap means that essential workers lost \$19,000 relative to non-essential workers over the course of 2020.

Unemployment for essential workers peaked at 12% in April of 2020.

Alternatively, non-essential workers were hit harder by unemployment than workers, though essential workers still faced a high level of unemployment. At its peak in April, the unemployment rate for non-essential workers was approximately 16%, while the unemployment rate for non-essential workers was almost 12% (**Figure 3**). By December, the unemployment gap between essential and non-essential workers had dropped, though overall unemployment remained above 2020 levels.

Given the lower rate of unemployment among essential workers and the higher concentration of people of color in these jobs, one might assume that they were relatively shielded from the worst economic effects of the pandemic. This is untrue. Black and Latinx workers faced higher-than-average levels of unemployment throughout the pandemic (**Figure 4**). The unemployment rates for all Black and Latinx workers were 16.7% and 18.5% respectively in April, while the unemployment rate for white workers was below that of all other workers at 12.7%.

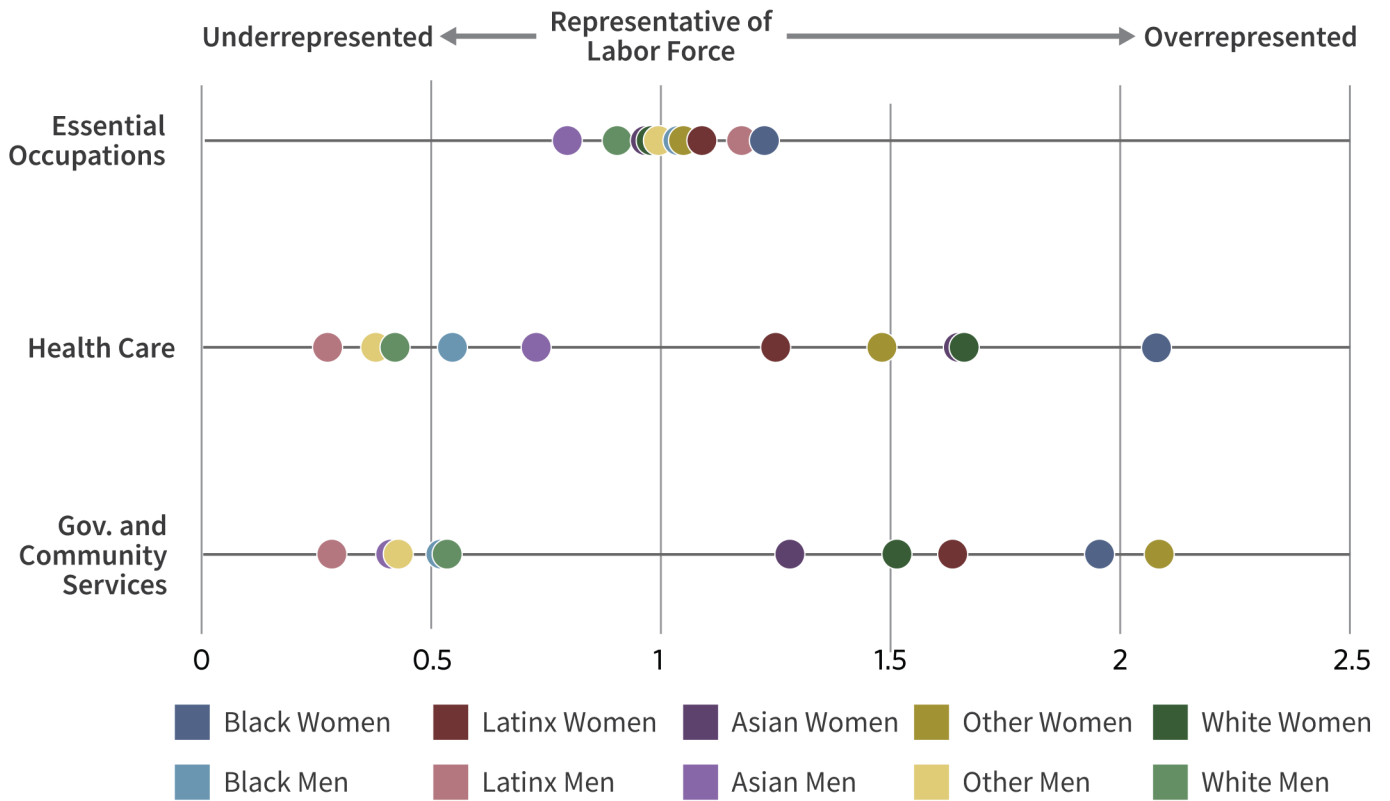
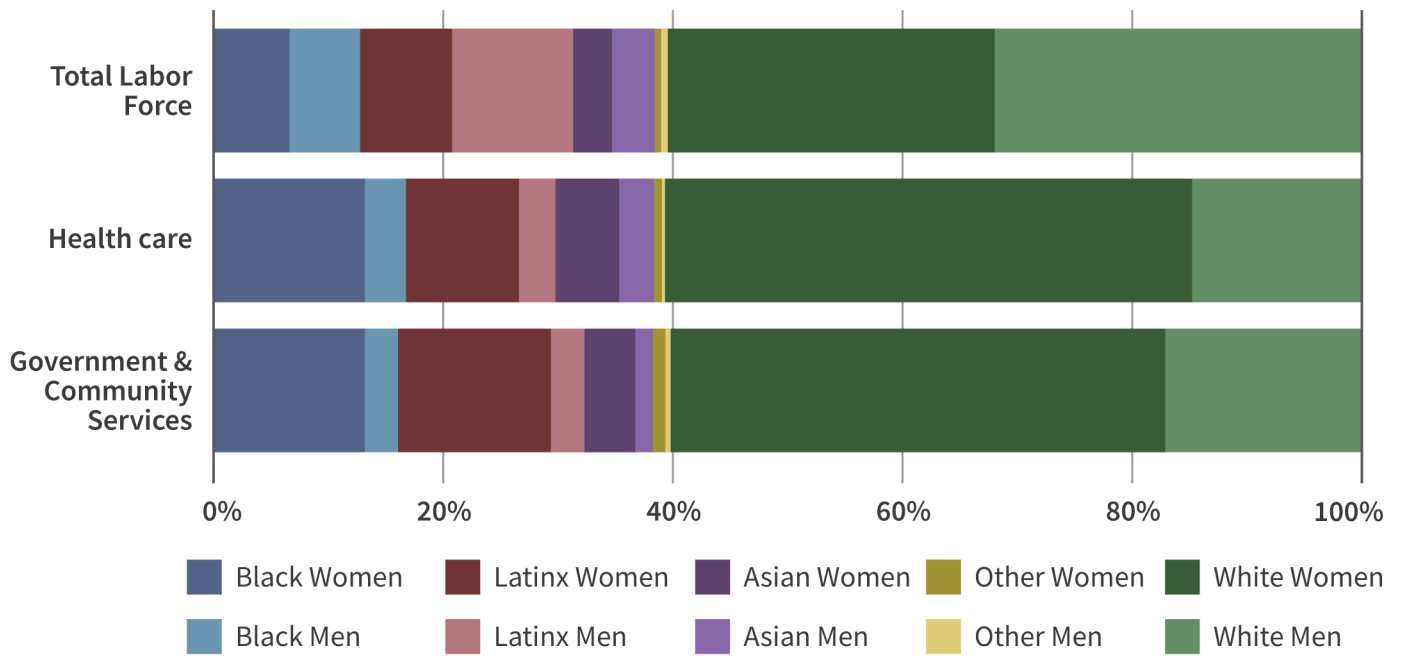
Figure 4: Black and Latinx workers faced higher levels of unemployment throughout 2020.



