Valuing Care by Valuing Care Workers

The Big Cost of a Worthy Standard and Some Steps toward It

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Executive Summary

Care workers—including providers of both child care and hands-on direct care supporting the elderly and people with disabilities—number 5.5 million and are employed in some of the fastest growing and lowest paying jobs in the American economy. Their "priceless" work, of such critical importance to families and society, rarely offers more than miserable wages and shoddy benefits. Improving these jobs and securing a decent standard of care requires fundamentally and dramatically reshaping the nation's understanding of what care work is, what it is worth, and how to pay for it.

Raising job quality and the standard of care requires a substantial infusion of public money and a simple and direct means of delivering that investment directly to care workers. To get there, we will need to connect to and build upon the important work already being done by coalitions on care work throughout the nation. Child care and health care workers, as well as their advocates and unions, need to be increasingly connected to city and state minimum wage campaigns to ensure that care workers are covered by increases, and to begin securing public and private resources needed to make higher wages for care workers a reality. These connections can provide a foundation to build stronger and more comprehensive community care work infrastructure that can identify, organize, and rationalize the work; develop systems to provide health insurance or other benefits directly to care workers; and build the case, constituency, and infrastructure for the transformation of these jobs.

Key Findings

The nation's care workforce—including child care workers and direct care workers supporting the frail and elderly—numbers 5.5 million and is growing rapidly. Earning roughly $10 per hour, these workers—nearly all women and disproportionately women of color—are seriously underpaid for the essential work that they do. Only a substantial public commitment to these workers and a significant public investment in their jobs will make decent care and decent jobs a reality. To raise care workers' wages to $15 per hour and provide decent benefits (valued at 30 percent of wages) would require an annual infusion of roughly $110 billion directly to care workers. Think of this as the social debt to the care workforce: $350 annually for every single person in this nation.

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Introduction

Care work is essential and invisible, private and public, denigrated and revered. It is essential because it makes decent life possible for those who need hands beyond their own to thrive. It is invisible because this gritty work of helping, supporting, and nurturing those who need it is intimate, personal, and ongoing. It is invisible to many people because, for part of their lives, they don't need it at all. And it is invisible to others because they do it all the time. As structured in the U.S., care work is intensely private, provided in intimate and personal spaces. At the same time, public interest and investment in the sector is pervasive, but the public investment is generally indirect, complex, and entirely inadequate in scale.

Providing care at these crosscurrents is a disregarded workforce—nearly all women, and disproportionately women of color—employed in some of the most dynamically growing and lowest paying jobs in the American economy. Their "priceless" work, of such critical importance to families, rarely offers more than miserable wages and shoddy benefits. This paper and policy proposal focuses on these workers and the necessary long-term transformation of their jobs.

Over the last 50 years, much has changed about women and work, especially in the professional ranks, but care work jobs remain at to the crumbling floor of our labor market. Over the last two decades, care work wages have stagnated or, in some cases, fallen. Wages are down despite the increasing demand for care workers, despite our growing understanding of the links between quality of care provided and quality of jobs held by care workers, and even resisting impressive innovation and organizing successes in these fields. We cannot afford to write the same story for the next 30 years. A society fit to live in provides a decent level of care to its most vulnerable members. The workers providing that care must be valued, not venerated as saintly or ignored as servants, but prized as workers that serve the public interest. And that will require serious, and public, investment.

The scale of investment needed for workers to reach a decent standard of living is considerable. The system is underfunding and its vulnerable clients need more services. But too often limited investment have bypassed or overlooked the nation's 5.5 million care workers. My proposal puts workers unapologetically at the front of the line for the new investment, provides a reasonable standard for their work—$15 per hour and good health insurance for starters— and therefore seeks to put real value and investment into care work. The money to support such a wage increase needs to be delivered through new infrastructure that routes funding from public coffers directly to workers' wages, not a sideways strategy through tax breaks or subsidies for consumers or providers, but directly from the public to the care workforce. The massive increase in public investment in the sector will require political support that in the short term can be generated at the local level. Local organizing on care work must make the work visible, develop infrastructure identify and monitor the jobs and their quality, build the coalition and case for greater investment, and provide training and systems that can improve the work though rationalizing scheduling or providing benefits to care workers. And political will needs to be fostered nationally through greater focus on these workers and their wages as well as the value of care. Making care work a priority requires organizing workers to create a voice that unites

care workers across diverse employers and funding streams. Further, truly valuing paid care work also requires valuing familial care as well, meaning that paid leave for families is a lynchpin of the argument for the social value of care, as well as a means to secure more care.
The impressive organizing and advocacy for care work already in progress at the local and federal level around care work provides a foundation for this direction. But care issues require a wider range of thought and action. We should start by including child care and health care workers, as well as their advocates and unions, directly in minimum wage fights, ensuring that care workers are covered by increases, and securing the necessary public and private resources to make higher care wages a reality. And we need to continue building strong community-based infrastructure to identify, organize, and improve care work today, to provide the infrastructure that would make public benefits such as health insurance accessible to these workers in the near future, and to build the case, constituency, and infrastructure for the transformation of these jobs in the long run.

In this paper, I make the case for a more systemic, expansive, and concerted approach to improving care jobs. The first section of the paper provides background on care work, the workers who do it, and the wages they receive, which illuminates my reasons for building a single policy approach that rewards these diverse workers. The second section discusses both the dynamic growth of these jobs and the forces that hold them at the bottom of the American labor market. The third section of the paper explores the dynamics of payment and the private and public funding that shapes these jobs, and offers a review of some of the strategies that have improved them. The fourth section of the paper offers a discussion of my proposal to improve these jobs, and details the scale of the investment as well as the infrastructure needed to deliver that investment directly to the care workforce. The fifth and final section describes foundational steps to pursue now—building stronger infrastructure for care workers at the local level, finding ways to support care workers, and engaging in the dynamic ongoing work surrounding minimum wage—to transform these jobs.

Care Work: The Wages and Workforce

While the very name "care work" can be contentious, for the purposes of this paper the term will refer to the substantial workforce of health and child care providers doing hands-on care work. This includes paid workers that provide direct care and support for elderly, frail, or disabled people in their own homes or in residential facilities such as nursing homes, as well as the child care workforce providing care to babies, toddlers and preschoolers.[1]

To be sure, used this way, care work unites a very diverse set of workers in varied settings and unique subsectors. Care work includes just over 3.5 million hands-on health care workers[2] and another 2 million workers in early childhood care and education.[3] In both child care and health

[1] Here "hands-on health care" is the same as the "direct care workforce," and includes home health and personal care aides (mostly in home health or private service to homes) as well as nursing assistants (mostly employed in long-term care settings).
[2] Using U.S. Bureau of Labor Statistics data on these occupations, the Paraprofessional Healthcare Institute (PHI) found 3.5 million direct care workers: just over one million personal care aides, just under one million home health aides, and roughly 1.5 million nursing assistants. Paraprofessional Healthcare Institute. 2014. "Occupational Projections for Direct-Care Workers 2012-2022." Bronx, NY: PHI Facts. Retrieved May 13, 2015. (http://phinational.org/sites/phinational.org/files/phi-factsheet14update-12052014.pdf).
[3] The child care workforce includes those working in their own homes ("family child care providers") and working in children's homes, and the workforce of both "child care workers" and "preschool teachers" employed in child care centers. According to the most recent National Survey of Early Care and Education Programs, this workforce of 2 million workers is evenly divided between center- and home-based care

care, a significant workforce is employed in homes alongside a substantial workforce in institutions such as child care centers and nursing homes. In child care, the in-home setting encompasses workers who attend to children in the child's home as well as those who provide "family day care" in their own homes. Home health aides and personal care attendants work in clients' homes. Some are hired and sent by agencies, while others connect directly with consumers in the private market. In child care centers, many are "child care workers," while others are "preschool teachers," a category generally used for workers who provide care and education to children between three and five years old. Child care workers are spread across the age spectrum. Calling all this care work minimizes attention to the substantial differences that separate these jobs.

