

## Cleaning and Caring in the Home: Shared Problems?

### Shared Possibilities?

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## Introduction

This paper focuses directly on some of nation's most invisible workers: those who work each day to clean homes and care for the people in them. Whether providing hands on health care and support to the frail, direct child care to the young, or housekeeping services for the busy, these workers share more than a common worksite – the home. These home-based cleaning and caring workers also earn exceedingly low wages, suffer generally weak labor standards, and hold jobs that remain some of the worst in our economy. In many ways, in-home work is a sector where the “gloves” of labor and job quality standards were never really put on.

Despite longstanding status as the quintessential low-wage job, in the last ten years, home-based cleaning and caring jobs have also generated significant and inspiring innovations for improving low-wage jobs. Unionization of home health and family day care have provided some of the labor movement's most significant membership increases in recent years, delivering substantial wage and benefits improvements for at least 300,000 workers. Co-op models have emerged for all types of in-home work, proving that better wages and working conditions are possible in home-based cleaning and caring jobs. And advocacy campaigns for child care, domestic, and home health workers have increased awareness of these jobs, and have won significant policy victories to help promote the interests of these workers.

However, despite the poor conditions and surprising innovation that these in-home workers share, significant differences separate these workers as well, especially when evaluating strategies to improve the jobs. Probably the most important difference is who pays for their work. Private household workers clean homes, cook meals, and/or take care of children are paid by the homeowners; home health workers support and care for the frail, disabled, and elderly in their homes, and are often paid by federal medical assistance or other insurance programs; child care providers who care for children in the employer's home generally work for more well-off families; and children are brought to the homes of family child care providers who, paid by parents (and sometimes, indirectly, state subsidies) care for children across the income spectrum. Strategies to improve the jobs then connect back to very different funding structures. Focusing instead on *the home as a worksite* illuminates both the real differences and the surprising similarities that these home-based workers share.

Throughout this paper, I discuss workers whose worksite is the home. Table 1 shows these key in-home occupations. In order to help draw a more complete picture of these jobs, the table compares key in-home occupations to more visible counterparts in out-of-home settings. In terms of child care, this paper focuses on workers who provide child care in homes, either in their own home or in clients' homes. This universe includes “nannies,” “au pairs,” and “babysitters” and “family daycare providers.” While the most common mental image of a child care worker may be of a teacher in a day care center, nearly half of the national child care workforce is actually home-based. The in-home workforce also includes home health workers providing hands-on care and support to the elderly, frail or disabled, allowing them to live in their own homes. Home health covers both home health attendants (providing hands-on care for the old, the frail, the disabled), and personal care workers (who assist with daily living, including getting up and dressed, laundry, cooking and cleaning). In institutional settings (principally nursing homes and

hospitals), hands-on health care is delivered by nursing aides, orderlies, and attendants. The hands-on home health care workforce comprises just under one-third of the total frontline hands-on health care workforce. Finally, in-home workers also includes housekeepers who work directly in homes as “maids” or “domestic workers” for private household employers. While “maids” and “housekeepers” are found in many sectors, outside of homes, they are especially evident in hotels and other lodging places as well as hospitals. One-third of all maids and housekeepers work in homes.

**Table 1: Occupations with a Substantial In-Home Workforce**

	<b>Inside the Home</b>	<b>Outside the Home</b>
<b>Child Care Workers</b>	Family Child Care Provider (in provider’s home) Nanny, Au Pair, Babysitter (in child’s home)	Day Care Workers and Pre-School Teachers <i>in child daycare centers, preschool programs, etc.</i>
<b>Hands-On Health Care</b>	Home Health Aides and Personal Home Care Workers	Nursing Aides, Orderlies, Attendants <i>in nursing homes, hospitals, etc.</i>
<b>Maids &amp; Housekeepers</b>	Domestics, Maids, and Housekeepers	Maids and Housekeepers <i>in hotels, hospitals, etc.</i>

Explicitly excluded from the in-home workforce identified here are the many people that care and clean in the home without pay.<sup>1</sup> The large numbers of people doing in-home cleaning and caring work for “free” has direct and negative effects on wages and standards for workers in the paid sector. However, in this paper, the focus is directly on the workers who do this work for wages.

Grouping these disparate occupations together makes clear a series of problems which define these in-home cleaning and caring jobs. First, purely in terms of work organization, work in the home is inherently isolated and intimate. The isolation and intimacy generate similar challenges for workers regardless of specific occupation. Further, work tasks are strikingly similar across some occupations (some personal care workers are doing exactly what a housekeeper does, but for a different client). While distinctions seem clear, in fact the occupational and industrial lines in these jobs can be quite difficult to discern; this grouping helps make those similarities clear. Finally, the home-based workforce shares many demographic characteristics, and anecdotal evidence suggests that many workers move fluidly through these occupations and industries (Brooks 2005:49); grouping these occupations together acknowledges that reality as well.

But when we turn to the options for improving the jobs, differences between the jobs re-emerge as most critical. The lessons generated by policy and program innovation in some occupations are impossible to extend to others. Funding source differences are especially critical in trying to fund enhancement of job quality. Strategies to improve jobs in a private pay market will always differ from strategies where public dollars dominate, even if the work content is exactly the same. So while it is clear that disparate in-home workers have much in common – from

challenges of work organization to poor wage and benefits to name just a few – it is equally clear that there is no single silver bullet strategy to improve these jobs.

The next section of this chapter draws a more complete picture of in-home jobs, the wages and benefits these jobs offer, and women who hold the jobs. Section 2 discusses the shared traits of in-home work, and why those key shared traits matter. Given that foundation, the third and fourth sections explore key elements of strategies to improve in-home cleaning and caring jobs and the ways that the in-home subsectors differ, especially when considering strategies for improving the jobs. Section 5 offers a description of some strategies that have worked to improve in-home cleaning and caring jobs and the promise and limits of those strategies.