Black women are particularly overrepresented in essential occupations, especially in those related to health care and community service, fields traditionally seen as safe and stable with opportunities for advancement (Figure 5). Nearly one-quarter (24.6%) of Black women in the labor force work in health care, representing 13.4% of all people working in healthcare occupations. This is approximately two times larger than their share in the total labor force. Despite this fact, wages for Black women were low throughout the pandemic, and unemployment among Black women ballooned, reaching its highest point of 17% in April 2020 (Figure 6). While the unemployment rate has dropped, as it has for all other sectors of the population as recovery begins, Black women’s unemployment remains high at 8.9% and was the only to rise between January and February of 2021. In both essential and non-essential sectors, Black women faced higher unemployment and lower wages than the sector average.

Nearly one-quarter of Black women in the labor force work in the healthcare sector

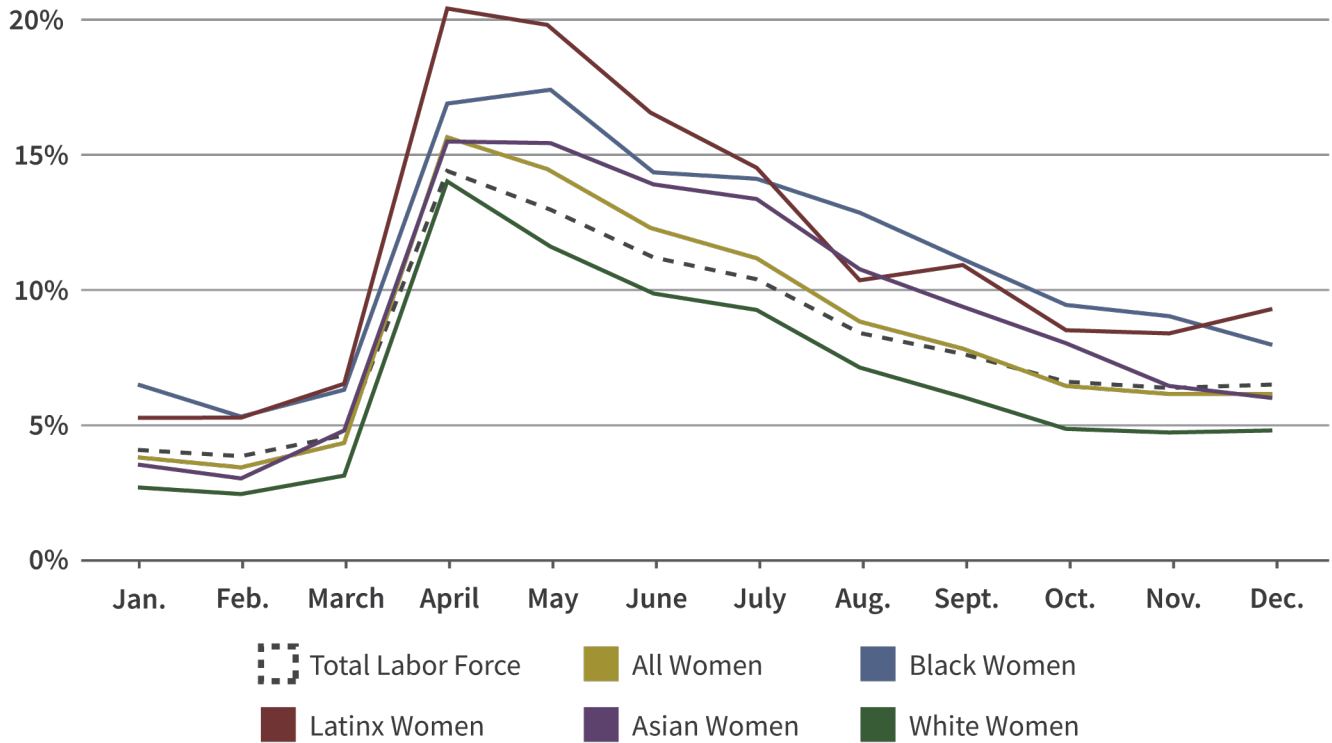
Figure 5: Black women are overrepresented in health care and government and community services.