I minimize the differences because of the overwhelming fundamental similarity that defines these jobs: poor and seemingly intractable job quality. Table 1 makes both the low quality and its consistency clear. Hourly wages for care workers hover in the $8 to $10 range—close to the floor of the labor market (with a current federal minimum at $7.25) and around half the national median wage. The median for care occupations taken together is just $9.88 per hour. Only two occupations—preschool teachers in child care centers and health aides (including nursing aides, etc.) in long term care facilities—have averages above $10 per hour. Inside homes, the wages are generally lower. Once inflation is taken into account, the median hourly wage for care workers is the same as or even lower in 2013 than it was in 2005. This is true for care workers overall where the median has fallen from $10.09 to $9.88 per hour, and it is true within nearly every occupational subgroup. The notable exception is in-home child care providers. With the lowest wages in both periods, they have at least experienced an increase over time. Their median now clears the minimum wage by one dime per hour.

providers. National Survey of Early Care and Education Project Team. Office of Planning, Research, and Evaluation. 2013. "Number and Characteristics of Early Care and Education (ECE) Teachers and Caregivers: Initial Findings from the National Survey of Early Care and Education (NSECE)." OPRE report No. 2013-38. Chicago: NORC at the University of Chicago. Retrieved May 13, 2015 (https://www.acf.hhs.gov/sites/default/files/opre/nsece_wf_brief_102913_0.pdf).

Table 1: Care Work Wages and Health Insurance, 2005 and 2013 (median hourly pay, 2013 dollars)

Care Work Sector	Industry/Site of Care Work	2005 ($)	2013 ($)	% with health insurance through work (2013)
Hands-on Health Care Workers	In Home Health Services (i.e., home health and personal care aides working for agencies, etc.)	9.87	9.78	32.3
	In private household services (i.e., home health and personal care aides working directly for clients)	10.79	9.48	30.5
	In Long Term Care (i.e., in nursing homes, residential care facilities)	11.52	10.87	52.8
Child Care	Child care workers providing care in clients' homes (i.e., "nannies")	8.27	8.96	45.4
	Family child care providers (care for children brought to provider's home)	6.89	7.34	38.8
	"Child care workers" at child care centers	8.98	8.82	53.5
	"Preschool Teachers" in child care centers (does NOT include those in schools)	11.20	10.87	59.6
	All Care Workers	10.09	9.88	47.0
U.S.	All Workers	17.78	16.79	66.6

Source: Author's analysis, American Community Survey data. See technical note at the end of the paper for details.

These are very low wages. Workers lucky enough to secure full-time hours in these jobs don't clear the poverty line for a family of three. Even regular and predictable hours of work can be a problem for many of these workers. Especially in in-home settings, the substantial costs of unstable demand are borne directly by care providers. Home health workers lose hours when their clients go on vacation or into the hospital. Child care providers suffer the volatility of demand that their parents face. When retail schedules are set and altered just-in-time, the family need for child care is impossible to predict. For these workers, low wages are further compromised by low and volatile hours.

As with most low-wage jobs, there are few benefits provided. The lack of health insurance through employment is evident in the final column of Table 1. As with wages, the care workforce in homes is especially bad: between 30 and 45 percent of in-home workers get health insurance through their work. In child care centers and long term care, reception of health insurance tops 50 percent but still falls well short of the national average covered of 67 percent.

Care work is gendered and the work of care is, clearly and unsurprisingly, women's work (Table 2). More than nine of every 10 workers in child care are women. The percentage of women in hands-on health care positions is similar. But this work is not just women's work. It is also disproportionately the work of women of color. This is especially true in direct health care jobs, where more than three

of 10 workers is African American, a statistic three times their workforce share. Blacks are slightly more likely to be in child care jobs in centers, but not in homes. Both non-citizens and Hispanic workers are disproportionately concentrated in home-based child care. The longstanding occupational segregation of this work and its ongoing connection to "free" labor provided by women in the unpaid sector is one factor that keeps wages down. Because of the discrimination these workers face—for reasons of race, gender, and ethnicity—care workers have fewer external options, which also contributes to their low wages.

Given the very low wages of these jobs, one might expect the education level of the workforce to be well below national averages. It is not. In-home workers in both child and health care are only slightly less likely to hold high school degrees: between 81 and 88 percent of these workers graduated from high school, compared to 91 percent in the national workforce. On the other hand, workers in institutions (child care centers and residential care) have higher levels of education—particularly the "pre-school teachers," who mostly work with children between the ages of three and five. Nearly all, 97 percent, of these workers have high school degrees. Their education exceeds the national average but their wage (the highest among the occupations in care) sits just under $11 compared to the national median of $16.79.

Table 2: Care Work Workforce Demographics, 2013

Care Work Sector	Industry/Site of Care Work*	Female (%)	Hispanic (%)	Black, non-Hispanic (%)	Non-citizen (%)	High school degree or more (%)
Health Care	In Home Health Services	90.3	18.7	32.5	13.6	81.2
	In private household services	84.3	16.9	16.9	15.5	84.6
	In Long Term Care	87.5	11.7	32.4	8.5	89.7
Child Care	Child care workers in clients' homes	96.2	22.6	6.8	18.6	88.3
	Family child care providers	97.2	25.8	13.3	17.7	83.3
	"Child care workers" at child care centers	90.8	18.1	18.0	8.3	91.2
	"Preschool Teachers" in child care centers	97.3	13.4	16.8	4.4	97.2
	All Care Workers	91.1	16.1	24.0	10.7	88.3
U.S.	All Workers	47.5	16.2	11.4	8.9	90.7

See Table 1 for more details on these occupation/industry details.

Source: Author's analysis, American Community Survey, see technical note at the end of the paper for details.

Finally, for child and direct care workers inside the home (meaning, those who provide care in their own home or others') even basic labor protections are very weak.[4] In-home workers that provide child care in private household services are explicitly denied many labor protections, including those of the Occupational Safety and Health Administration, as well as the right to organize unions. Some workers, namely "part-time babysitting" service providers -- are explicitly exempted from federal minimum wage and overtime law. Likewise, the Fair Labor Standards Act's minimum wage and overtime requirements exclude some home health workers. A long-awaited executive order to extend these basic protections to home health workers has now survived an extended court battle. But the fact that workers waited until the summer of 2015 to get these protections is an indication of how weak the regulatory infrastructure around these jobs is.