## **1. Getting a Handle on Work in the Home**

The work of caring and cleaning in the home is as old as the home itself. The work is also inherently domestic – a maid doesn't face ruinous wage competition from Singapore – and immune to outsourcing. The jobs have not been fundamentally reorganized by technological change over the last twenty years. While globalized capital and technological change popularly shoulder the blame for poor labor standards, these jobs stand as a reminder that other forces are at work as well.

Why care about work in the home? These jobs are with us and, taken together, will grow in the foreseeable future. These jobs also consistently provide very low wages, volatile hours, and few, if any, benefits. Further, significant numbers of these jobs are explicitly and effectively outside the basic labor protections that are the presumed framework for workers in this nation. The demographics and vulnerability of the workforce also encourage attention to in-home workers. Finally, many of these jobs provide badly needed service of great social value. Their social importance requires that we find ways to improve the jobs as well.

### *The size of the workforce and forces behind growth in jobs*

In-home jobs are notoriously invisible and surveys almost certainly under-report the size of the total workforce, both because the work often verges toward “under the table” arrangements that individuals are less likely to report, and because we know that a major sub-segment of the workforce – immigrants – is almost certainly underrepresented in national surveys (GAO 1998:42-44). Given this, it is reasonable to assume that the current American Community Survey count of 1.8 million in-home cleaning and caring workers almost certainly understates the total employment in these jobs.

Table 2 provides the 2005 employment breakdown for the key in-home occupations. The largest employment sub-sector is in-home health workers (both personal care workers and home health aides): some 680,000 workers held jobs in the sector in 2005. These workers are found principally in the home health services industry but a substantial number are in the private household services industry as well. Those who work in home health services are employed by agencies while those in private households generally are hired directly by one or more clients. Home health aides generally deliver hands-on health care: moving, bathing, dressing, and

otherwise physically assisting clients. Personal care workers provide supportive services in the home: cooking, cleaning, and attending to clients' needs. These jobs will continue to post strong growth in the face of an aging US population and increasing pressures to move more care work from nursing homes into homes and communities (Hecker 2006:74-75).

**Table 2: Employment, Wages, and Benefits of In-Home Workers, 2005**

<b>Occupation</b>	<b>Industry</b>	<b>Number of Workers</b>	<b>Median Wage (2005\$)</b>	<b>Emp. Health Ins. (CPS)</b>	<b>Participate in Pension (CPS)</b>
<b>Home Health Workers</b>	Home Health Services	560,570	\$8.14	22.9%	12.2%
	Private Household Services	119,736	8.89	13.9	2.0
	<b>Total Home Health</b>	<b>680,306</b>	<b>8.24</b>	<b>21.9</b>	<b>11.1</b>
<b>Child Care Workers</b>	Private Household Services	199,563	6.82	8.3	3.2
	Family Childcare Providers	449,652	5.68	8.5	4.3
	<b>Total Child Care</b>	<b>649,215</b>	<b>6.00</b>	<b>8.4</b>	<b>4.0</b>
<b>Maids and Housekeepers</b>	<b>Private Household Services</b>	<b>426,614</b>	<b>8.33</b>	<b>4.8</b>	<b>1.3</b>
<b>Total in-home</b>		<b>1,756,135</b>	<b>7.60</b>	<b>13.2</b>	<b>6.4</b>
<b>National all workers</b>			<b>14.66</b>	<b>54.8</b>	<b>46.4</b>

*Source: Author's analysis. Number of workers and median wage from 2005 American Community Survey; health and pension benefits from 2006 March Current Population Survey.*

*Note: For tabulations on health care and pensions, only workers working more than half-time, all year are included.*

In 2005, another 659,000 workers provided child care in homes, split across the child daycare and private household service industries. Child care providers in private households include both those who "live in" with employers and those who live in their own homes but work in employers' private residences. In private households, child care workers most often provide care for the child or children of a single family. Identifying in-home providers in the "child daycare" sector (which includes center-based care) is a bit more difficult. To do so, we select those child daycare providers who report being self-employed (thus center- and preschool-based staff are excluded). These workers generally have children from more than one family in their own homes. Identified this way in the 2005 American Community Survey, we find some 450,000 family based providers. Again, it is very likely that this substantially undercounts the family provider sector; some researchers estimate that as many as 650,000 individuals provide family child care services (Burton et al 2002).<sup>2</sup>

Finally, in 2005, some 427,000 maids and housekeepers cleaned, cooked, and provided other domestic maintenance for private households. The housekeepers in private households have a one-to-one relationship with the employer/homeowner, with workers having one or more employers. In-home cleaning is very often informal, and the workforce of maids and housekeepers in private household services is almost certainly underreported and undercounted.

Taken together, these in-home occupations are growing rapidly. The growth is driven largely by the strong trajectory of home health employment. According to the U.S. Bureau of Labor Statistics (BLS), health care support occupations are projected to grow dramatically over the next decade: personal and home care aide employment is projected to grow by 41 percent by 2014; the base of home health aides will expand some 56 percent, making it *the fastest-growing occupation* in the economy. What's more, these two occupations are amongst those with the largest numerical job growth and are projected to add nearly 650,000 jobs to the economy by 2014. Projected expansion results from the aging of the baby boom and the continuing move toward home-based rather than institutional care (preferred often for both cost and quality reasons). The child care workforce is projected to grow by 38 percent between 2004 and 2014 (Smith and Baughman 2007:2). Interestingly, the BLS projects decline for the Private Households Industry over the next ten years.