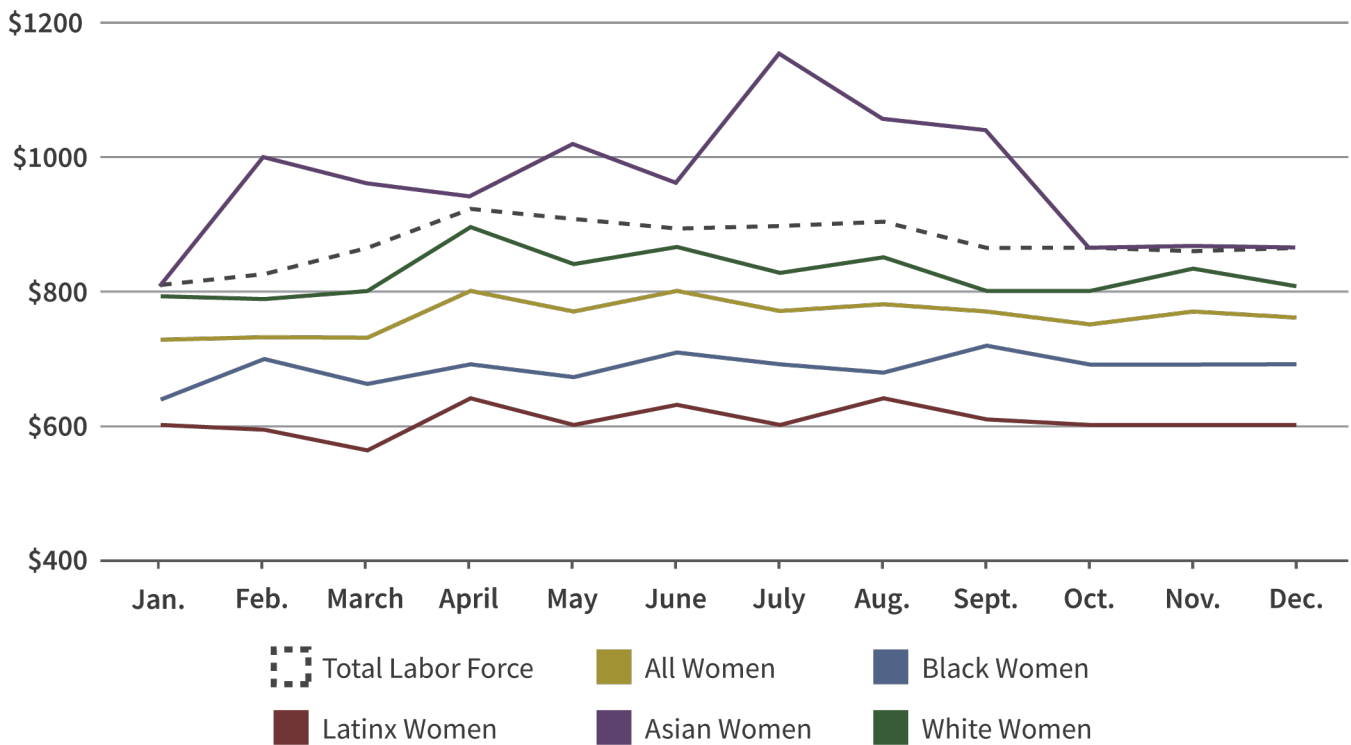
Authors' calculation of representation ratios in essential occupations compared to total labor force participation

Figure 6: Black women faced high unemployment and low wages throughout 2020.

Unemployment Rate for Women Jan. 2020-December 2020



Weekly Wages for Women Jan. 2020-December 2020



Occupational Segregation

Occupational segregation, or when groups of people are over- or under-represented within and across industries or occupations helps to explain the disparities in unemployment and wages for people of color during the pandemic. Black and Latinx people are overrepresented in essential work, and within the broad industry categories, they are segregated into the lowest-quality jobs – those with the least job security, the lowest wages, fewest benefits, and least amount of autonomy.

Labor Market Segmentation

One way of examining occupational segregation within an industry is by utilizing segmented labor market theory. Theorists have developed different criteria for how jobs differ in an industry. Piore (1970) separated jobs into the categories of *primary* and *secondary*. *Primary* jobs have high wages, good benefits, good working conditions, and a high degree of autonomy, while *secondary* jobs have low wages, bad working conditions, and a low degree of autonomy. For the ease of the reader, we will refer to *primary* jobs as “*Valued*” and *secondary* jobs as “*Undervalued*”. Later, Doeringer & Piore, (1971) sorted jobs into two categories on the basis of working conditions, level of responsibility, and closeness to the core operations of the employing firm. *Internal* jobs, which require a high level of skills and are engaged in firm-specific tasks, and *external* jobs, which have less specific tasks and are engaged at the periphery of an organization. For ease of reading going forward, we will refer to *internal* jobs as “*Secure*” and *external* jobs as “*Insecure*”.

Four Labor Market Segments

Valued

- High wages
- Good fringe benefits
- Good working conditions
- High degree of autonomy and responsibility

Undervalued

- Low wages
- Poor working conditions
- Low degree of autonomy and responsibility

Secure

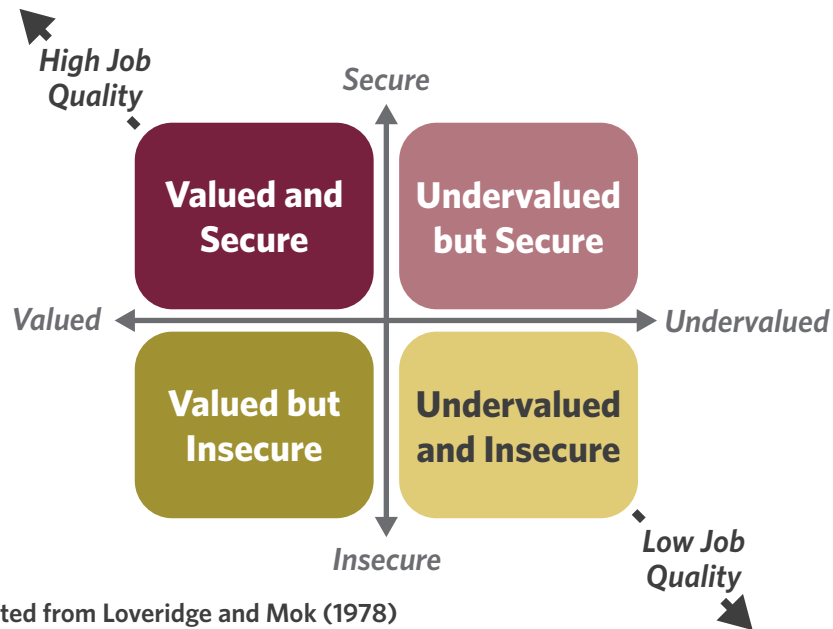
- Firm-specific tasks
- High level of skills required
- On-the-job training required
- Good opportunities for advancement in internal market

Insecure

- General tasks
- No on-the-job training required
- No opportunities for advancement or access to internal jobs
- On the periphery of an organization, inside or outside the firm
- Marginal work