Perhaps more important, the effective protection of labor standards is very weak in markets where workers connect directly to clients. In part, this is due to the invisible, informal, and "under the table" nature of many in-home care jobs. Formal labor protections mean very little for workers whose jobs are off the books. For the many immigrants in these jobs, especially those without formal work status, labor protections are remote or virtually irrelevant, regardless of the letter of the law. Further, among the in-home workforce, some workers are truly independent contractors, but many more believe themselves to be or are treated as such by their employers (the care consumer). Independent contractors have no standing for basic labor protections such as minimum wage, overtime, workers' compensation, and unemployment insurance. In this context, the rights of workers and the responsibilities of employers are routinely ignored, if they are even understood.

With low wages and few benefits, care workers often turn to Medicaid programs and other forms of public support to make ends meet. A recent estimate suggests that some 46 percent of child care workers participate in public "work support" programs, and that the annual public cost of their program participation is $2.3 billion.[5] Medicaid for the workers and Medicaid/CHIP for their children accounted for the most substantial costs, but child care workers also received significant support in earned income tax credits and food stamps. The high cost of public program participation for frontline health care workers has been demonstrated as well. The fact that these jobs do not pay enough to support a family not only generates substantial stress among the care workforce, but also creates significant public costs in terms of "work support" programs. A more rational and efficient system would deliver this public investment in the wage and benefit package of the jobs, rather than cleaning up after the "market wage" fails these workers and their families.

Consistently Low Wages and Dynamic Growth

In Caring for America,[6] Boris and Klein provide a useful overview of the reasons that care work pays so poorly. They argue that once care work moves into the market and is no longer a "labor of love," it "becomes unskilled work that allegedly any woman could perform." They go on to point out that the

[4] Bernhardt, Annette, James DeFilippis and Siobhan McGrath. 2007. "Unregulated Work in the Global City." New York, NY: The Brennan Center for Justice at New York University School of Law. Retrieved May 13, 2015 (http://www.brennancenter.org/sites/default/files/legacy/d/download_file_49436.pdf).
[5] Whitebook, Marcy, Deborah Phillips and Carollee Howes. 2014. "Worthy Work, STILL Unlivable Wages: The Early Childhood Workforce 25 Years after the National Child Care Staffing Study." Berkeley, CA: University of California, Berkeley, Institute for Research on Labor and Employment, Center for the Study of Child Care Employment. Retrieved May 13, 2015 (http://www.irle.berkeley.edu/cscce/wp-content/uploads/2014/11/ReportFINAL.pdf).
[6] Boris, Eileen and Jennifer Klein. 2012. Caring for America: Home Health Workers in the Shadow of the Welfare State. New York: Oxford University Press.

intimate and essential work of cleaning bodies and houses has been highly stigmatized and devalued "because of the race, class, and gender" of the workers who do it and further marginalized by the way that the state has organized it. Further, low pay has consistently been "justified in terms of the paramount needs of the recipients," a line of thinking that "grants moral license to expropriate [care workers'] labor on the cheap." Care workers themselves are susceptible to these moral claims, speaking of their work in terms of a calling: they work longer than scheduled or paid for because clients "need them." Taken together, these forces exert a considerable drag on wages for care work.

The weight that holds down care wages is evident across decades in the U.S. Twenty-five years ago, child care workforce advocates released a report that identified wages as the essential problem facing the industry, with child care workers struggling to get by and turnover and stress undermining the quality of care. "Worthy Work, STILL Unlivable Wages," released in 2014, revisits the themes of that paper and notes the nation's distressing failure to make any real progress on wages in the sector. As the authors point out, this lack of progress is especially disturbing given advances in the last quarter-century in terms of knowledge—stronger evidence of significant returns to early childhood investment, and of the significant contribution of child care workers to quality of care—and public investment in the sector.[7] Meanwhile, the home health industry continues to boom with no positive impact on wages in the sector: the 2013 median wage for such jobs, $9.76, was actually five percent lower than the 2000 value, correcting for inflation.[8]

These jobs are not going away. In fact, they are growing faster than most sectors in the economy. Hands-on home health care jobs—personal care attendants and home health aides—are consistently at the top of occupational projection lists. Even the more modest projected growth of child care outpaces projections for the economy overall.

Care work is also essentially human and local. Technology will not massively displace these workers any time soon. Globalization will not move these jobs overseas. Care work is with us and will be so in the future. The relative position of these jobs must improve, but there is no evidence that current forces and innovations can lift them.

[7] Ibid.
[8] Paraprofessional Healthcare Institute. 2014. "State Chart Book on Wages for Personal Care Aides, 2003-2013." Bronx, NY: PHI. Retrieved May 13, 2015 (http://phinational.org/sites/phinational.org/files/research-report/pcawages-2003to2013.pdf).

Who Pays for Care? What Works for Improving Wages?

A long-term proposal for improving care work requires understanding

- The structure and funding of these jobs.
- Strategies for improving care work, and their limitations.
- Lessons from some of the best advances that have occurred in these jobs.

I address each of these in detail below.

Care Structure and Funding: Who Pays and How?

The structure of the state approach to the care sectors sheds light on the unique position of care workers in the U.S. The U.S. is not alone in producing inequality in labor markets as the result of sexism and racism. However, other industrialized nations have tied care provision more directly to the public sector and extended generous paid family leave policies to enable family members to provide care. In contrast, the U.S. policy and approach to care emphasizes private provision, consumer choice, and private market delivery of care services.

The U.S. system almost completely privatizes care for children during the earliest years of life. Until children reach school age, most parents pay directly and completely for care. The cost of care is burdensome—commonly reaching or surpassing $1,000 per month—and many workers simply cannot afford it. Costs decline slightly as the infant grows into a toddler and preschooler. A recent report found that the cost of center-based infant care exceeded 25 percent of the median income of a single parent in every state.[9]

High child care costs and their own volatile work schedules often drive low-wage workers toward gray market options—neighbors, friends, or family—in order to meet their need for less costly care. The quality of care in this informal market is variable and sometimes troublingly low. Higher wage workers can afford higher quality care. As a result our system of child care reinforces inequality from the very first moments of life. Once children reach school age, the costs of their education and care are covered publicly. However, while movements to universalize pre-kindergarten for four and even three year olds are shifting the age of public investment downward, the earliest years remain firmly private, leaving too many parents stressed by costs and too many children in substandard arrangements.

Even though this system is private, there are a number of streams of public funding in the child care industry. The divergence of state systems on child care makes a national accounting difficult. A Kauffman Foundation study estimated parents paid about 60 percent of the total amount spent on child care in the U.S. for children age five and under, who are not in kindergarten. Federal, state, and local government accounted for virtually all of the remaining support through vouchers and other direct payments, direct provision of child care services (for example, Department of Defense and Head Start), and tax credits and deductions.[10] Since then, the national and state movements

[9] Child Care Aware of America. 2013. "Parents and the High Cost of Child Care 2013 Report." Arlington, VA: Child Care Aware of America. Retrieved May 13, 2015 (http://usa.childcareaware.org/sites/default/files/Cost%20of%20Care%202013%20110613.pdf).