One clear contributor to the growth in these jobs is the increasing labor force participation of women. Women have long done most of the caring, cooking, and cleaning for their own families, including their own parents as they aged. But as they work in the paid labor market, families turn to other women to do the tasks they once did. A second important contributor over the last 20 years may be growing income inequality in the nation. As Milkman et al (1998) point out, inequality feeds home work both because it implies that there are a number of very poor individuals for whom work in the home will present the best option; and because income at the top allows for increasing demand from rich households for domestic help: "The elite corps of professional and managerial women, whose ranks have expanded so dramatically in recent years, can now purchase on the market much of the labor of social reproduction traditionally relegated to them as wives and mothers (485)." The continuing growth of inequality in the US may fuel growth in these jobs. However, the modest declines of the domestic work sector may suggest that market alternatives (meals out, for example) are also part of the picture.

### *Low job quality*

Poor job quality is absolutely clear for in-home workers: wages are extremely low, benefits non-existent, and even basic labor standards do not effectively cover many of these workers. Table 2 summarizes wage and benefit data for the in-home workforce.

Workers cleaning and caring in the home earn some of the lowest wages in the economy. In 2005, the median wage for these 1.8 million workers was \$7.60, just barely above the 10<sup>th</sup> percentile wage (\$7.20 per hour, (Mishel, Bernstein, and Allegretto 2007:121)) and essentially half the national median (\$14.60 per hour). Providing just over \$15,000 in annual income (in the unlikely case where the job offers full-time year round employment), these jobs can't keep a

family of three out of poverty. These are exceedingly low wages, even within the low-wage labor market. And self-employed child care workers are the worst off, reporting a median wage of just \$5.68 per hour: a rate attesting to the long hours and low pay that child care consistently delivers.

Such low wages combined with concerns about data quality and representativeness for this group may lead to some skepticism regarding these wages. However, comparison with wages in the same occupations in more “on the books” industries suggests that these wages are quite consistent. For example, the median wage of maids and housekeepers in traveler accommodation is \$7.82; slightly below but roughly in line with the \$8.33 median for maids and housekeepers in private service. The in-home care workers actually face an “in-home” penalty: center-based child care workers earn roughly \$2.00 more than family providers and home health workers earn between \$1 and \$2 less than nursing home-based attendants and orderlies.

Low and chronically unstable hours combine with low wages to generate low income for the workforce. When clients leave town or don’t want services, most workers, in all three occupations, simply don’t work. The median worker gets some 30 or 35 hours of work per week, though family daycare providers work longer hours than any other group.

Few in-home workers receive health insurance from their employers; just 13 percent of in-home workers with half-time/year round work or more get health insurance compared to 55 percent of the national workforce. Home health providers working for home health agencies have the highest access to employer health insurance; one-in-five workers report employer-provided health insurance. Just eight percent of in-home child care providers and less than five percent of private maids and domestics receive health insurance through their employers.

The pension picture is even grimmer, again even for the workers with year-round employment at least half time. Home health is again the strongest; just over one-in-ten home health workers participates in an employer pension plan. The participation is lower among child care workers (six percent). Only one percent of private household maids and housekeepers participate in employer provided pension plans. The benefits levels for these in-home workers are rock bottom. Paid vacation, holiday time, and sick leave are also rare (Families and Work Institute 2006:6-7).

### *Basic labor standards*

The basic labor protections for these workers are also weak for a number of reasons. First, labor laws contain explicit exemptions and exceptions which target specific in-home workers (Bernhardt, McGrath, and DeFilippis 2007). In-home workers in private household services, both those that clean and those that care for children, are explicitly excluded from coverage of many labor protections including OSHA, and the right to organize unions (Bernhardt, McGrath, and DeFilippis 2007, Domestic Workers United and DataCenter 2006:8). “Part-time babysitting” services are explicitly exempted from federal minimum wage and overtime law (Bernhardt, McGrath, and DeFilippis 2007). Likewise, minimum wage and overtime requirements of the Fair Labor Standards Act exclude some home health workers; an exclusion upheld in a June 2007 federal Supreme Court ruling.<sup>3</sup>

Labor regulation is also weak for some in-home workers that are truly independent contractors and for others that are misidentified as self-employed. Independent contractors have no standing for basic labor protections like minimum wage, overtime, Workers Compensation (Bernhardt, McGrath, and DeFilippis 2007:61-72), and Unemployment Insurance (Shulman 2003:42-43). For an in-home worker to be an independent contractor she must be found to be running her own business. Determination of employment status is complex and decided case-by-case depending on the facts of the particular relationship. Factors to be considered vary depending on what law is being enforced, with wage and hour laws having the broadest definition of who is a covered employee, and workers' compensation and some anti-discrimination laws having a narrower one. Thus, many family daycare providers are self-employed and running their own businesses. (The notable exception being family daycare providers working with children whose families receive public subsidies; rates and important working conditions for these care providers are determined by subsidy policy.) Some housekeeping workers may also be independent contractors, but only in cases where they have substantial control over the terms of their work (with rate schedules, their own equipment, and multiple clients). Finally, some states have established home care systems that define home health workers as independent contractors as well. Such definition is contentious, as home health workers are not running their own businesses and do not control the terms of their work. Though misidentified as independent contractors, the effect of the definition is to exclude home health workers from basic labor protection. (Many of the successful strategies to improve in-home work hinge on the definition of the employer; these strategies are discussed in greater detail in section 5.)

But perhaps most important, the *effective* protection of these workers is even weaker than the formal legal protection. In part this is due to the invisible, informal, and "under the table" nature of these jobs. Formal labor protections mean very little for workers who are working "off the books," because successful enforcement of the protection depends on workers being willing to come forward to complain with evidence of the mistreatment. In this context, the rights of workers and the responsibilities of employers are routinely ignored, if they are even understood. And while financial advantages can accrue to both employer and employee if the work stays "off the books," the informality of the work relationship makes it ripe for neglect, evasion, and violation of basic labor standards.