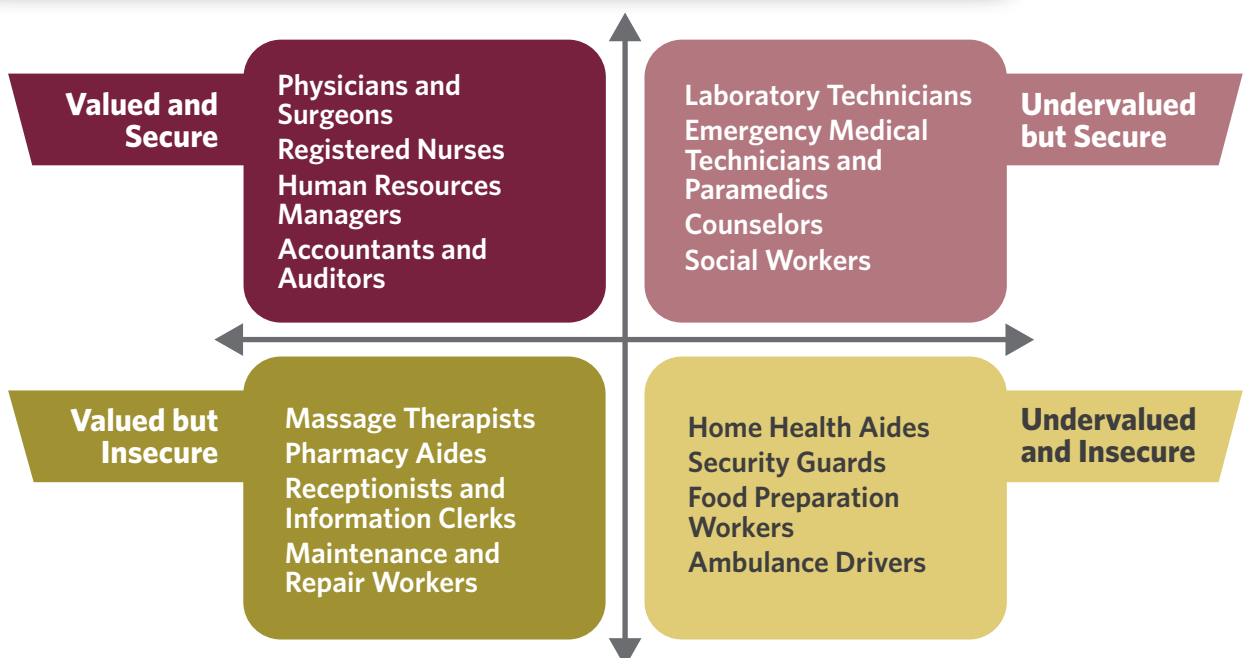
Segmentation in Health Care

Segmented labor market theory applies particularly well to health care, which has internal credentialing mechanisms that enable advancement for some occupations but not others. Loveridge and Mok (1978) first intersected the dual labor market models. We adapted this model to develop a framework for understanding job quality and advancement, we matched to Standard Occupational Classification (SOC) codes to allow for career trajectory analysis.



* Matrix adapted from Loveridge and Mok (1978)

Selected Healthcare Jobs by Labor Market Segment



*Healthcare segmentation analysis by IERE

Health Care and Occupational Segregation in 2020

People of color, particularly Black women are overrepresented in undervalued and insecure jobs, the segment with the worst job quality (57.8%), while white workers are overrepresented in valued and secure jobs, the segment with the highest job quality (67.7%). While most labor market segments within healthcare earned more than the average for essential workers as a whole, wages for undervalued and insecure healthcare jobs hovered around just \$500 per week throughout the pandemic, well below the average of other essential occupations. As one would expect, healthcare workers in insecure occupations were hit harder by unemployment than those secure occupations. The unemployment rate of valued but insecure occupations was highest in May (11.1%) and that of undervalued and insecure occupations was in April (7.9%). Unemployment rates for valued and secure and undervalued but secure jobs reached their height in April at 5.8% and 6.5% respectively.

Figure 7: Black women are overrepresented in the lowest-quality healthcare jobs.

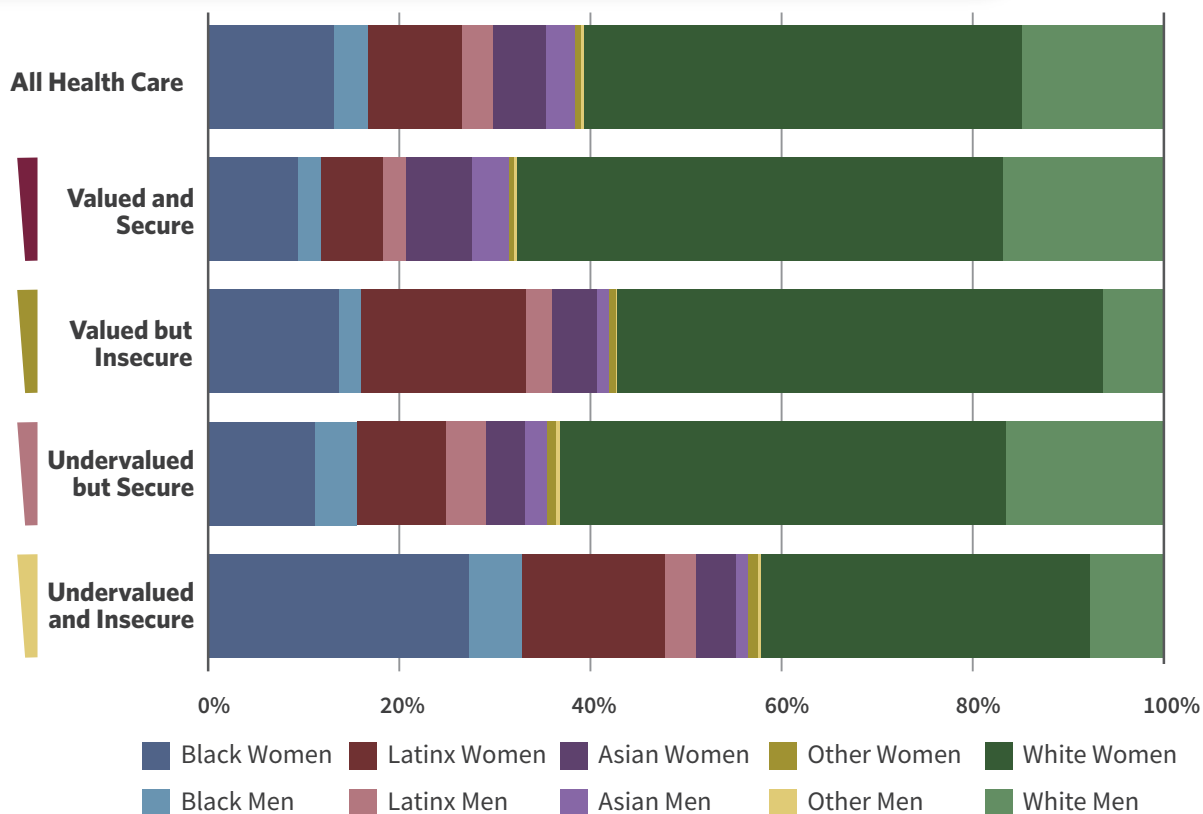


Figure 8: Workers in undervalued and insecure jobs earned the least through 2020.