[10] A. Mitchell, L. Stoney and H. Dichter, "Financing Child Care in the United States: An Expanded Catalog of Current Strategies, 2001 Edition," Ewing Marion Kauffman Foundation, p. 3.
Mitchell, Ann, Louise Stoney, and Harriet Dichter. (2001). "Financing Child Care in the United States: An Expanded Catalog of Current Strategies." North Kansas City, MO: Ewing Marion Kauffman Foundation.

toward Pre-K have moved more public money into the field. But parents are paying more as well. Out-of-pocket costs for child care have risen substantially faster than subsidy rates or income. Family payments for child care increased 89 percent in real (inflation adjusted) terms from 1997 to 2011, from an average of $94 per week in 1997 (in 2011 dollars) to $179 per week.[11]

In health care, the forces are different. The national approach to hands-on health care runs through private infrastructure: an array of non-profit and for profit providers, independent contractors, and agencies, as well as residential care facilities and institutions. But public money is abundant, so much so that Medicare and Medicaid policy and implementation at the state level can directly influence labor standards for hands-on care work. It is clear that the hands-on health care workforce is much more substantially funded and affected by federal policy—and state management of it—than the child care workforce. The resources in Medicaid and Medicare are substantial; the potential for health care workers to secure savings in those systems, and leverage those savings into wages, is a significant advantage and distinction in comparison to child care work issues. But the downward pressure on total costs in the system, and the long stagnation of wages for these workers in spite of incredible growth in the occupations, make it clear that strategies beyond those focusing only inside given funding streams may also be required.

Even though the public money is generally driven through private routes, it directly impacts the structure and restructuring of this work. The National Landscape of Personal Care Aide Training Standards identifies the ways that policy has shifted the field away from long-term residential care and into the home: "While 15 years ago 75 percent 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.... 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."[12]

In health care, public money is evident and growing (as the population ages) and public policy is directly fueling the growth of specific, very low-wage jobs. In child care, the case for the public good provided by care is increasingly salient, but the nation's investment is insufficient to support the industry, let alone decent jobs in it. And many parents lack the money to drive a new level of job quality. The substantial grey market for care work, substandard lower price options, and the choice to simply forego care for children or the elderly all further complicate markets for care and care workers.

Retrieved May 13, 2015 (http://sites.kauffman.org/pdf/childcare2001.pdf).
http://sites.kauffman.org/pdf/childcare2001.pdf

[11] Whitebook 2014a cites L. Laughlin, "Who's Minding the Kids?" for this data.
Laughlin, Lynda. 2013. "Who's Minding the Kids? Child Care Arrangement: Spring 2011." Washington, DC: U.S. Census Bureau. Retrieved May 13, 2015
(http://www.census.gov/content/dam/Census/library/publications/2013/demo/p70-135.pdf).

[12] Marquand, Abby and Susan A. Chapman. 2014. "The National Landscape of Personal Care Aide Training Standards." San Francisco, CA: University of California San Francisco Health Workforce Research Center on Long-Term Care. Retrieved May 13, 2015
(http://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Report-The_National_Landscape_of_Personal_Care_Aide_Training_Standards.pdf).

Improving these Jobs from the Inside

The brutal reality of austerity politics at the national level keeps many experts and advocates looking for answers to job quality inside their industries. Strategies here focus on "value added," the business case for decent work, and strategies to improve jobs or training. These are ways of securing a greater share of current resources for workers. And to be sure, there is much about these jobs that can be improved. New, and more worker focused, priorities for scheduling and technology to support them could improve work for care providers in child and home health care. Minimizing transition time between clients, or supporting means of coordinating parents' work schedules, can help workers develop steadier and more reliable stream of work and income. Centralized lists of providers and clients is a first step in this direction. And scheduling technology could certainly be deployed or altered to place greater priority on worker interests (i.e., more clients, shorter transitions) when establishing schedules. Advocacy for more predictable work schedules for hourly workers could also benefit child care providers, especially family providers, who must juggle the numerous responsibilities of children when their parents' work schedules are in constant flux.

Even in residential long-term care and child care centers, job quality can be improved. As in any industry, there is a range of wages (though the wages are low) and specific employers stand out for offering higher quality compensation packages than direct competitors. Worker-owned co-ops (especially in home health, from New York to rural Wisconsin), model social purpose non-profits, and employer-subsidized providers are consistently able to provide better wages and income for care workers. Their existence proves that there is most certainly a competitive way to provide care that rewards workers and makes them feel valued. Care work can and should be improved in these ways. But steps toward exemplary practice in scheduling or wage policy do not fully realize a solution on care work. The constraints of current funding systems are simply too tight.

In both child care and hands-on health care, strategies around workforce professionalization and training have also been pursued with the hopes of building a route to higher quality care and increased pay. This is perhaps especially true in child care, where increased focus on educational content for children and formal training for providers is reflected in phrase "early care and education" which advocates and others now commonly use when referring to the industry. Professionalization has been a theme in health care as well. Most notable here is attempts to build advanced roles for home health workers. The advanced training allows in-home workers the skills they need to work with clients in in a more proactive prevention role, helping clients stay healthy and generating substantial savings in the process. To be sure, there is a compelling case to be made for training in both sectors. Care work requires skills and knowledge and improving care will certainly rely on better knowledge and skills in the workforce. Further, there is much to be gained in these strategies, for the workers and for the recipients of the care. So there is much to gain from pursuing these lines of work. But low wages and chronic turnover mean that, without substantial wage increases, much of the investment in training can simply be lost. Training is important to the industry, but training alone cannot change the wage problem that care workers face.

Without changing the scale of public investment in these jobs, training and professionalization levels provides little leverage on wages. Evidence from an important child care training initiative in North Carolina, is instructive. The program, called TEACH (Teacher Education and Compensation Helps) has had an impressive impact on overall education levels in the child care workforce. From 2001 and 2013, the percentage of North Carolina child care teachers with an associate's or bachelor's degree in early childhood education (ECE) rose from 10 percent to 33 percent, and the number of teachers with at least an associate degree and some ECE training from 20 percent to

almost 50 percent. While the education increases considerably, there is no corresponding evidence of higher industry wages for child care workers in the state. A large-scale survey of child care workers in North Carolina in 2013 showed real wages for most child care teachers were lower than in 2003. Wages were lower, in spite of dramatic increases in education.

Further, training and professionalization in child care can also increase inequality in the sector between more formal (and more expensive) child care centers and less formal, family-provided parts of the market. If higher education levels lead to higher child care costs, many lower-wage parents, already stressed by care costs, may be pushed away from the higher quality segments and into less formal and less costly segments of the market for child care.

Quality rating systems for child care, implemented by a number of states, are another policy model to increase child care quality. These systems seek to measure and reward (and thus incentivize the development of) quality child care. These rating systems evaluate a center on a range of variables related to essential ingredients of child care quality and generally reward degree attainment by teaching staff. But very rarely (if ever) do such systems actually gauge or reward for higher job quality (measured, for example, by wages). Like training, these policies provide only a very indirect route to improving wages. And there is no evidence yet that these system will qualitatively alter the structure of child care jobs.