### *Demographics of the workforce*

Table 3 makes it clear that these jobs are fundamentally women's jobs: 95 percent of the workforce is female. The child care workforce is slightly more feminized, the home health workforce slightly less, but no occupational group falls below 90 percent female.

Further, these jobs are also dominated by women of color and immigrants. Though Latinos/as make up 13 percent of the national workforce, more than 50 percent of maids and housekeepers are Hispanic. And while blacks make up 11 percent of the national workforce, fully 3 in 10 home health workers are black. Non-citizens make up just 9 percent of the national labor force, yet 45 percent of in-home maids and domestics are non-citizens. Looking at the overall in-home workforce, more than one in four is Hispanic; another 17 percent black; and fully one in five are non-citizens.

**Table 3: Demographics of In-Home Workers, 2005**

<b>Occupation</b>	<b>Industry</b>	<b>Female</b>	<b>Hispanic</b>	<b>Black</b>	<b>Non-Citizen</b>	<b>HS Degree or more</b>
<b>Home Health Workers</b>	Home Health Services	92.2	19.1	30.0	13.6	74.4
	Private Household Services	90.0	16.8	20.5	16.7	76.2
	<b>Total Home Health</b>	<b>91.8</b>	<b>18.7</b>	<b>23.0</b>	<b>14.1</b>	<b>74.8</b>
<b>Child Care Workers</b>	Private Household Services	96.1	21.3	7.5	20.8	80.3
	Family Childcare Providers	97.4	20.0	15.3	13.4	82.5
	<b>Total Child Care</b>	<b>97.0</b>	<b>20.4</b>	<b>12.9</b>	<b>15.7</b>	<b>81.8</b>
<b>Maids and Housekeepers</b>	<b>Private Household Services</b>	<b>95.0</b>	<b>52.1</b>	<b>6.5</b>	<b>45.5</b>	<b>58.2</b>
<b>Total in-home</b>		<b>94.5</b>	<b>27.4</b>	<b>17.3</b>	<b>22.3</b>	<b>73.3</b>
<b>National all workers</b>		<b>47.1</b>	<b>13.5</b>	<b>11.0</b>	<b>9.0</b>	<b>88.6</b>

*Source: Author's Analysis, 2005 American Community Survey.*

Finally, more than 25 percent of the workers who hold these jobs have not completed high school degrees. This more than doubles the national share without high school degrees. Ironically, child care workers have both the highest educational attainment *and also* the lowest wages for any of these in-home occupations.

### *High social value*

In spite of miserable pay and benefits, much of the work that goes on inside homes has a very high personal and social value. This is obvious across the range of care work that happens in the home. Indeed, work in the home may conjure up the image of the maid working for a very rich family in urban America, and while that is an important part of the picture, in fact many of these workers are working directly with children and adults who need support and care to develop and maintain independence. Many of these workers are providing an absolutely critical social service. Their jobs deserve attention because of the high value of the service they provide, even in the context of very low rewards for it.

## **2. Shared Traits of In-Home Work**

There are at least three defining features of in-home: the work is inherently isolated and autonomous; the work is inherently intimate; and the work is socially perceived as inherently “women’s” work, and often the provenance of women of color with few alternatives.

*In the home = Isolated/Autonomous*

Work in the home is inherently isolated and autonomous and much of the good and bad of this work find their roots in that truth. For many of these workers, the isolation is evident before a job is secured, as the negotiation and agreement on the terms of work requires a one-to-one deal with the employer. Indeed, for many of these workers, each new negotiation basically starts from scratch. From the time a job connection is established, working in the home is basically a solitary endeavor. If coworkers or supervisors exist at all they are remote. There is no “water cooler” and none of the relationship building and problem solving that can happen at a more standard worksite. There is no natural community for support, for checking on what’s reasonable, for seeing a repeated problem. Perhaps more important, there is no one there to observe the situation and defend the worker if a client accuses her of something, makes unreasonable demands, or treats her unacceptably. These women workers, many without the resources provided by years of education or native facility with English, face their employer one-on-one and the employer can have a very strong hand. For many of these women,

But for many workers, “isolation” is also “independence and autonomy.” Many in-home workers prefer the autonomy and self-reliance of individual work. There are no coworkers to slow you down, no supervisor staring over your shoulder, no one to second guess your decisions or approaches. Also, there’s no office gossip and in-fighting. Home health workers with prior experience in nursing homes state a preference for the autonomy and relationships they can build in home health settings (Dresser, Lange, and Sirkus 1999:6). Within broad parameters, they can decide what order to do tasks in, stay a bit longer, or provide extra service. Indeed a 1999 study in the area around Dane County documented both lower rates of pay and turnover in home health compared to nursing homes (*Ibid.*:20). Clearly, for some autonomy and independence in home health more than made up for the lower wages.

Some domestic workers appreciate autonomy in terms of the control of their own schedules, and their ability to bring their children to the job site (a very hard thing to do at a traditional worksite) (Romero 1992:40-41). There may be more space for negotiation between employer and employee in domestic work because of its one-on-one character leading, at times, to flexibility for the workers.

While all these jobs are isolated in ways, it is also clear that there is substantial variation in the isolation. At one extreme is the domestic worker or nanny who actually lives with the client family. These “live-in” workers quite literally cannot escape work when they sleep. These jobs can be extremely stressful; interview and survey evidence from New York City make it clear that these can be the worst jobs in the industry (Domestic Workers United and DataCenter 2006). This level of isolation, especially for workers with little English and no connections outside of the client family, can lead to the abuse of the worker and violation of basic labor and human rights.<sup>4</sup>

As this example suggests, one factor which reduces the isolation of the worker is having multiple clients. Such a structure provides a more diverse base of demand, and allows the worker to check

standards in one situation against another. Multiple employers also minimize the financial impact of a loss of a client and income. But multiple clients can also come with heavy costs. Scheduling, transportation and other logistical issues are often stressful and costly. (See Dawson and Surpin 2001:10 for discussion of these issues in home health work.)

