

Demanding Quality:
Worker/Consumer Coalitions and “High Road” Strategies in the Care Sector

Draft of May 10, 2005

Nancy Folbre
Department of Economics
University of Massachusetts Amherst
folbre@econs.umass.edu

Paper prepared for Conference on Caring Labor, Harry Bridges Center for Labor Studies,
University of Washington, Seattle, WA
May 20th & 21st, 2005

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Economists worry endlessly about the manufacturing sector (could GM really go bankrupt?), not to mention the high-tech sector (whither the Nasdaq?). Economists sometimes refer to the service sector, and pay attention to specific industries such as health. They probably don't even know there is something called the “care sector” unless they are girls or as Governor Schwarzenegger puts it, “girlie men.” Yet the care sector is a topic of increasing interest among political activists and trade unions, as well as feminist scholars. Tonight, I will try to persuade you that some economists actually have something useful to say about it.

I define the care sector as economic activities in the home, market, community and state that have a particularly strong personal and emotional dimension: activities such as childrearing, child care, health care, elder care, and education. These are activities that are often provided on a face-to-face or first-name basis, and they often involve the care of dependents. Much of my work on the care sector has focused on women's non-market work in the home, but tonight I will focus on the portion of the care sector that involves paid employment.

Economists and policy makers often mistakenly assume that paid care services can be produced like any other commodity. They are, obviously, subject to the laws of supply and demand. The supply of care services seems to be declining while the demand for them is increasing, driving up their relative costs. This creates strong pressures to increase productivity. Unfortunately, it also creates strong pressures to lower quality and reduce public provision. Workers and “consumers” (dependents, patients, students, clients) in care services share common

interests and should try to develop stronger coalitions to protect quality and preserve access.

In this presentation I explain why the relative cost of care services is rising in the United States and emphasize the distinctive features of paid care work that make it particularly vulnerable to deteriorating quality. I outline five related strategies that could help improve paid care quality by improving the pay, benefits, and voice of care workers.

The Relative Cost of Care

During the last half of the twentieth century, both technological change and increased investment in other countries contributed to a significant reduction in the share of the U.S. labor force devoted to manufacturing. Employment in the service sector grew rapidly in both absolute and relative terms (Folbre and Nelson 2002) . Economists predicted that labor productivity in services would lag behind manufacturing because it was less susceptible to automation and also less geographically mobile. By this reasoning, the relative price of services would be likely to rise relative to manufactured goods. William Baumol (1967) famously called attention to what he called the “cost disease of the service sector.”

For much of the service sector this prediction proved wrong. The rapid development of digital information technology in the 1980s and 1990s transformed many aspects of service work: clerical, retail, and banking jobs were all profoundly affected. Although measures of output per worker are harder to come by in these occupations, the relative cost of processing information in these jobs has plummeted. The growth of call centers overseas substantiates the relevance of outsourcing: basic question-and-answer functions that initially seemed to require geographic proximity are now untethered (and automation in this area continues apace).

Some service jobs, however, are both less information-intensive and more person-

oriented. Jobs of “care” such as nursing, teaching, child care and elder care often entail trusting relationships between workers and consumers in repeated interactions over a relatively long period. Potential for substituting capital for labor is more limited, and the consumers—in this case, patients, students, toddlers, and the elderly—cannot easily be relocated (Donath 2000).

An additional factor driving up the cost of care services is the growth of opportunities for women outside the care sector. Women’s increased labor force participation has reduced time available for non-market work, contributing to what might be termed a “care deficit” (Misra and Merz 2004). Teaching and nursing, once considered attractive professions for women, now pay considerably less than jobs in management, banking and finance or more credentialed occupations in the care sector. After increasing steadily for many years, the number of women applying to medical school in the U.S. exceeded the number of men for the first time in 2003-2004.¹ Meanwhile, the declining supply of nurses is reflected in a steady increase in the average age of the nursing workforce, a factor that has given rise to warnings of serious nurse shortages in the future.