Finally, due to the complexity of these care systems and their multiple funding streams, initiatives and investments can have contradictory, confounding, and unintended results. Progress made on one front can and often does increase the complexity (or even irrationality) of the system. For example, increasing emphasis on pre-kindergarten for four olds is surely laudable. But in general, such initiatives are inattentive to the private system that serves babies and toddlers before they reach pre-kindergarten age and can directly undermine quality in the private child care system even as they expand the public commitment. As older children are siphoned into pre-kindergarten, the private system must adjust to falling demand and the higher costs of babies and toddlers that remain. The private system which often informally subsidizes the higher costs of younger children with older children can be devastated as the public programs expand. Additionally, the process of creating public prekindergarten programs introduces further and significant disparities in the market for teachers, with widely disparate pay for the same work, depending on whether a teacher works for the schools or in the private system. Some communities and pre-kindergarten programs have worked hard to integrate pre-kindergarten into and alongside the private system, but generally private child care providers find themselves worse off after the public system expands.

In health care and support positions, the client and funding stream that supports their work can have a dramatic impact on pay, in ways that defy reason. In a given community, the exact same care processes and tasks may pay more or less depending simply on whether that care is for a senior or for a person with disabilities. And depending on the state and county systems for delivering that care, a worker may be an independent contractor or work for an agency instead. A strategy that targets one funding stream and group of workers (as many do) inevitably leaves other workers out. Highly tailored strategies have been critically important for some care workers, but they too tend to be limited by these systems' insufficient resources and the complex flow of dollars and policy inside the systems.

Strategies of Note: Organizing "Independent Contractors" and other Steps toward Collective Voice

A few models have demonstrated the potential of systematic improvement of this work. In Los Angeles, the Service Employees International Union (SEIU) created a "public authority" model that incorporated mechanisms to organize and represent home health workers, especially in states where services are provided through an independent contractor model. This has been the most influential innovation in in-home care work. The roots of the model go back to the 1980s, when SEIU was first trying to organize personal care assistants in California's In-Home Supportive Services home care program. Hired and fired by clients, these workers were independent contractors. Although public money and policy directly shaped the structure and quality of these jobs, a 1987 court ruling found that neither the state nor the county was an "employer" for the home care workers. SEIU pursued a legislative and advocacy strategy to establish a public authority to serve these workers as "employer of record" for purposes of bargaining. The establishment of county-based public authorities finally redefined these home health providers as "workers" and established their legal employment relationship with the county. Once an employer of record was identified, SEIU could organize, represent, and bargain for improved wages and working conditions for these workers.

Since 1999, when 74,000 home care workers joined SEIU in Los Angeles (the largest union organizing victory since the 1940s), the model spread across California, up the Pacific Coast, and into other states including Illinois, Massachusetts, and New York. SEIU now represents more than half a million home health workers, turning them from independent contractors into "workers," establishing the critical role of the state in defining the terms of their jobs, and bargaining with the state to improve them. Wage and benefit gains for these workers have been substantial.

Although these strategies have effectively promoted the interests of in-home care workers, they cannot benefit all in-home care workers. The model, which uses public authorities or simply organizes the independent contractors at the state level, applies only in those states and situations where direct care work is organized through independent contracting. In many other states, agencies hire home health workers and send them to clients. When work is organized through agencies, the model doesn't apply. Further, the model requires political support from a strong labor and consumer coalition. In some states, that coalition may not be strong enough to secure needed executive orders and/or legislation.

The U.S. Supreme Court's 2014 decision, Harris v Quinn, creates a serious challenge to the public authority model. The court's conservative majority ruled that unions that represent workers in public authorities have no right to charge "agency fees" to workers who benefit from collective bargaining but do not want to join the union. Essentially, the court decided that those workers that most need union representation have fewer labor rights than other public workers. The long-term impact of this decision on the public authorities and their unions remains to be seen, but it presents a serious challenge not only to expansion but to the current reach of the model.

The most important lesson from this model, and from related innovations in the representation of these "independent contractor" home health workers, is that aggregating and representing care worker interest is essential to improving the job. Future improvement in care work will almost certainly draw on the strengths of this model: a convening point and a voice for a broad set of care

workers, and the stronger collective voice to bargain directly with the state over the conditions and pay for those workers.

A related approach has been to bringing workers together with consumers around an agenda to improve job and care quality. National and regional coalitions have made some important progress in this area. Effective advocacy captures public attention and makes compensation issues explicit. At the national level, coalitions and organizations such as Caring Across Generations, the Paraprofessional Healthcare Institute, and others are making care work visible and amplifying the voices of care workers and consumers. At the state and local level, numerous projects identify and bring together care workers, connect them with consumers, and develop policy that builds quality care and jobs. This work is essential in the field, and it will continue to be so. But much more is needed to fundamentally transform care work.

We must dramatically alter and redefine care jobs. But such change requires much more than piecemeal strategies jerry-rigged around confusing funding sources, and strategies beyond those which simply presume that better wages will magically follow training or professionalization. We will not fundamentally change these with a strategy that exclusively frames work quality in terms of clients need because that strategy inevitably puts the legitimate needs of clients at the front of the line. As important as each of these is, they are insufficient to the task of transforming and valuing care work. The long-term vision must lead with wage justice for care workers and must not shy away from the serious costs implied by that approach.

Transforming Care Work: Significant Money and Infrastructure to Deliver it

There are two critical insights that I draw from this understanding of the industry and efforts to improve care workers' wages and jobs. First, these systems and funding streams are both entirely inadequate and complex. A long-term strategy around care work needs to increase resources dramatically, but also find a new infrastructure to manage and organize the industry.

Second, all care workers serve in the joint interest of both public and private parties, and require an infrastructure to reflect and channel the public interest. We do not yet have a formal means of channeling this public interest, but legal argument around the public authority model may provide some direction. Writing for the majority, Justice Samuel Alito called care workers "partial public employees" and denied them the rights extended to public workers. In her dissent, Justice Elena Kagan pointed out that employment law provides the position of these workers with "a real name—joint employees—for workers subject...to the authority of two or more employers." And that idea, of joint interest and joint employment, is central to this proposal for the development of infrastructure to embrace the public interest in care jobs.

The truth is that all care workers are, to varying degrees, subject to both public and private interest. Rather than limit the "joint" concept to situations where services are delivered in the independent contractor model, better care work can only be realized if we build and extend that conception of joint interest—both public and private—for all care jobs. There are significant state interests and investments at play in all care work, whether care workers are employed through agencies, at child care centers, in nursing homes, or as independent contractors. The public needs new infrastructure to provide a stronger and more direct line from public interest to the quality of care jobs.

With these lessons in mind, we turn to my proposal for improving care work in the long run. A transformation of care work will require a substantial infusion of public investment and a new infrastructure to deliver that investment to workers wages. That transformation of jobs will not be possible without political and social transformation of the value of care and inexorable links between the quality of the jobs of caregivers and the quality of care they are able to provide.