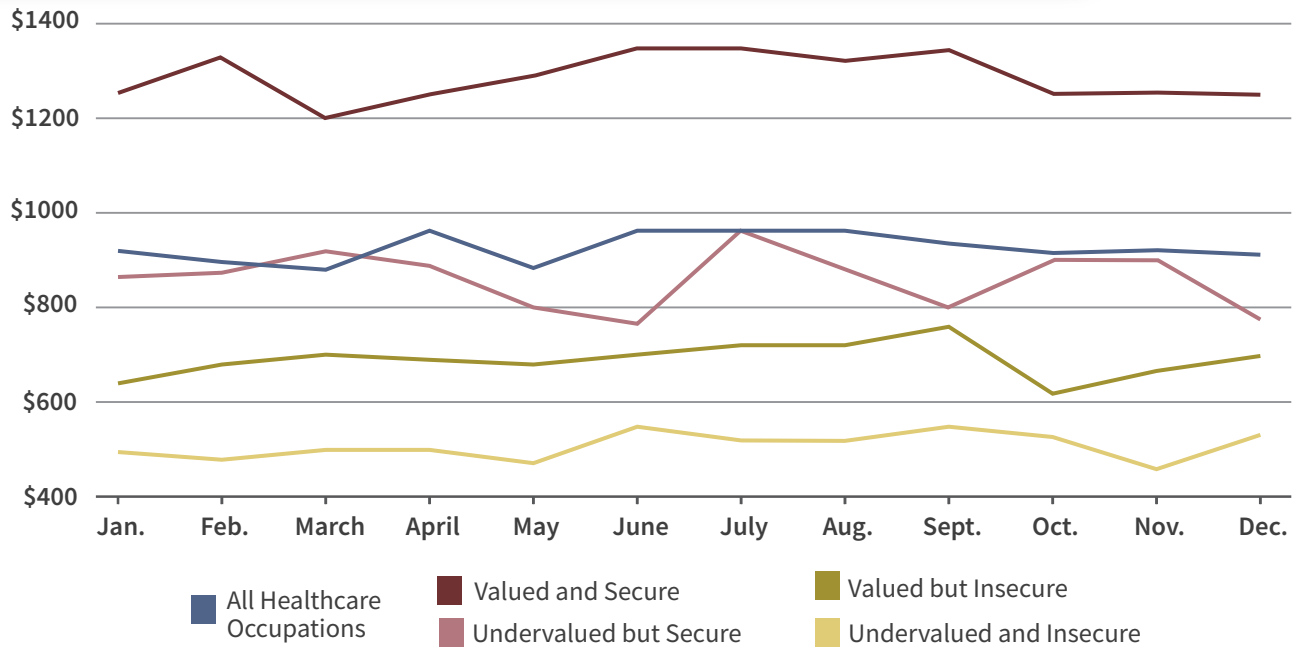
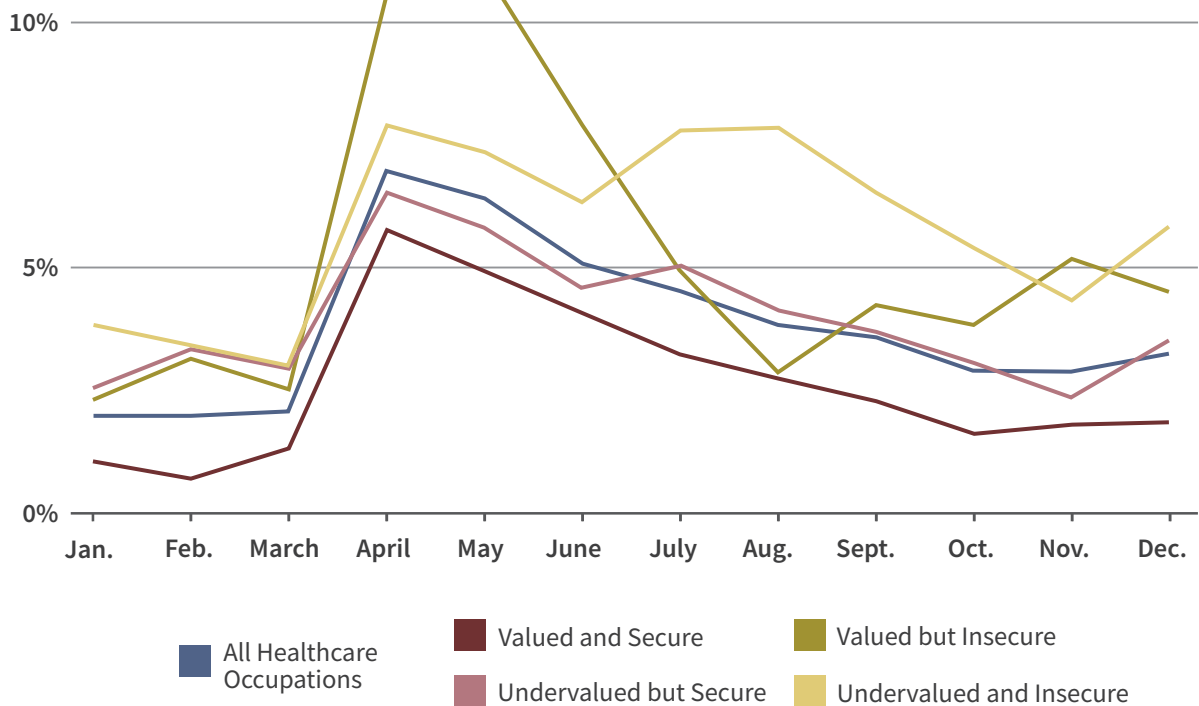


Figure 9: Unemployment was higher for healthcare workers in insecure occupations.