If the price of manufactures and information goes down more quickly than the price of care services, the relative price of care goes up. Health care services represent a particularly extreme case. Between 1994 and 2004, the overall Consumer Price Index for urban consumers in the U.S. increased 27%, while the index for medical services increased 51%.² Many who need care are unable to pay for it; the number of individuals under age 65 lacking health insurance in the U.S. has now reached about 15%.³ Medicaid rolls are expanding rapidly as a result, imposing ever more pressure on state budgets.⁴

As mothers increased their participation in paid employment in recent years, child care

services have consumed a growing portion of family budgets. In 2002, estimates for approximately full-time care (corresponding to a 40 hour work week for a parent) ran from a low-end of \$3,600 to \$7,800 for a family child-care home, to \$6,000-\$9,000 for a child-care center to \$18,000 to \$30,000 for a live-in nanny.⁵ In recent years, costs have risen considerably faster than the rate of inflation.⁶ Low-income families enjoy some public subsidies, and most families are able to take advantage of help from relatives, and friends, so out-of-pocket expenditures are generally lower. The 1997 National Survey of America's families indicates that that 48% of working families with children under age 13 had child care expenses; of those families who paid for care, the average monthly expense was \$286 per month, or an average of 9% of earnings.⁷

Many of those who need care services find it difficult to pay for them. Yet because care often represents a necessity rather than a luxury, the elasticity of demand for it is low. Rising prices often exacerbate preexisting income inequalities or increase the burden on the public sector (England and Folbre 2002). The flexibility that families have to meet their own care needs is limited by the demands of paid employment. Distributional struggles intensify as conservative coalitions cut taxes to block increases in spending on health, education, child care, and elder care. The result is increased pressure on institutions such as hospitals, schools, and nursing homes to cut costs. While that pressure can promote efforts to increase productivity, it can also lead to reductions in care quality.

Care, Competition and Quality

Most of us can remember a nurse who held our hand through a painful medical procedure, or a teacher who guided a memorable flash of insight. The impersonal dynamics of

supply and demand are better designed for the invisible hand than the invisible heart (Folbre 2001). In what Arlie Hochschild and Barbara Ehrenreich aptly term a “heart transplant,” increased demand for care workers has created a global “care chain” in which many immigrant women leave their own needy families and communities behind in order to seek higher paying jobs within the United States (Hochschild and Ehrenreich 2004). Automation also has disquieting implications. Can distance learning over the web substitute for the interaction of the classroom? Do we really want nursebots taking our pulse, rather than humans who can sense our need for reassurance?

Yet immigrants make invaluable contributions to our care economy, and all of us potentially benefit from improvements in medical technology. Neither immigration nor automation pose inherent threats. They become problematic when they take place within an institutional context that could lead to “over-commodification” and reduction of care quality. Any time a service is bought or sold it becomes, in technical terms, a “commodity”(Radin 1997). The *American Heritage Dictionary* defines a commodity as “something useful that can be turned to commercial advantage.” Over-commodification can be defined as what happens when commercial advantage creates incentives to lower quality. There are good reasons—economic as well as philosophical—why not everything should be for sale (Kuttner, 1997). There are also good reasons why some things should be produced for sale only under conditions that protect the interests of both workers and consumers.

In the idealized world of economic textbooks, over-commodification cannot take place because consumers are sovereign: perfect information, unlimited choices, and low transactions costs allow buyers to punish opportunism and drive low quality producers out of business. The

more competition, the better. The more choices consumers have, the better off they are. I love my plastic, often shop on line, and marvel at Ebay. But some things are easier to click on than others, and the real world does not always respect convenient assumptions. Sometimes we're not sure what we are buying, get locked into deals that are difficult to modify, and feel that genuine choices lie beyond our grasp.

The new institutional economics, which emphasizes the difficulty of obtaining perfect information and monitoring effort, provides important insights into circumstances that can lower quality. In classic early articles, George Akerlof (1970, 1982) explained why the market for used cars may result in a large number of "lemons" changing hands and why employers often benefit from paying wages that are higher than those required to clear the market. Work within the classical tradition is also relevant. Marx's concept of "commodity fetishism" aptly describes the pressure to focus on market prices and incomes while ignoring more complex dimensions of our standard of living, which are more difficult to measure. Harry Braverman's *Labor and Monopoly Capital* (1973) argues that capitalist competition forces employers to cut costs by deskilling jobs and reducing the intrinsic satisfaction might otherwise be derived from work. Robert Reich provides a modern example when he notes that many people find it easier to appreciate the low prices that Wal-Mart offers, than to challenge their employment practices, even when they are hurt by them.⁸

Ecological economists state the argument more forcefully in terms that emphasize spillovers and coordination problems. Thomas Princen (1997) explains that institutions always try to conceal the extent to which they enjoy beneficial inputs from—and dump detrimental byproducts into—the territory beyond their boundaries: their optimal strategy is to internalize

benefits and externalize costs.⁹ “Shading and distancing” of problems that are difficult to measure deflect attention from their negative effects.