Workers that are employed by a third party agency, or assigned by a “broker” or “matching” service may be (but are not necessarily) less isolated as well. They may get training, assignments, and supervision from a central source. But this connection can often be quite weak, with the worker never hearing from the agency unless the schedule changes. And, in fact, written assignments or job descriptions are often disregarded once the worker is engaged with a client.

### *In the Home = Intimate*

In-home work is also inherently intimate, as the lines between work place and the private are consistently crossed. This is especially true for the workers who enter their clients’ homes. Whether the worker is cleaning or providing care or support, she is often presumed to be or treated as “a part of the family.” The workers develop a deep store of information about clients’ lives; many develop strong affection for their clients.

Like isolation, intimacy is a double-edged sword. For many care and support providers, the relationship to the client is a critical element of job quality. Workers, especially those providing direct care to the old or young, develop strong connections to their clients. The bond makes the work rewarding, and the quality of care received can be higher when relationships are stronger.

Even so, intimacy raises many problems for workers. Being “part of the family” can be both fulfilling and demeaning. First, while the worker may be a “part” of many client families, she is a more central part of her own family. The expectations and presumptions of clients can often creep and expand, leaving the worker hard pressed to draw a line (Domestic Workers United and DataCenter 2006:19-24). Exact distinctions about what should and should not be included in the work are hard sometimes to discern and difficult to navigate. While a home health aide may know that she is not supposed to do laundry, saying no to a frail client can be very difficult, especially when the bond between client and care provider is strong. Family child care providers can find it nearly impossible to refuse care to a child when his parents have no money to pay for the care.

Again, while this work is all intimate, some is substantially more so. In general the more hours with a single client, the more intimate the relationship. Live-in domestic workers are clearly inextricably connected to the client family, as are full time workers with just one client. But even less intensive hours with a family can develop deep intimacy. Caring for a frail or dying person, even just a few hours a day, may be the most deeply intimate work, requiring the client, the client’s family, and the care provider to develop a strong relationship of trust. Caring for children also brings up intimate and essential issues about the family’s priorities for child rearing. Housekeeping comes with an intimacy of knowledge of the client’s private life (from phone calls to underwear), but in general the work does not require the emotional connection and investment

that the provision of good care generally requires. And housekeeping for multiple clients (rather than one) is clearly less intimate than cleaning only for one.

For many workers, the fact that this work is autonomous and intimate is one of its rewards. But the isolation and the intimacy can also lead to higher levels of exploitation and instability in the jobs.

*In the home = “Women’s work” and done by women of color*

These jobs also share a legacy of low status. In part, this has to do with the fact that women, usually mothers, have always done this work, and done it for free. Care work within the home is not seen as “real work” and therefore is not paid as such. Sexism and the consistently low social value placed on women’s work is clearly a core issue in wage setting. Indeed, it is hard to drive up the wage for workers who have such an active “free” alternative.

Additionally, and equally important and clear from the demographic data, this work, when paid, has been systematically and predominantly the domain of women of color and immigrants (Rollins 1985:108). In the last century, domestic work was a key occupation of black women in the North and the South: 60 percent of employed black women worked in domestic service in 1940. Today, domestic work is dominated by Hispanics and other immigrant women: more than half of maids and housekeepers in private household services are Hispanic. Blacks are dramatically overrepresented in home health jobs. Like sexism, discrimination against people of color has also fundamentally structured the presumed value of and rewards offered for this work.

Discrimination pushes wages down twice here. First, the work is considered to be of very low worth and is paid as such. Second, the women workers who hold the jobs – women of color and immigrants – have fewer opportunities outside these in-home jobs. Anecdotally, at least, when women can get out of these jobs (either because they have a better grasp of English or a better understanding of external options) many of them do so (see, for example, Gordon 2005:100). As with day labor for many new male immigrants, women immigrants often try to move out of in-home work in order to get into better pay and/or working conditions.

*Why These Shared Traits Matter*

Though the in-home workforce is often divided along industrial and occupational lines, the characteristics identified here apply to all of them. Another way to note just how much these workers share is to think a bit harder about what really is the difference between the work of a “maid/domestic” (in private household services) and a “personal care worker” (in home health). The federal definition of both jobs includes cleaning the home, laundry, cooking, and shopping for food. In private household services, most (but certainly not all workers) are paid with private dollars, whereas in home health many workers are often being paid through public or private insurance. And the home health worker is always working with someone who is frail or needy in some way, and the domestic may not be. But these concerns of pay and or client base don’t change the fact that the actual content of the work can be very similar. We know also that these jobs can shift across occupations: a worker is hired to do child care and then discovers she is

expected also to clean and do laundry; a home health aide is approached by the family to do a few hours of cleaning and cooking to assist the client; a full time domestic worker works with a family over the years, shifting from child care to cleaning to elder care. The lines between these jobs aren't always easy to establish. Workers themselves report moving across the occupations in a California study of home health workers which finds that many in-home workers had "always worked in caring professions" such as home care, child care, and house-cleaning (Howes et al 2002:3-4).

The shared traits of isolated, intimate, and undervalued work go a long way toward explaining why these jobs can be extremely hard to improve. Extremely low wages and poor job quality invariable lead to high turnover. Indeed, child care and home health are riddled with high turnover (Smith and Baughman 2007:5), and at least anecdotally, domestic work is as well. The workforce has only weak professional identity; the worker may feel more identified with her client than with other in-home workers. And worksites are not only isolated but also widely dispersed. Collective action to improve wages of in-home work requires building collective identity but extremely small work units (most often a unit of one), very low social value and little professional identity, and high turnover stand directly in the way of building collective voice.