The Scale of Investment Required

A rough estimate of the the public investment required to transform and value care workers is instructive. The nation's 5.5 million care workers are currently paid roughly $10 per hour. Raising their wage by $5 per hour to $15 would substantially change these jobs for the better. To do so would cost roughly $55 billion or $60 billion annually.[13] That cost is the increment needed to improve the jobs and so it is a cost over and above the various streams of public money that already support and shape these jobs. In addition to the wage increase, workers also need a meaningful benefit package —decent health care and retirement valued at 30 percent of the wage. Benefits for care workers would generate additional costs of roughly $55 billion per year. The total annual cost for this worthy care work package comes in around $110 billion. This is, no doubt, a rough calculation. At a minimum, though, it should shake us all into realizing how grossly underpaid our care workforce is and how significant the public investment would need to be to overcome that deficit.

An annual cost of $110 billion is substantial. Spread across the entire U.S. population, it amounts to $350 per person per year. Think of this as the social debt to the care workforce: $350 annually for every single person in this nation. To be clear, a universal care tax of $350 is not the right way to raise this kind of money. But a serious transformation of these jobs will require a substantial infusion of public money.[14] At the same time, however, that this is not an impossible sum. In the context of a $17 trillion economy, and a $3.4 trillion federal budget, $110 billion can be managed. This increment is about one-third of the annual federal expenditure for children's programs of $348 billion in 2012.[15]

In the current political climate, such considerable public investment in care work is a non-starter. And this paper is not the place to develop a new progressive tax agenda to fund care work. An Economic Policy Institute review of progressive federal revenue generators suggests that tax policy to "reform current income tax rates, create additional brackets for top earners, and tax capital gains as ordinary income" would generate $1.6 trillion annually and "make the tax code fairer and more

[13] This is a very rough estimate intended to provide context. There are reasons the number should be higher or lower. It overstates costs because not all 5.5 million work full-time, year-round. It underestimates costs because a decent and accessible care regime would bring grey market and unmet demand for care into the market as well. Also, the benefits package would surely reduce Medicaid and other existing health care system costs, so 30 percent may overestimate the public cost of the benefits.

[14] Care workers currently rely on publically funded work support programs for low-wage workers like Medicaid and the Earned Income Credit. As we noted earlier, a recent estimate of the cost these public programs supporting child care workers was $2.3 billion annually. If care work was transformed, these costs would certainly be avoided and this savings could be the first pool of dollars to fund care work improvements. Even so, the money saved in work supports alone is simply not the right order of magnitude to transform these jobs.

[15] Isaacs, Julia, Sara Edelstein, Heather Hahn, Katherine Toran, and C. Eugene Steuerle. 2013. "Kids' Share 2013: Federal Expenditure on Children in 2012 and Future Projections." Washington, DC: The Urban Institute. Retrieved May 13, 2015 (http://www.urban.org/UploadedPDF/412903-Kids-Share-2013.pdf).

progressive, without unduly restraining economic growth."[16] Clearly, there are progressive ways to raise these funds. This is not to say this is politically easy. But it is most certainly economically possible.

But without this significant price tag in our sights, our efforts will almost certainly be too small to make a difference. Only an investment of more than $100 billion is sufficient to raise care workers well above the floor of the American labor market.[17]

Infrastructure to Deliver the Increase to Care Workers

Quality care requires a direct and trusting relationship between care worker and client/customer. That relationship is central to quality of care, but not to our payment systems. Our care systems nearly always engage at least three, and often four, key parties. There is the customer. (Note: This "customer" role is often dual. The child receives the care, but the parent is the customer. Or, a family member arranges care for a frail relative unable to personally arrange it.) There is the worker who provides the care. There is state interest—both public interest and investment—in the care. And there is often a non-profit or for-profit provider of care that employs the worker. Federal, state, and local sources mix and cross with private funding and resources in this web. Some resources move directly from the state to the consumer of care (as when a senior is eligible to select a care worker or when low-income parents qualify for state child care subsidy program). Others run from the public sector directly to non-profit and for-profit care providers. In general, however, it is rare for a payment to go directly from the state to a care worker. An infusion of $100 billion of public investment in the care workforce requires a new and more direct infrastructure to deliver resources from state coffers to care workers' paychecks. Because this public investment in care jobs comes into a pre-existing and largely privately funded system, the investment needs to be made in ways that do not displacing or supplanting private funding.

Are there effective ways to get public money to care workers? State contracts could require care providers to document a certain and stated wage and benefit level as a condition for receipt of state investment. Or the state could develop a new and direct route to the worker. In this case a state agency would be a joint employer, paying all or part of wages and providing benefits, will the agency would hire and fire workers, etc. Either approach requires substantial administrative capacity and may seem impossible even to imagine. However, in the home health sector in states that already manage the programs that directly connect workers and consumers without agencies in the mix, such infrastructure is not nearly so hard to imagine. In home health, the state is already often acting as co-employer already deliver the care worker package straight to the workforce. Given that home health is the most rapidly growing care sector, there is great promise here. Extending this new states and developing the model even in the context of agency employers could raise the floor in the sector quite rapidly. But the next hurdle would be to extend the model to institutional hands-on health care (nursing homes and residential care) as well as the entire child care sector. The most

[16] Thiess, Rebecca. 2013. "Many Options Exist for Raising Revenue in a Smart and Progressive Manner." Washington, DC: Economic Policy Institute. Retrieved May 13, 2015 (http://www.epi.org/publication/options-exist-raising-revenue-smart-progressive/)./

[17] In the long-run transformation of the sector, private and corporate resources may also make up some of the gap. But I focus on unified and public resources in order to generate a public system of equal access to decent care and decent jobs for care workers. In general, private sources exacerbate inequality in the system rather than remedy it.

efficient and effective means of delivering this investment will require some direct the line from state investment to the worker.

Clearly, there are significant challenges in terms of designing an effective system to support and build job quality. The indirect routes to pay – through tax subsidies or quality ratings – are insufficient to this task. Developing local or state care work registries or other systems to identify the care workforce may help establish the administrative capacity to connect the needed infusion of funds directly to the care workforce.

Issues of Quality and Choice

The question of delivering "quality care" instantly raises at least two thorny problems with an improved system of care work. The first has to do with the centrality of "consumer choice" to so many of our care models. If we establish a "right to decent care" for children, the elderly, the frail, and others who need care, how willing is the public to allow policy to direct resource to real quality? We need a system that balances consumer interest with the public interest in high quality care and a decent standard of living for the worker. There are many tensions here, perhaps most obviously in child care. Family-based and in-home provision can be very flexible and more directly targeted to a specific child's needs, or more convenient to a family's needs. Family-based provision is also widely variable in terms of quality and can be very difficult to improve. For children's development, the public interest in quality is almost surely more consistently secured in centers or well-established and regulated in-home programs. From the perspective of parents, especially those dealing with fewer resources for transportation and/or erratic work schedules, the local and more informal choice may be preferred.

In short, consumer choice and public interest do not always line up. Valuing care work requires a better balance between these two concerns, moving public investment in ways that may inevitably limit the choices of consumers. In the long-term, if we extend the right to quality care for all the system may occasionally reduce consumer choice, but only in cases where consumers seek low-quality care. This makes sense in theory, but I have no illusions that such balancing is easy or implies simple and universally supported structures.