In *The Invisible Heart* (2001), I argue that there are important analogies between our collective reliance on Mother Nature and our collective reliance on Mother Care. Both metaphorical mothers provide services for reasons that have little to do with the market economy. In the short run, the supply curve for many natural and social services is not a function of price. We don't pay for these services out of pocket, and as a result, we tend take them for granted. But in the long run, pollution, overexploitation and plain old disrespect reduce supply. They can hamper the replenishment of positive motivation and capacity in complicated, disruptive, and virtually irreversible ways. If you think global warming might prove to be a serious problem, think about the possible consequences of social chilling.

I am struck by the convergence of problems in our natural and social environment that cannot be analyzed in terms of market forces. Medical evidence shows that breastfeeding offers infants important health and developmental benefits. Yet a study of breast milk among the Inuit of Greenland discovered toxic levels of hazardous waste (PCBs and mercury). A diet that relies heavily on marine mammals, which feed on fish, which feed in turn on smaller organisms, leads to a high concentration of these toxic chemicals.¹⁰ Among the Inuit, mother's milk is now hazardous to children's health. In the U.S., social policies toward poor families have some hazardous effects. Despite high average income we rank poorly compared to Europe in most measures of public health. A statistical analysis of the impact of welfare reform in 1996 suggests that it reduced breastfeeding at six months after birth by 5.5% (Haider et al., 2003).

Environmentalists and care advocates share a common skepticism about the supposed magic of the market. In a recent *New York Times* column, Paul Krugman describes the atherosclerosis of bureaucracy in private health insurance, rhetorically asking why this persists despite market competition. His answer: Private insurers don't compete by delivering care at lower cost. "Instead, they compete on the basis of risk selection—that is, by turning away people who are likely to have high medical bills and by refusing or delaying any payment they can."¹¹ The result is not only a low level of efficiency and dangerously variable quality, but a growing level of alienation and frustration among health care workers.

Similar trends are evident in our education system: Under new federal monitoring rules, primary and secondary schools are judged on the basis of test scores, achieved partly by constricting the curriculum and "teaching to the test." Colleges and universities don't compete by offering better quality services, but by attracting a student body with high average test scores. Teaching. In the wake of promises that a new writing test on the SAT would finally reward "quality" the director of MIT's writing program just released a study showing that the College Board process grades primarily on length, with no penalty for factual errors. For students wanting to maximize their scores, Dr. Perelman explained, "I would advise writing as long as possible, and include lots of facts, even if they're made up."¹²

Most child care centers pay low wages not only because they know that few parents can afford to pay the full price for high quality care, but also because they are largely unencumbered by the training and licensing requirements that are imposed on other establishments. In most states it is far more difficult to obtain credentials as a hairdresser than a child care worker. Many nursing homes and long term care facilities screen out private applicants who might prove costly.

They have become repositories for indigent patients financed by Medicare who can exercise little choice.

There's a pattern here. The care sector is particularly susceptible to quality problems for at least three major reasons:

1) Beneficiaries of care work are not merely consumers. They are patients, or students, or children, or other dependents. Care services are often paid for by third parties—insurance companies, the public sector, or family members. Those receiving care often lack the information or experience required to assess the quality of what they are receiving, and seldom have the flexibility to engage in “comparison shopping.”

2) Information problems loom large because both inputs and outputs of care are difficult to measure. Care cannot be measured in physical units. Its quality is often person-specific and context-dependent. Consumers often don't know what they have purchased until they are already locked in to a given health insurance policy or specific care provider. Workers cannot be easily monitored. Standardized measures of productivity such as patients' “length of hospital stay” or a students' scores on multiple choice exams may be misleading.¹³

3) Intrinsic motivation among workers helps ensure quality, but workers may have little control over their work environment. Care workers often identify emotionally with those they care for (indeed, good care often requires the development of empathy). Because owners, employers and managers are less likely to come into direct contact with clients or patients than are care workers, they can generally engage in cost-cutting strategies without “feeling” their consequences. Yet such strategies often lead to changes in jobs and work environments that reduce intrinsic motivation.¹⁴

These problems are not unique to the care sector. Coke vs. Pepsi is hardly a liberating menu, and relatively few restaurants or vending machines even provide a choice between the products offered by these two conglomerates. Markets do not allow consumers to express their preferences for public goods such as the quality of the natural and social environment (Graves, 2003). Studies of information and banking services note growing pressures to cut corners on service quality (how much time have you spent on the telephone “on hold” this week?) (Rogelio and Sterman, 2001).