### **3. Strategies for Improving In-Home Work**

Any successful strategy to improve in-home job quality will necessarily have two elements. First, the solution will necessarily bring a set of workers together and build some collective sense and awareness among them. Second, that group of workers will need to identify some source of money or other resources to raise the standard in the job. In some ways, improving in-home work is both as straightforward and difficult as that.

Collective action requires a collective identity for workers. The very isolation of the workers pushes squarely against collective identity. But it is only in conversation and connection with others that these in-home workers can begin to understand their own situation in the larger context. Further, given their often strong connection to clients, in-home workers need some collective connection both to remind them that their project is not only about their own position, and to help them think more broadly about how improving the conditions of their work could actually improve their service to the client. Collective action can also make visible this otherwise socially invisible work and force the issues of value and wages into public discourse. Without collective action, the work is too easily discussed in terms of (often positive) anecdotal experience rather than collective reality. But building some collective framework only begs the question of money.

The second obvious and necessary ingredient is finding some money. The low social value of the work, and the relatively weaker external opportunities for many of the workers who do it, mean that the collective consciousness needs to be directed at raising wages – and that takes money. But a central problem here, especially in family child care and home health care, is that many clients simply cannot pay more for the services they receive. So the search for money does not always end with the client, it can extend beyond, to the public sector, especially when attention

can be drawn to the connection between the quality of the care provided and the quality of the job.

#### **4. Important differences in these occupations**

From low job quality to work in isolation, in-home jobs share many fundamental characteristics, regardless of industry and occupation. Even key steps to improve in-home jobs are similar. But focusing on the means of taking those steps – how to create a collective organization or voice and where to find the money – reveals very real differences that separate these in-home workers.

In-home jobs cannot be improved without finding more money to improve them. Because the fundamental issue to improving the jobs is money, probably the most salient strategy to create a collective identity is by carefully targeting the employer in it. Though obviously a straightforward question – who is the employer? – in fact, for many in-home workers the very simple first step of trying to identify the employer may be one of the most confounding. For housekeepers and maids with a single client, the employer is unambiguously that client. For home health workers with one client who are paid privately and childcare workers who work for one family, the same is true. For maids and housekeepers, private health care, and childcare workers with multiple clients, however, there is no single employer. In these situations, the employers actually far outnumber the workers. Further, family daycare providers are certainly self-employed and some maids and housekeepers (with substantial control over the terms of their work) are also self-employed.

Once public money enters the system, however, even the above answer on who exactly is the employer becomes even more complex. In the case of home health work, much of the money coming into the system is, in fact, public money: the majority of financing of long-term care comes from Medicaid and Medicare (see Dawson and Surpin 2001:14-15, for 1998 data). In some localities, the client has the ability to select and hire the care worker, while the state or local unit of government directs Medicaid and/or Medicare money to the care worker. In some instances, the payment for work goes directly from the state to the care worker, in others the client receives and redirects the money to the care worker (Boris and Klein 2006:89-90). Other insurance providers may also work this way, providing payment while still allowing consumer choice in hiring. Given the very heavy public investment in home health care, these workers have the most to gain from finding ways to identify the public sector as their employer.

There is public money in child care, but not as much as in home health, and the money follows an indirect route to child care providers. Public subsidies to child care are extended to specific low-income working parents; the government covers some or all of the cost of care while the parent has the ability to choose the child care arrangement they want (Child Care Bureau 2006). A family day care provider with five or six children in her care may or may not have publicly subsidized children in her client base. And many family providers will see the number of children with subsidies shift dramatically over time, not only because their client base shifts but also because family's eligibility for subsidies (or willingness to put up with the bureaucratic system of getting those subsidies) will change over time as well. That means that family

providers, clearly self-employed, may have a partial relationship with public funds, but also that the depth of the reliance on state subsidies can be low and quite variable.

Family providers and other self-employed in-home workers also face an anti-trust barrier to their collective action. As providers of services in a competitive market, federal and state anti-trust laws actually prohibit family child care providers from meeting to discuss rates. Such a prohibition extends to any set of self-employed or small business owners who meet to discuss and raise rates. So not only family child care providers, but also housekeepers with multiple clients, are actually prohibited from taking the first step identified for raising rates, which is to create and build a collective organization and agenda.

Public money is one measure of public commitment to these in-home jobs, and the variation in public money in the different jobs is extreme. Another important question when it comes to creating identity and leveraging money is related but distinct: is there a significant public good being produced by the in-home workers? Home health workers have a strong positive argument here. The shift from institutional to home-based care for the frail and elderly over the last generation has clearly promoted better health and well-being for clients, while saving the state money in medical assistance budgets. The home health workers who make such a shift possible are literally the point at which these larger public medical systems touch the client, and the quality of the care provided is directly and clearly related to the quality of jobs the system supports. Finding more money for these home health workers, whether employed through agencies or as independent contractors, hinges not only on finding the public money already in the system, but also on making arguments and coalitions around the public good that the workers produce.

As discussed above, the actual public money flowing to family child care providers is significantly more constrained. But the argument for the public good they provide is equally strong. The system of early childhood education and care in the United States is nearly entirely privatized in the first four years of life and then shifts dramatically onto the public sector when children head to kindergarten. The public interest in children doesn't simply begin on their first day of kindergarten, however. Indeed, the quality of care and education leading up to their first day in school has very direct effects on how well they can do in schools, and how intensively schools need to deal with them. The ever-expanding number of states committed to universal-four-year-old kindergarten is just one testament to the strength of the public good argument and its political salience. When child care providers, in homes and in centers, make clear their contribution to the public good through quality care, they begin to build the coalitions and political will that make finding money possible.