A second issue is defining "quality care," which takes us back to the consideration of training. The tension here is that most of our systems for defining quality tend to place a high value on post-secondary degrees. To be sure, care jobs require exceptional technical, interpersonal, and problem-solving skills. But the impulse to require greater formal education can cut out many capable workers already engaged in providing care. My proposal for the long-term is an approach to quality that embraces training and learning, but for the existing workforce. A training, learning, and development program should be focused on adult learners and build the skills of the care workforce in ways that are integrated with care and led by other advanced care workers. This is especially important if we are interested in maintaining the diversity of this workforce. We should resist an approach to quality of care that increases pay in these jobs while simultaneously cutting out the very workers—especially women of color and immigrants—who have so long and so capably done this work.

To ensure a right to good care, infrastructure should be built around two lists. First, we need to develop and maintain a list of those who have a right to care due to age or health or disability. In some ways, such a list already exists for in-home direct care, as the existing system already extends

in-home care to certain community members on the basis of need through various senior and disability programs generally managed by counties. For child care, the list should include extend the right to quality care to all children of pre-school age. The second list we need is the list of quality providers of care. Only quality providers could be selected by those with the right of care. There is consumer direction within the qualified provider list but the right to care would not support providers outside the list.

The state role is then to maintain the lists, connect consumers and providers of care, and monitor and uphold standards in care and job quality produced by the system. I propose that we secure (1) a vision based on the right to decent care, which must be maintained by sufficient state infrastructure to (2) uphold worthy labor standards for care workers, and (3) strong care quality for those who need it. Note also that if we uphold the right to care, that right could be secured not only by paid care but also by a paid family-leave program. Developing a social conception of and support for the right to decent care in times of need means simultaneously developing support for strong paid family leave.

Steps Along the Way: Hubs, Benefits, and the Minimum Wage

Earlier, I mentioned models that aggregated worker interest and amplify the voices and concerns of the care workforce. These models —specifically, the unionization of independent contractors in home health, and local coalitions organizing around care work. – unite the interests of care consumers, quality care providers, and the lowest-wage care workers to support quality jobs, quality care, and equality. The required transformation of care work will be rooted in these sorts of efforts. As care workers are increasingly understood to be essential to care quality and allies in building a stronger system of care in the nation, they will also be able to redefine the conditions and quality of their jobs.

The first steps I suggest, then, build on this existing foundation but also to expand more adventurously from it. First, advocates should continue to develop community-based infrastructure to create public awareness of the scope of care work, and to rationalize (i.e., improve scheduling) and organize (in the sense of increasing unionization as well as bringing order to the complexity of the system) these jobs. Second, we should begin experimenting with infrastructure that can deliver benefits directly to care workers at the community level rather than through employers—a step towards strong community or statewide health insurance and retirement benefits for all care workers. Pooling demand for health insurance, establishing access to it, and publically funding it would be a significant step towards public investment in care workers. And finally, and perhaps most important, care worker advocates and others need to connect more directly to minimum wage campaigns at the community level, and fight for decent care work in those campaigns. In time, care workers could extend from the minimum wage fight into community care wage campaigns. Each step strengthens and unifies efforts to better support worthy care jobs.

"Care Hubs" to Organize, Rationalize, Train, and Provide Benefits

The unionization of independent contractors in home health provides a model for considering and asserting the public/private nexus in care work. The unionization of this workforce allows for bargaining wages. Equally important, however, this central infrastructure for the entire home health workforce can help match workers to clients and provide training and skills workers need. In

Wisconsin, child care workers register with the state to establish their skill and experience levels and to qualify for training and tuition support. The most significant steps forward for care workers have been taken when those workers have been identified and organized and when those workers move together with unions, consumers, and other advocates to pursue legislative or administrative reforms to improve jobs.

Based on these models, new care work infrastructure might best be conceived as locally based "care hubs." Such infrastructure can represent the front line of advocacy for care jobs and, eventually, take on more ambitious goals to organize and rationalize care work. Administratively, the hubs can provide quasi-public infrastructure that would allow the state a more direct relationship with care workers and the ability to raise labor standards for them.

Think of care hubs as dynamic spaces to register, coordinate, and support the field. These hubs can serve as a care-focused worker center; a hiring hall for connecting demand and supply; a nexus of adult training and learning infrastructure; and an organization with the capacity to research the field. These hubs would provide a mechanism to develop the list of providers and consumers, document the wages, benefits, and attributes of the workforce, and document the needs of consumers and the quality of services they receive. Care hubs would be led by workers, consumers, and key stakeholders in the field. Their mission would start, perhaps, with advocacy campaigns around care work and move to more structural work on improve connections between consumer and provider, delivering better benefits, and developing worker focused training supports.

A critical project for care hubs will be to do the hard work of figuring out the many public resources flowing into care work. A first step would be to identify and measure public resources at the local level. That inventory would allow for attention to means of consolidating and aligning those resources so that care work can be improved. The hubs could also identify private resources in the field, both those coming in from buyers, and from local philanthropic resources. The hub could then disseminate this information in order to inform the community conversations around care work, and to help propose new administrative policies that might streamline the system delivering funds in ways that improved care jobs.

Health Care and Retirement Security for Care Workers

From this origin as a nexus of organizing and advocacy for care work, care hubs could over time broaden focus to deliver a strong benefits package to all care workers in a community. Hubs could move into a position as joint-employer of care workers and use the position to delivering a strong benefit package. Agencies, institutions, centers, or individuals would continue as the other employer, writing paychecks, making hiring and firing decisions, and establishing working conditions. This would provide a means of experimentation with the joint employer model and would allow hubs to become avenues for state interest, influence, and investment in the care workforce. To support the costs of benefits, resources could be generated from saved costs from Medicaid programs and other public programs, savings from agencies and centers and other providers of care (given the reduced costs of their own benefits), and new community resources. By establishing the hubs' interest, investment, and joint employer role in this workforce, the hubs could be consciously positioning themselves to move into the provision of wages in addition to benefits over time.

This long-term vision reaches toward a new way of thinking about care workers and a practical strategy for channeling and aligning public interest and investment in these workers. The hubs are one way to start building infrastructure that could eventually direct public investment directly to care workers. The motivating concern should be to develop the framework and infrastructure necessary to hold together the complex interests at play, and to efficiently distribute a larger pool of public resources into a private/public market for care in ways that focus on care workers' job quality.

Another route might simply be to demand that this work be treated like that of all other public workers, and to have the state employ the care workforce directly and unambiguously. The upside to this approach as a long-term goal is that it connects workers with a decent employer and helps uncomplicated the current system of myriad programs and providers. However, this route is remote from contemporary political reality not only as a result of the general political climate but also because there is a well-established and influential private sector that currently provides care that would surely resist the public sector moving into (and taking over) the market for care.

If we can't make these jobs public, then we should try to develop the quasi-public infrastructure to channel public interest into these private markets. We should start now trying to build that infrastructure.

Starting now, care work organizing, advocacy, and policy reform should seek to build a broad coalition, and start to build long-term infrastructure that can not only advocate for care workers, but also transform these jobs. At policy levels from the local to the federal, the coalition for care worker needs to engage the care providing sector, as well as its public funders and private resources. These coalitions need to bring care workers out of the shadows and margins of the economy and the welfare state, and directly into the center of conversations about wages and working conditions.