Some level of intrinsic motivation is probably important to the successful performance of most jobs. In today’s economy workers can seldom be paid a piece rate that rewards them for what they actually produce, and workplace productivity is strongly affected by trust and cooperation. The risk of opportunism looms large in many economic environments. Surveys of CEO pay are seldom able to explain any systematic link between pay and performance, and stock option packages almost certainly created incentives for CEO’s to misreport profits (Lavallo, 2005).

But problems of quality and motivation are particularly salient in the care sector and have more immediate—and often more serious—consequences for human well-being. Many consumers might opt for lower prices even when these lead to negative spillovers on workers, communities or the natural environment. Consumers of care services find it harder to engage in such “shading and distancing.” The link between consumers and workers is stronger in the care sector precisely because of its emotional and personal valence. Almost by definition, care workers and care recipients have the opportunity to talk to and interact with one another. This care/competition/quality nexus has important strategic implications.

High-Road Strategies

Deborah Stone's (2000) call for a "new care movement" has found a wide audience. Yet there has been relatively little strategic discussion about how about how to build such a movement, or the role that trade unions might play in it. The concept of a "high-road" strategy seems particularly apt for care work. The logic is simple. Organizations, including profit-maximizing firms, often face choices in the ways they can achieve efficiency: "Low-road" implies low cost but high labor turnover and poor quality; "high-road" implies higher cost but sufficiently higher effort and quality to compensate. Stephen A Herzenberg, John A. Alic, and Howard Wial provide a compelling overview in their book *New Rules for a New Economy* (1998), contrasting "unrationalized labor-intensive work systems" with "high-skill autonomous work systems." They point out that the service sector has lagged behind the manufacturing sector in developing autonomous systems. Unionization—and its decline—help explain the difference.

Many of the general recommendations made by Herzenberg et al. apply with special force to the care sector: increase the minimum wage, establish equivalent compensation for non-standard employment, promote performance improvement, and launch multiemployer institutions to promote training and career ladders. These recommendations dovetail neatly with many concerns expressed by advocates of policies to improve work/family balance (Gornick and Meyers 2003). If part-time workers could obtain prorated benefits and protections, their family life—as well as the quality of the paid care they provide—would improve.

Here's my list of high priority strategies for employees in the care sector, ranging from general to specific, 1) Build links among care sector workers. 2) Emphasize the common interests of care providers and care recipients. 3) Challenge the claims that "care should not

pay.”4) Promote unionization. 5) Affirm and strengthen the public sector. 6) Publicize and encourage “best practices” management.

Build Links Among Care Sector Workers

The very concept of a “care sector” is a relatively new one that has scarcely been heard outside the academy. Yet it has the potential to forge a stronger collective identity among the predominantly women workers employed in what are sometimes called “human services” (as opposed I suppose to “inhuman services”). In a paper forthcoming in the *American Journal of Sociology*, Kim Weeden and David Grusky (2005) argue for the importance of a new “class map” that puts more less emphasis on “big classes” and more on the “institutionalized social categories that develop at the detailed occupational level.” The care occupations represent a case in point.

For a variety of reasons women dominate the care sector. Obviously, occupational segregation plays a role. But women may “select into” care work for important positive reasons—they value both the process and product of care.¹⁵ Organizing strategies could build on these shared values, while acknowledging important differences based on class, race, and ethnicity. Women of color are overrepresented among the most poorly paid jobs in child care centers and nursing homes. As Mignon Duffy (2005) points out, white women dominate the more professional care occupations, while women of color are more likely to engage in less easily idealized housework and domestic labor. Female immigrants often land in pink-collar jobs that involve emotional labor in body-related service provision such as hair and nail salons (Kang, 2003). Live-in nannies are often paid under the table and therefore denied access to basic benefits such as unemployment insurance and Social Security.