The in-home workers with some of the strongest strategies for job improvement are those who can identify public money and public good to support the demands. In-home workers in private markets, working directly for one or multiple clients, are in a much more difficult but not impossible space. Strategies on the purely private side of the market still require stronger collective voice and finding money for building better jobs. But the money in these instances is with the employer/householder base, and the movement needs to build not only regulatory but also social infrastructure. Putting regulations on the books for a market that is, in many ways,

largely off the books, cannot change the industry without an accompanying broad and strong social movement.

## **5. What Has Worked to Improve In-Home Work?**

In-home jobs have been “bad” jobs for a very long time in the US. But new thinking in the last twenty years about how to organize and improve these jobs has begun to produce meaningful results. Unions, coops, and legal and advocacy campaigns have all found ways to take on the project of improving these jobs.

### *Unions and Public Authority Strategies*

The development of the public authority model is the most influential innovation in in-home work. The roots of the model go back to the 1980s, when SEIU was first trying to organize home health workers at the state’s home care program. In 1987, the court found that neither the state nor the county was an “employer” for the home care workers. At that point, SEIU began pursuing a legislative and advocacy strategy to establish a public authority to serve as “employer of record” for purposes of bargaining. The county-based public authorities finally redefined the home health providers as workers and established a legal employment relationship between the county and them. As Boris and Klein point out in their review of these strategies: “The public authority, which made the local or state government into an employer to bargain with, became the mechanism to end the fiction of the home care worker as independent contractor and cut through obfuscations stemming from home care’s place within the welfare state (Boris and Klein 2006:84).”

The public authority model in home health has had some dramatic successes (see Schneider 2003 for a very accessible summary). Most famously, in 1999, 74,000 home care workers joined SEIU in Los Angeles, the largest union organizing victory since the 1940s. The model in California has spread to nearly all counties in the state. Oregon and Washington also have public authorities, and all together at least 300,000 workers on the Pacific Coast are now union members and employees of public authorities. Wage and benefits gains for many (but not all) of these home health workers have been substantial. Home care workers have gained the right to organize also in Illinois, Michigan, Massachusetts, and New York.

These public authority strategies leverage both the public dollars in home health, and the public good produced by it. Labor has played a leading role in developing the model, but it has been joint work with consumer advocates that have made the progress possible. In the public authority states, consumer and worker advocates have joined together because of the strong links between job and care quality. Their common interest in decent standards for the jobs and their influence on public policy has secured a new model in this previously invisible sector of work.

The public authority model has been adapted now to family daycare providers, though the logic shifts slightly. As competitors in the market providing daycare services, family daycare providers are prohibited from meeting to discuss and establish rates. In most states, the process starts with an executive order, issued by the governor, that allows family daycare providers to organize and

negotiate with the state on a specific set of issues. These executive orders allow the family daycare providers to work together in a union, but they do not establish the state as an employer of record as in home health. Indeed, the orders always explicitly state that family providers are not employees of the state (Chalfie, Blank, and Entmacher 2007).

Illinois is the leader in the family childcare public authority. In Illinois, a union of all 49,000 family daycare providers that receive (via parents) subsidies from the state negotiates with the state over reimbursement rates, health benefits, and administrative policy. The negotiations have led to substantial increases in subsidy rates, the development of a health insurance option, and formalization of grievance procedures. Similarly, family child care providers in Washington state are organized and have negotiated with the state over the same sorts of issues. Organizing in this model is also ongoing in Oregon, Iowa, New Jersey, New York and Michigan where governors have all signed executive orders (or, in Michigan, an “interlocal agreement”) which have started the organizing and bargaining processes (*Ibid.*).

Public authority strategies have been truly powerful for the promotion of the interests of in-home care workers, but they have run into multiple and sometimes surprising road blocks. Indeed, spreading the model within California to in-home workers who assist the independent living of the developmentally disabled, has been extremely slow going because the independent contractor model is not as prevalent in that sector in California. Public authority strategies work best where in-home health care work is arranged all through independent contracting. In many states, however, agencies hire home health workers to provide in-home care. If work is organized through agencies, then there is no need for a public authority to serve as the employer of record; the agency already holds the title. The public authority model also requires political support from a strong labor and consumer coalition. In some states, that coalition may not have sufficient leverage to secure the executive orders and/or legislation required to get the process going.

### *Worker Cooperatives*

As SEIU was developing the public authority strategy in Illinois and California, another project to improve home health jobs was established in the Bronx. Cooperative Home Care Associates (CHCA) was established as part of a community-based economic development program to create jobs through worker-owned firms. Since its genesis in 1985, CHCA has grown both in scale and advocacy ambition. The organization “anchors a national cooperative network generating over \$60 million annually in revenue and creating quality jobs for over 1600 individuals (CHCA 2007).” Worker cooperatives have proved that better jobs can be economically viable in other parts of in-home work as well. Philadelphia has Childspace Cooperative Development, Inc. (CCDI) which works with its affiliated worker-owned child care centers and pursues advocacy for stronger job quality in child care.<sup>5</sup> Domestic workers cooperatives have been established in California and Long Island. In rural Wisconsin, a worker-owned home care cooperative has improved quality of care and the quality of jobs (Bau 2006).

These enterprises alone do not approach the scale of impact that the public authority models do. But they are critical in at least three ways. First, the very existence of an in-home business with different priorities and higher quality jobs proves that a different way of designing and rewarding

in-home jobs is possible. Second, and probably more important, these coops, especially CHCA and CCDI, have entered directly into advocacy and policy making, bringing the voice and needs of workers more centrally into debates on job quality in their industries. Third, in their advocacy, the care-focused coops have continued to help build the consumer/worker coalitions that better jobs require.