Essential Work, Occupational Segregation, and Health Care

Throughout 2020, Black and Latinx women and men were concentrated in low quality occupations (i.e. those in the undervalued and insecure segment), which include home health aide, food preparation, housekeeping, and childcare jobs. White and Asian men and women are concentrated in high quality jobs in the valued and secure segment, such as physician, surgeon, and registered nurse positions. Women found in the highest quality job segment are predominantly white and Asian (**Figure 7**).

Healthcare wages primarily stagnated throughout the pandemic.

Healthcare workers on average experienced lower unemployment and higher wages compared to non-essential sector workers, but differences between segments within the healthcare sector are obscured by the average trend. As a whole wages in the healthcare sector stagnated, though small weekly wage gains were seen in the valued but insecure segment and small losses were seen in the undervalued but secure segments. Only undervalued but secure and valued and secure jobs drew above the average weekly wage of essential workers for every month in 2020, while the wages of undervalued and insecure occupations were far below average (**Figure 8**).

As one would expect, healthcare workers in insecure occupations were hit harder by unemployment than those in secure occupations (**Figure 9**). The unemployment rate of valued but insecure occupations soared from approximately 2.5% to a peak of 11.1% in May 2020. Pre-pandemic, healthcare workers in undervalued and insecure occupations faced an unemployment rate of approximately 3%; by April 2020, the unemployment rate for this segment had risen to 7.9%.

The low wages and high unemployment seen during the pandemic were primarily driven by the realities of workers in the undervalued and insecure segment. These insecure segments are already lower-quality jobs, which are difficult to move out of, and the workers in these segments are among the most vulnerable in health care. As we saw during the Great Recession, unemployment during economic crises can be far-reaching and have significant effects on the lifetime earnings, advancement prospects, and job quality of those who experience it. Within health care itself, we have seen unequal returns for labor and growing wage gaps between segments over the years, with wages in the valued and secure segment rising while others' wages have shrunk or stagnated, masking the true nature of job quality and advancement within the healthcare sector. Finally, because Black women are overrepresented in insecure healthcare jobs, we see further racialized effects, which were exacerbated by the pandemic.

Essential Work and Mobility in Health Care

These trends might not be so troubling if we saw equitable job mobility in 2020, with workers in undervalued and insecure positions moving into valued and secure positions. After all, the most prevalent frameworks for workforce development that we currently use rely on getting people entry-level jobs in the hopes that they are able to advance without further intensive interventions. In fact, we do see some transitions into better healthcare jobs, but not for Black healthcare workers (see [Page 17](#)).

In looking at four time points during the pandemic, we see that the majority of white workers in our data started and ended in valued and secure occupations ([Figure 10](#)). At time point 1, the majority of white healthcare workers are in valued and secure jobs. Some who begin in valued and secure occupations drop out of the sector in some observation periods (primarily in time point 2, when a small but sizable number move to non-healthcare occupations), but an overwhelming

majority of our sample returns to valued and secure jobs by time point 4. Moreover, a significant number of those who are unemployed or employed in undervalued and insecure segments have valued and secure jobs by time point 4. Except in the case of observation period 2, perhaps the first shock related to COVID-19, the majority of movements are to labor market segments that offer greater stability.

The majority of job transitions for white women in health care in 2020 were to less vulnerable jobs.

Black healthcare workers faced a very different advancement story through the pandemic ([Figure 11](#)). The majority of Black healthcare workers began in undervalued and insecure positions, the most vulnerable occupations in health care. While a sizable portion also began in valued and secure positions, we see many fewer transitions to valued and secure positions from those in undervalued and insecure occupations. In fact, transitions out of healthcare occupations or into undervalued and insecure positions are much more prevalent among Black healthcare workers in all segments, especially among those who begin in valued and secure positions. While career advancement has not halted through the pandemic, we see that Black and white healthcare workers are experiencing wildly different advancement stories. Even during the pandemic, white healthcare workers transitioned to occupations associated with better jobs, higher pay, and more advancement opportunities, while Black workers were less likely to advance, in many cases experiencing setbacks.

Black women in health care saw their careers stagnate or moved into more vulnerable jobs.

Figure 10: White women in health care moved into less vulnerable jobs in 2020.