A care movement should be based on a broad, inclusive definition of care work. It should

also rise above turf battles and institutional inertia. Nurses and teachers, who are relatively well-organized, need to pitch in and include less empowered workers such as nurses aides and child care workers in a broader coalition.

Emphasize the Common Interests of Care Workers and Care Recipients

Care workers and care recipients are natural allies, sharing a common interest in quality of care. Care recipients, like workers, are disproportionately women and children. Organizing efforts need to emphasize and strengthen this commonality by educating the public about threats to service quality. The relative power and “voice” of care workers often determines the relative quality of services that care recipients enjoy.

Nursing provides a clear example: The Nursing Code of Ethics stipulates that “The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.”¹⁶ Pressures to cut health care costs have led to institutional changes that have significantly decreased nurses’ ability to do their job. As Jean Chaisson of the Community Health Network in Holliston, Massachusetts put it in a letter to the journal *Health Affairs* in March/April 2002:

Approaching sick people as though they were running a factory, consultants now refer to our most complex and vulnerable patients as “product lines”, focusing on “throughput” instead of healing. Sadly, most health care institutions have followed this industrial model. Large numbers of nurses have been diverted to case management, where their interventions aim to ensure reimbursement and rapid patient discharge. Gone are the monitoring, evaluation, intervention, and compassion that were one the pride of in-patient nursing services.

Nurses are responsible for more—and needier—patients than they have been in the past, and many are required to work mandatory or unplanned overtime. Such working conditions are deterring young people from entering the profession: According to one U.S. study, almost a quarter of nurses claimed that they would actively discourage someone from going into nursing and almost half stated they would choose a different career if starting over (Heinrich, 2001). Indeed, nurses in Canada, England, Scotland, and Germany agree with those in the U.S. that problems in work design and labor management lower the quality of care (Aiken et al., 2002). A survey of over 7,500 nurses released in 1996 reported that 73 percent felt they had less time to comfort and educate patients (Gordon, 1998:255). Deborah Stone, who has extensively interviewed home health care workers, reports “The more I talked with people, the more I saw how financial tightening and the ratcheting up of managerial scrutiny are changing the moral world of care giving, along with the quantity and quality of care” (Stone, 1999:62).

Child care provides another example of the link between working conditions and care quality, a link consistently and successfully emphasized by the Worthy Wages Campaign, a grassroots effort to build alliances between child care providers, teachers, and parents.¹⁷ Many child care purchasers probably realize that shiny new facilities and toys matter less than skill and commitment levels of the workers providing care, but few fully understand what is wrong with the larger organization of child care. Low pay and the resulting high turnover among child care workers, averaging about 40% per year, reduce the consistency and quality of care children receive (Bergmann and Helburn, 2003). Many child care workers, especially those in informal family care settings, lack sufficient education and training (Whitebook, 1999; Galinsky et al. 1994). Similar problems are evident even in state-funded prekindergarten programs for which

high formal standards have seldom been effectively enforced (Gilliam and Marchesseault, 2005).

Quality issues are even more problematic in elder care. Nursing homes now employ more workers in the U.S. than the auto and steel industries combined. Almost 95 per cent of these homes are privately run, though most are subsidized with public dollars. Turnover rates among workers are high, amounting to almost 100 per cent within the first three months. According to *Consumer Reports*, about 40 per cent of nursing homes repeatedly fail to pass the most basic health and safety inspections (Eaton, 1996). In a 1999 study, the General Accounting Office reported government inspections of nursing homes across the country showing that more than one-fourth cause actual harm to their residents (GAO, 1999).

Given their poor track record at meeting even basic needs, it is chilling to consider how poorly nursing homes meet the emotional needs of the elderly. Susan Eaton describes the things companies “can’t bill for, but that make all the difference if you’re living in a nursing home: time to listen to somebody’s story, time to hold their hand, time to comfort somebody who is feeling troubled. And you can’t exactly put that on your bill; imagine finding “holding hands” on the bill. You have to have a ‘treatment,’ you have to have some formal procedure” (Eaton, 1996:7). Similar problems are characteristic of the growing home care industry, especially in areas where it is poorly regulated and un-unionized (pretty much everywhere except in California) (Howes, 2004).