Starting with the Minimum Wage and Paid Leave

The dramatic success of the Fight for $15 across the nation has put the minimum wage at the forefront of political organizing. The rising wage floor holds great promise for care workers, but it should be attended to. The most important and immediate step that advocates need to make on care workers is to direct more attention to these campaigns. Child and health care worker advocates and coalitions must enter into a direct conversation about the structure of minimum wage policies at the local and federal level.

The early integration of care work issues into minimum wage campaigns is critical for two reasons. First, advocates need to be sure that care workers are actually covered by the policy. Too many exemptions (for instance, on the basis of employer size; child care centers are often small) can mean that the increase leaves care workers behind. In some instances, exemptions for this workforce are embraced by non-profit leaders who can't see a way to provide the same necessary care at a higher minimum wage. But this raises the second concern. Care workers should be covered by wage increases, but communities must find ways to make the increased wages possible as well. A community that says "We can't afford decency in care work" should be forced to reconsider.

Arguments about the minimum wage generally avoid the hard question of how the non-profit care sector (and even the for-profit sector, with its frequent thin margins) will respond to increases. Minimum wage advocates focus on the private impact of the minimum wage on fast food and retail,

where studies find little impact. But the dynamics of wage increases in care work are simply not parallel to the dynamics in retail, hospitality, and fast food. In these sectors, labor is a smaller share of total costs and price increases, new technology, and/orproduct mix changes can be used to cover increasing wage costs. In care work, labor represents a higher share of overall budgets, and price changes can be difficult or impossible to make. For example, as much as 80 percent of total revenue is directed to wages in some non-profit child care centers. And staffing ratios are mandated and regulated. But, given the very high costs of child care already, a change in prices can undercut the market and move more children into unregulated sectors. We need to know more about how higher wages will impact care workers and consumers as wages go up in cities across the nation.

The entire care work sector -- the workforce, providers, and consumers -- needs to embrace a higher minimum wage, but equally resources need to be gathered and directed to make the increases possible. Medicaid, Medicare, and state administration of those programs require policy changes on reimbursement. Child care requires new kinds of subsidies and new strategies for securing private resources to support care work (including, perhaps, local taxes and sliding scale payments from parents). Jobs with Justice, together with National People's Action and other organizations, are now perusing "fair share" fees, assessed on low-wage employers. These fees would seek to evaluate workers use of public supports and tax employers that are responsible for high public support costs. The revenue from these fees could provide an important revenue stream to support care work.

Imagine that, in communities with substantial minimum wage increases already on the horizon, local collaboratives on care work were convened. Such local collaboratives could (1) ensure that these standards would be extended to all care workers regardless of legal exemptions and (2) develop political and funding strategies to cover the cost of wage increases. Like Living Wages, the idea would be to build formal community commitments to stronger labor standards in non-profit care jobs. But from the start, these collaboratives would acknowledge that higher wages require more money in the system. Care work advocates would join with non-profit care work sector leaders and community funders such as the United Way. A first step for any collaborative would be to develop a reasonable accounting of what care work wage increases would cost. That process—identifying the community care work field, the current wages in it, and the cost for increasing those wages—is the very first step required to build hubs for community care. Those hubs could eventually take on more functions, as described above.

Once the strategy around the minimum wage increase is undertaken, the hub could easily turn to the issue of providing health insurance for care workers, or other pressing issues identified in the process. The collaboratives would provide the infrastructure for more ambitious agendas for care work and care workers in the future.

Finally, paid family leave is another public policy area that puts real value on care. The care work community should support progressive and strong paid family leave. If thoughtfully and progressively designed, such policy can serve the interests of care workers and help support them when they need to attend to family needs. But it also expresses the value of care and the need to invest socially in it. And for this reason, too, the care work community should support paid leave.

Conclusion

We must dramatically reshape the nation's understanding of what care work is, what it is worth, and how to pay for it. We need to put the workers and the question of wages at the center of this project;

they have too long suffered the lack of investment; their needs are too often relegated to the back of the queue, and their vocies are essential to changing the way we value these jobs.. Care workers deserve a significant wage increase and the funds for it must come from the public sector. . Communities mobilized around care work issues and building a real care investment package for the care workforce may provide the first step toward a necessary transformation.

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Technical Note

Figures in Tables 1 and 2 are based on micro data from the Public Use Micro Sample (PUMS) version of the American Community Survey one-year estimates, for years 2005 and 2013, provided by the Census Bureau. The figures are based on the population of individuals in the sample who are between 18 and 64 years old, and who worked within the 12 months previous to the interview.

The categories presented in the tables are generated in the following way:

- Home Health workers are those whose occupations are classified as "Nursing, psychiatric, and home health aides" (occupation code 3600) or "personal and home care aides" (occupation code 4610). Within this category, we selected workers classified within two sets of industries:
  - Home health care services (industry code 8170), and
  - Private households (industry code 9290).

- Health Aides includes workers whose occupation is classified as "Nursing, psychiatric, and home health aides" (occupation code 3600) or "personal and home care aides" (occupation code 4610), who are
  - not included in the Home Health group defined above,
  - and are classified in one of the following industries:
    - Nursing care facilities (industry code 8270)
    - Residential care facilities, without nursing (industry code 8290), and
    - Other health care services (industry code 8180)
  - Note that this definition excludes people working in Hospitals.

- Child care workers include those whose occupation is classified as "child care worker" (occupation code 4600). Workers in this group are classified in the following subgroups:
  - Private household services (industry code 9290)
  - Family child care providers, if workers are classified in industry "child day care services" (industry code 8470), and who are classified as "self employed."

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

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

Variables

- Given the restrictions imposed by the data and variables structure in the PUMS data set, median total person's earnings are calculated in the following way:
  - Total person's earnings in the past 12 months (variable wagp) is divided by the total number of weeks worked in the past 12 months. This generates an estimate of weekly earnings.
    - In the case of the 2005 data set, the number of weeks is available in the variable wkw.
    - Starting in 2008, the Census changed the way it reports the number of weeks worked, and now reports it as a discrete variable. The number of worked weeks is presented in

discrete intervals: fewer than 14 weeks worked during the last 12 months; 14 to 26 weeks worked; 27 to 39; 40 to 47; 48 to 49; and 50 to 52 weeks worked. We impute the number of weeks worked by assigning to the worker the median value of the interval he is classified in.

  - We divide our estimated weekly earnings figure by the usual number of hours worked per week in the last 12 months (variable wkhp). This generates an estimate of the hourly earnings.
  - Note that we use total person earnings instead of wages because many workers who are self-employed report wages that are too low or zero, while at the same time reporting non-zero earnings.

- Female reports the percentage of workers in each category who are women. Percentages in this and other demographic variables are calculated using the population weights provided.
- Hispanic reports the percentage of workers in each category who identify as being of Hispanic or Latino origin.
- Black reports the percentage of workers in each category who report black as their race, and who are not of Hispanic origin.
- Noncitizen reports the percentage of workers in each category for whom their citizenship status is classified as "Not a citizen of the U.S."
- High School degree or more reports the percentage of workers in each category who have completed a high school degree or greater level of education.
- Insurance through an employer or union reports the percentage of workers who declare to receive health insurance "through a current or former employer or union."