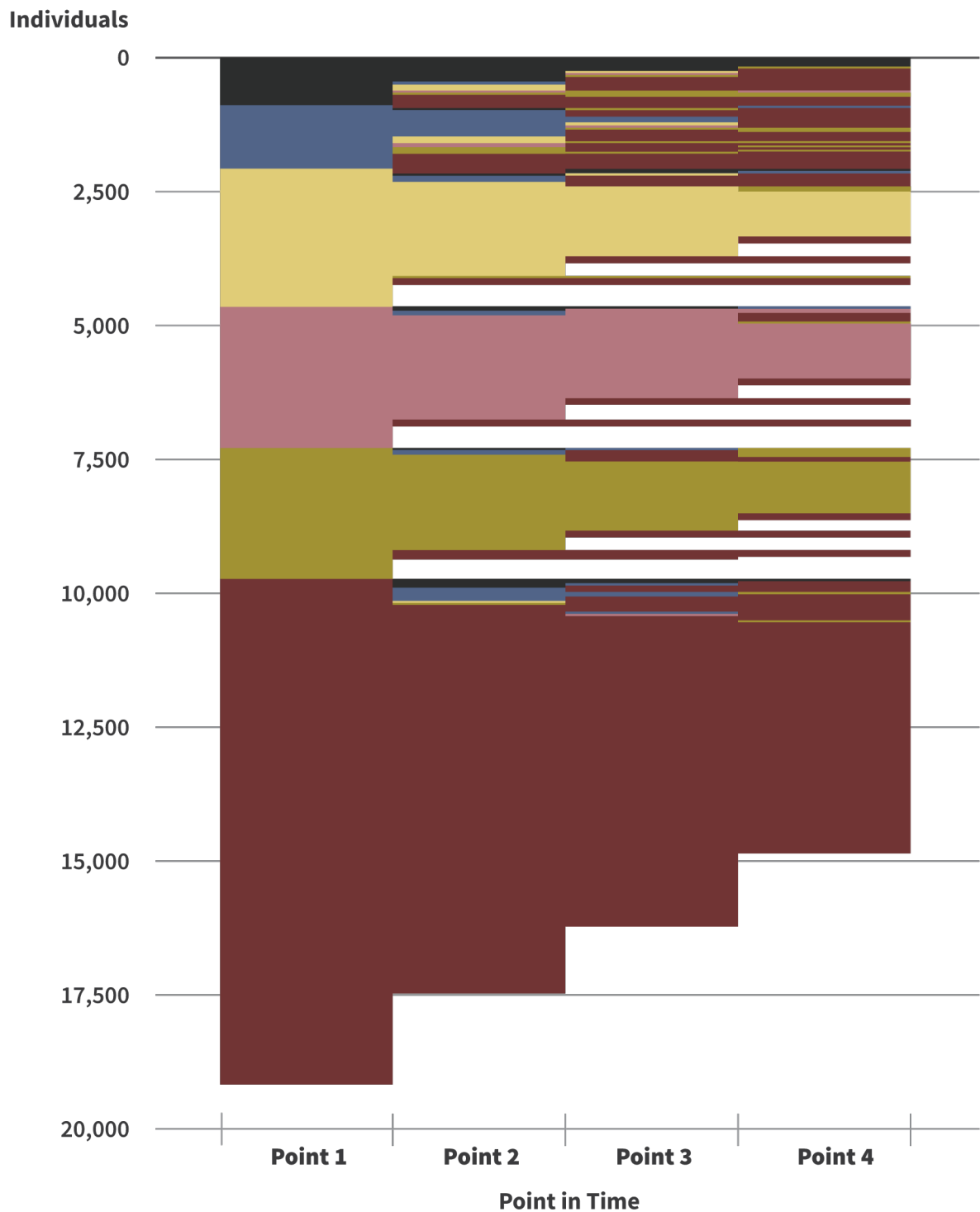
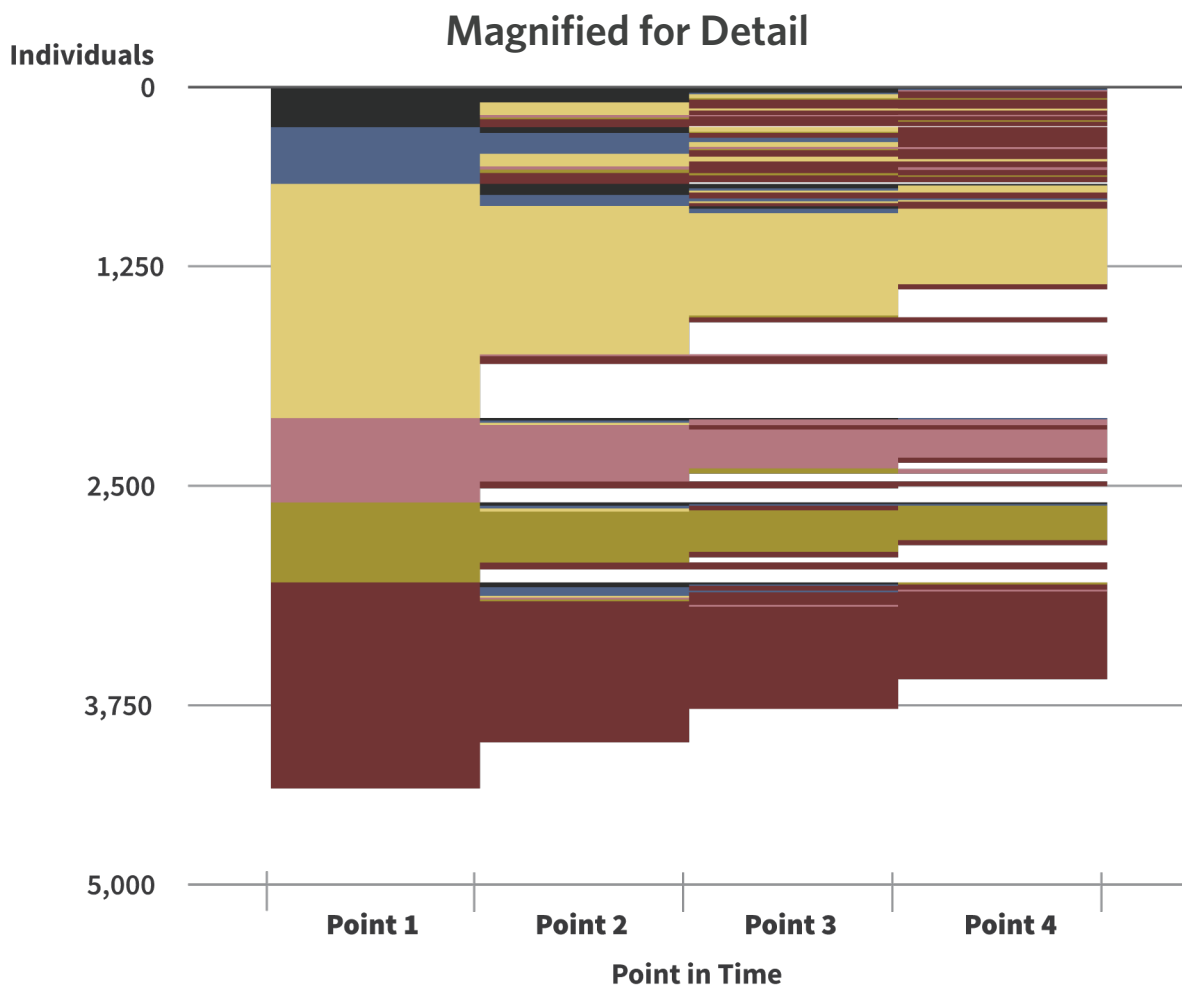
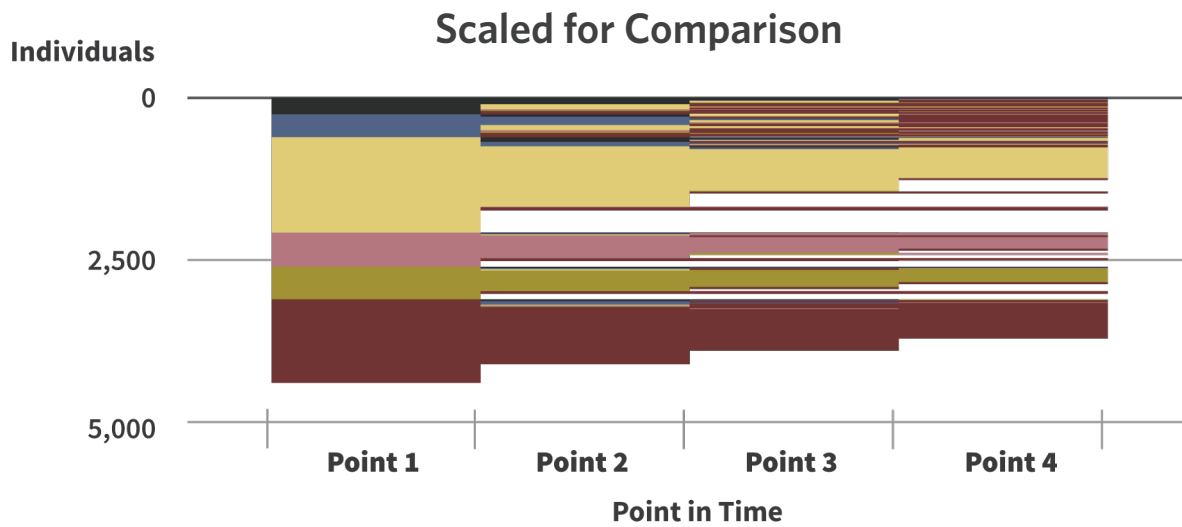