Challenge Claims that “Care Should Not Pay”

A care movement must challenge the notion that virtuous women should offer care “for free” (Nelson, 1999). Traditional gender ideology is often used to justify low pay, on the grounds that part of the remuneration that women receive is psychological in nature—the

inherently feminine pleasure of taking care of others (Whittaker, 2003). Yes, many care workers derive great satisfaction from their jobs. But that doesn't mean they should be paid less as a result.

Neoclassical economists hypothesize that low-paid jobs are rewarded by a "compensating differential" of psychic satisfaction, but don't provide evidence that this actually explains occupational wage contours. An even more insidious version of this argument suggests that low pay helps screen out workers who lack the requisite motivation, as though any care worker seeking higher pay is unlikely to provide high quality services.

In a recent article entitled "The Economics of Vocation or 'Why is a Badly Paid Nurse a Good Nurse?'" Anthony Heyes (2004) argues that willingness to accept a lower wage, all else equal, distinguishes a "good" nurse from the "wrong sort." Raising nurses' pay, he argues, would reduce the proportion of virtuously motivated nurses and decrease the quality of care. No, it was not published on April Fools Day, and it is not a joke. And a detailed critique that was fired off to the editors of the professional journal that published it was rejected out of hand.¹⁸ The critique explains that Heyes' argument fails to distinguish adequately between motivations and the quality of the job accomplished, uses a theory about individual behavior to make assertions about the characteristics of the entire nursing labor market, neglects the impact of pay and working conditions on employee morale and retention and overlooks the empirical realities of current nursing shortages.

The need to challenge gender stereotypes that reinforce low pay is beautifully explained by the Center for Nursing Advocacy, whose website addresses the rhetorical question "Are nurses angels of mercy?" with admirable tact:

Although the Center appreciates positive comments about nurses, we believe that the image of the “angel” or “saint” is generally unhelpful. It fails to convey the college-level knowledge based, critical thinking skills, and hard work required to be a nurse. And it may suggest that nurses are supernatural beings who do not require decent working conditions, adequate staffing, or a significant role in health care decision-making policy. If nurses are angels, then perhaps they can care for an unlimited number of patients and still deliver top-quality care. To the extent nurses do seem to suffer in such working conditions, it may be viewed as merely evidence of their angelic virtue, not a reason to alter the conditions.¹⁹

Gender stereotyping also hurts child care workers, who are sometimes fearful that demands for higher pay will come into conflict with parents’ ability to pay. Here again the quality nexus is crucial: workers must recognize that parents and children are harmed by the low quality that results from low wages, high turnover, and poor working conditions.

Promote Unionization

Advocates of unionization have long emphasized that the benefits of improved productivity help pay for the higher wages and working conditions that unions bargain for (Freeman and Medoff, 1984). This logic works even more powerfully in the care sector. For instance, nurse unionization and other factors improving their working conditions have been statistically linked to improved outcomes for patients (Ash and Seago 2002; Aiken et al, 1994). Researchers need to develop more and better ways of documenting the connections between unionization and care quality. And research results also need to be communicated effectively to

health care consumers.

Care sector advocates also need to track union efforts across the country. The California Nurses Association deserves special recognition for its role in establishing minimum staffing ratios in hospitals in the state—and fending off efforts by Governor Schwarzenegger to eliminate them. Although less than 5% of child care providers are covered by collective bargaining agreements, both SEIU (here in Seattle) and AFSCME (especially the United Child Care Union in Philadelphia) are making modest headway in this area. A recent account of the efforts of SEIU Local 880 in Illinois provides important insights (Brooks, 2005). Look north for inspiration. In 1999 the Confederation of National Trade Unions in Quebec won a large increase in the average wage of the child care workforce, along with greater public support for child care.

One of the biggest success stories is the successful unionization of home care workers in California—an effort that began with the formation of a consumer-labor coalition that revised state laws. Unionization clearly improved wages and benefits, and also gave clients greater choice of caregivers (Howes, 2004).

Activist groups such as Jobs for Justice have built support for organizing campaigns by holding public hearings on poor wages and working conditions in child care and elder care.²⁰ We should look for opportunities to strengthen such efforts by building broader coalitions and improving communications between East and West.

Affirm the Role of the Public Sector

Many care workers are employed by a public sector that is increasingly pinched for funds. Living wage campaigns that set higher standards for state and municipal employees often specifically target workers in human services.²¹ Organizers need to openly confront the need to

raise progressive taxes to provide high-quality care, and to explain the link between the two. Without more activism on budget issues, advocates of health care, child care, and education are likely to be pitted against one another. The only way to resist is to demand a large increase in the overall “care budget” on the state level, taking advantage of the kind of information on public spending provided by the National Priorities Project and the Center for Budget and Policy Priorities.