Alone, worker coops cannot transform the quality of jobs in in-home work. This is due, in part, to the vagaries of the competition that coops face. Like other businesses, some worker coops will thrive while others fail. The Day Care Justice Coop in Rhode Island faded away as foundation and state budget support dried up (Roder and Seavey 2006). If the business is competitive, then it can stand as a model for a new way to treat in-home workers. But even then, proving that a competitive higher wage and a more worker-focused model are possible does not mean that others will follow suit. Some may, but many will continue with business as usual. That is why systemic advocacy in these industries is important in addition to the demonstration projects that coops provide.

### *Advocacy Campaigns*

Bringing workers together around an agenda of job improvement is another approach to improving the jobs. The advocacy must capture public attention and make issues of compensation explicit. Most public authority campaigns start out with a labor/consumer coalition and advocacy agenda, before they secure the changes needed to build the public authority model. But many coalitions have been formed around a more general agenda of job quality and have pursued other strategies as well.

Domestic workers in Long Island, NY, pursued an advocacy campaign to change the behavior of the placement firms through which many domestics and clients are connected (Gordon 2005:97-103). Placement firms agreed to provide domestics with detailed description of their rights in their jobs and to provide both domestics and clients with a written job description including wages. These changes were important innovations, both to prove to the domestic workers that they could secure changes through organizing and to provide better information on jobs to domestics. However, as Gordon points out, this policy was insufficient to really change the domestic's experience on the job; after the placement agency makes a connection, they step out of the picture, and at that point the job description and statement of rights can be easily overlooked by clients (*Ibid.*:103).

A key next step in advocacy for domestic workers has been the work in New York to pass a "domestic workers' bill of rights." (See Sugimori in this volume for a description of the bill and campaign). It is clear that such a campaign needs to promote both a legislative and social agenda. Given that the substantial majority of these jobs are held "off the books," a purely legislative strategy to secure formal rights is insufficient. Only in the context of a broad social movement of domestic workers themselves, and their mutual commitment to upholding stronger labor standards in the private domestic market, can such regulations gain the foothold they need to reform the structure of jobs and pay in the sector.

## Conclusion

The in-home work of home health workers, child care workers, and maids and housekeepers shares many fundamental characteristics. In-home workers earn exceedingly low wages, face volatile hours, rarely receive benefits, and are often effectively or explicitly excluded from basic labor protections. Further, the home *as a worksite* creates similar problems for these diverse workers. Their work is isolated, making it difficult, even impossible, to determine functional norms and standards for the work. The work is intimate, often building strong bonds between worker and employer, but few connections to other workers. The work is dominated by women of color and immigrants, with fewer external options and less knowledge of their own rights and standing in the American labor market. Finally, and given these problems, the strategies to improve any of these jobs require development of collective identity and money to support the wage and benefit increases that would make such jobs family supporting. Though diverse in occupation, the shared problems of the in-home cleaning and caring workforce are striking.

Turning to the question of shared possibilities for improving jobs, however, restores some complexity to the picture of in-home work. Success in unionizing home health workers illustrates this most clearly: creating a public authority to serve as employer of record moves the workforce, en masse, from independent contractor to worker status. Negotiations with the state over rates and benefits then lift the wages for these in-home workers. The strategy, requiring the aggregation of workers and negotiations with the state, has only been successful when strong coalitions around the quality of care have also supported the change. Essentially, the success in home health care, and in family child care as well, has hinged both on the public authority model to aggregate the workforce and the public goods argument about the importance of improving the quality of jobs in order to improve the quality of care. This strategy has led to the development of more significant and systematic approaches to improving the jobs.

On the private-pay side of the in-home workforce, the public dollars and public goods arguments evaporate, and the prospects for systematically changing the structure of the industry diminish. Changing private-pay in-home jobs requires both sweeping regulatory change and, perhaps more important and difficult, the development of a broad understanding and support of those regulations on the part of both private householders and the in-home workers they employ. With the jobs so consistently “off the books,” with arrangements made generally one-to-one, with workers who often have little understanding of American labor market standards and few options outside of in-home work, regulatory changes are a necessary but insufficient first step to improving jobs. The second step is to develop the sort of collective voice and solidarity on the workforce side, and the social awareness among the public and employers, that would make stronger regulations enforceable.

For all in-home workers, the shared lesson is clear. These jobs will not be improved without increasing collective identity, and finding the money (in private or public pockets) to substantially improve wages and benefits. And in spite of the isolation of these workers across the country, in-home cleaning and caring workers are building the awareness, the coalitions, and the policy models that can do just that.

## Notes

- (1) I also exclude those who run businesses or have home offices or otherwise work on external projects inside the home.
- (2) Burton, et al. note the “available data sources and estimates . . . of the U.S. child care workforce [are] . . . unreliable” particularly for home-based child care workers for a few reasons. The Department of Labor does not track self-employed workers and therefore does not include home-based providers in its surveys or data. Though the Census does track the self-employed through its Current Population Survey (CPS), it is highly likely family child care providers are undercounted as a result of respondents’ failure to disclose their occupation (Burton et al 2002:8-9).
- (3) *Long Island Care at Home, Ltd. v. Coke*, No. 06-593, 127 S. Ct. 2339, decided 06/11/07. Note also that coverage under state laws varies but some states do provide minimum wage and OT for domestic workers. The National Employment Law Project actively monitors state level policies on this issue.
- (4) Indeed, the most extreme “live-in” cases are actually victims of human trafficking. For example, The Break the Chain Campaign of Washington D.C., a coalition of more than two dozen organizations that litigates, proposes legislation, and negotiates with the US and other foreign governments on behalf of domestic workers, details the recent cases of such abuse it has worked with on its website, available at: <<http://www.ips-dc.org/campaign/stories.htm>>. For other examples of human rights violations in domestic work, please see “America’s Dirty Work: Migrant Maids and Modern-Day Slavery” by Joy M. Zarembka.
- (5) To learn more about Childspace Cooperative Development, Inc., go to <<http://www.childspacecdi.org/about.cfm>>. [October 22, 2007].

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