Figure 11: Black women in health care experienced stagnation or moved into more vulnerable jobs in 2020.



- Unemployed
- Valued and Secure
- Valued but Insecure
- Employed but not in health care
- Undervalued but Secure
- Undervalued and Insecure

Conclusion

The COVID-19 pandemic has already produced concerning racial and ethnic health disparities with higher rates of death and infection in communities of color than white communities.^{xxiv} with higher rates of death and infection in communities of color than in white communities.^{xxiii} In this study, we expected to find that COVID-19 significantly multiplied pre-pandemic inequities. This was confirmed. Black women, overrepresented in both essential work and in healthcare, have taken on significant risks throughout the pandemic, working in the occupations that have kept the rest of us safe. Despite this, Black women have experienced few economic returns, facing significantly higher rates of unemployment, lower pay, and little advancement.

We did not expect to find explicit patterns of advancement for white workers. While all healthcare workers, whether they were in practitioner or support roles throughout the pandemic, worked grueling hours, often in unsafe conditions, to treat and support our country during this public health crisis, white workers advanced while Black workers did not. What makes this so worrying is that career advancement, especially across the matrix from undervalued to valued and from secure to insecure, takes a significant amount of time and investment. It also comes with some cumulative advantage—those in better jobs are more likely to be able to advance to the best jobs in healthcare through mechanisms such as networking, experience, and the availability of benefits such as secure hiring and tuition offsets. What we saw during the COVID-19 pandemic was Black women healthcare workers missing out on a full year of advancement while their white colleagues advanced into better jobs. This may mean that the field has taken several steps backwards in diversifying its well-paying jobs, and that Black healthcare workers may face even more difficulties advancing in the coming years. This would translate to a less equitable healthcare workforce and, thus, a less equitable U.S. workforce. Of course, this report is missing an important piece of the puzzle, both for career advancement and the workforce more generally—education. Our team is currently analyzing education and debt trends, with a special focus on non-degree credentialization. In the next few months, we will be publishing a sister report to add more context to the question of how COVID-19 has affected career advancement and professional development.

To achieve a truly equitable recovery, policymakers, advocates, and employers must examine the nature of racial and gender inequities in their own sectors and areas of expertise, take action, and prepare for an open policy window to improve the compensation, benefits, workplace environments, and rights of workers across the country. This will undoubtedly require significant resources directed at the communities that need it most, but anything less will only serve as a band-aid on a gaping wound. To ensure sustainable change, we must prioritize creating clear and equitable career pathways, focusing not only on getting people their first job, but on facilitating movement into increasingly better jobs, especially for Black women.

Our findings indicate the need for a comprehensive policy agenda oriented around equity-driven career pathways. Equity-driven policies are essential to reverse the effects of disparities in healthcare, labor, and other sectors to ensure an equitable recovery post-COVID and to improve community well-being. At the same time, it is possible that COVID-19 has created new opportunities for career advancement that are being tested right now and are less visible in national datasets. Understanding the career trajectories of essential workers and the racialized impacts of COVID-19 on this workforce may also assist policymakers in applying promising practices at a greater scale to build a robust and resilient post-pandemic economy.



The research in this report was funded partly through a grant from Lumina Foundation and is part of a larger study entitled Pathways and Payoffs for Attainment Equity. We would like to thank Lumina for its continued support and flexibility, even as we shifted our focus to address career pathways in relation to COVID-19.

Methodology

We used the Basic Monthly Current Population Survey (CPS) and the merged Outgoing Rotation Group (ORG) data between January 2019 and December 2020, downloaded from the Integrated Public Use Microdata Series (IPUMS). We pooled observations across 24 monthly surveys and used person-level weights (WTFINL and EARNWT) divided by number of surveys (months). Our sample was individuals in the labor force between the ages of 16 and 64, excluding military personnel. The unweighted counts of person-month records of sample individuals of age 16 - 64 in the labor force are 655,161 in 2019; and 570,805 in 2020.

We then drew a sample of healthcare workers from the labor force sample and constructed a panel dataset by matching individuals across monthly CPS. We first excluded records that did not match to the 2010 Standard Occupational Classification detailed groups.

Next, we constructed a panel dataset using this healthcare sample. The CPS is a monthly survey of households with a 4-8-4 rotating panel design, in which each household is interviewed for four consecutive months, excluded for eight months, and interviewed again during the same four months of the subsequent year. Using this longitudinal nature of the CPS, users can link individuals across the monthly surveys using the variable CPSIDP, which is available in the CPS-IPUMS (Drew et al., 2014; Madrian & Lefgren, 2000). To reduce the possibility of mismatch, we excluded person-month records as age, gender, and race did not match across those records. The number of repeated observations ranged between one and eight, with the most frequent length being four (33.14%); 72.28% of the sample individuals have at least four observations over time.

Endnotes

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