Many state initiatives to improve working conditions in the care sector deserve special recognition. Here in Washington, the Kings County Career Development program for child care workers sets a great example.²² An Urban Institute study of how to get compensation for child care workers on the policy agenda provides a comparative analysis of efforts in Washington, Georgia, and Massachusetts (De Vita et al., 2002). In Massachusetts, a Nursing Home Quality Initiative passed in 2000 included a wage-pass through, a scholarship fund, and a career ladders initiative. Evidence suggests that it improved wages and increased retention of Certified Nursing Assistants (Eaton, 2005).

Regulatory standards for care quality need to be strengthened and extended. While immigration may help the U.S. economy meet labor shortages, it can also have negative effects. U.S. hospitals are increasing international recruitment of nurses (from the Philippines in particular) as a way of avoiding the more costly solution of improving current working conditions (Bach, 2003:30). In Great Britain imported nurses (largely drawn from sub-Saharan Africa) supply more than half of all new nurses (Aiken et al., 2004; Brush et al., 2004). In order to expedite the “outsourcing solution” conservatives in the U.S. Congress have advocated legislative changes that would expand the number of visas, and eliminate requirements that

include English proficiency testing and educational curriculum reviews. Particularly telling are related efforts to rescind the existing requirement that facilities employing foreign-educated nurses only require them to work hours commensurate with those of American nurses (Glazer, 2003). Nurses' unions and organizations play a crucial role in challenging such forms of speed-up. Rather than adopting a simplistic anti-immigration stance, the California Nurses Association has suggested a code of practice for the international recruitment of nurses.²³

Child care also requires more effective regulation. Child care quality is low partly as a result of poor public oversight (Bergman and Helburn, 2003). Voluntary accreditation by the National Association for the Education of Young Children tends to improve quality. One California study rated 61 per cent of accredited centers as good in 1997, compared to only 26 per cent of those seeking accreditation the previous year. Nationwide, however, only 5,000 out of the nation's 97,000 child care center were accredited (Whitebook, 1997). Many children in paid child care are in small informal family settings, rather than centers, where quality is even more variable. In the rush to expand child care slots to accommodate the exigencies of welfare reform, some states have provided child care vouchers that can be used virtually anywhere and may actually have a negative effect on quality by segregating low-income users. Immigration also poses a challenge here, since the growing demand for live-in nannies and housekeepers often takes advantage of illegal immigrants.

Publicize and Encourage “Best Practices” Management

Owners and managers may have a greater incentive than care workers to keep care costs low. But as a result, they also have an incentive to reduce care quality. One way to balance these countervailing incentives is to give direct care workers a stronger voice in management. Some

hospitals have experimented with productive forms of labor-management cooperation.²⁴ The Pioneer Network has brought together a variety of constituents to improve the quality of elder care (Eaton, 2005). Both Atlantic Philanthropies and the Robert Wood Johnson foundation have funded demonstration projects in five states to explore the better jobs/better care nexus (see the Better Jobs Better Care website at www.bjbc.org).

Conclusion

I don't think that a "care movement" can solve all our problems, and I certainly don't believe it can be launched in isolation from other political efforts. Still, I hope the analysis that I have offered here can help both care researchers and care activists challenge conventional market-centric economics. You don't need to obey the laws of supply and demand if they're not working. You need to write new laws.

In the fall of 2000 (I remember the date because it was the same November in which Al Gore was denied the presidency) a group called Scholars, Artists and Writers for Economic Justice brought child care activists, academic researchers, and members of the trade union movement together in Washington D.D. to encourage their collaboration. I'd like to see more conferences like that materialize. It takes a long time to build the high road, and of course it sometimes feels like tunneling through solid rock.

But many people of principle are care workers, and most are highly respected in their communities. If nurses and doctors demand high quality health care, their patients will hear them. If teachers demand high quality education, parents will listen. If child care and home care and elder care workers explain they can do a better job earning a living wage, ordinary families will try to pay it. Joined by others who identify themselves as care providers and recipients, we

could make a mighty roar. We might even be able to win a damn election.

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