

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

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Paid care services such as child care, elder care, teaching, and nursing are vulnerable to competitive pressures that often generate low-pay/low-quality outcomes. Both workers and consumers suffer as a result. This article develops an economic analysis of the “care sector” that emphasizes the potential to build political coalitions that could push for a high-pay/high-quality alternative.

Keywords: *care; contracts; workers; consumers; coalitions*

Economists worry endlessly about the manufacturing sector (could General Motors 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. Few even acknowledge there is something called the “care sector” unless they are girls or, as California Governor Schwarzenegger puts it, “girlie men.” Yet similar problems are emerging in education, health care, child care, and elder care. This loose collection of “industries”

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is receiving increased attention from political activists, trade unions, and feminist scholars. A better understanding of their economic dynamics could help shape new political strategies.

I define the care sector as economic activities in the home, market, community, and state that fit loosely under the rubric of human services and have a particularly strong personal and emotional dimension: activities such as childrearing, child care, health care, elder care, social work, 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. A considerable amount of research focuses on care work that takes place outside the market economy.¹ This article focuses more narrowly on that part of the care sector that overlaps with the market economy, involving paid employment. I will refer to this as the care sector of the market economy, which provides paid care services.

Economists and policy makers often mistakenly assume that paid care services can be bought and sold like any other commodity, simply relying on the forces of demand and supply. If the supply of care services declines and the demand for them increases, the price of these services goes up. Increased wages in the care sector should attract more workers, while the increased price of care services should induce consumers to reduce their demand, using care more efficiently. This textbook fantasy, however, assumes that both workers and consumers have perfect information and that price changes therefore induce efficient adjustments.

In reality, the quality of care is difficult to measure and monitor. As a result, pressures to increase supply or reduce demand often have negative effects, reducing the quality of care in ways that can become self-reinforcing, even to the extent of undermining support for increased public provision. Workers and “consumers” (dependents, patients, students, clients) of paid care services share a common interest in maintaining quality of care and should try to develop stronger coalitions to prevent market forces from lowering it. Higher wages in the care sector would benefit consumers as well as workers.

This article offers both an economic analysis and a political strategy. The economic analysis emphasizes the vulnerability of paid care services in poorly regulated markets to a low pay/low quality outcome. The political strategy describes ways of framing this problem and creating coalitions that could push for an alternative high-pay/high-quality or “high-road” outcome. The first two sections draw from heterodox political economy to explain why the relative cost of care is increasing in the U.S. and to offer examples of deteriorating quality. The third section outlines 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

How does the cost of a given quantity of care services compare to the cost of the other goods and services that people buy? This unit price determines the rela-

tive cost of care. Inflation is caused by an overall increase in prices. But the prices of the different components of a standard basket of goods and services rise over time at an uneven rate. The quantity of care services that families purchase depends on many different factors, including their stage in the life cycle. As a result, the proportion of family budgets devoted to care services varies considerably. But virtually all individuals and families are affected by changes in the unit price of care.

Economists have long predicted an increase in the relative price of services in general. 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.² Economists predicted that labor productivity in services would lag behind manufacturing because services were labor intensive. They were considered less susceptible to automation and more likely to be adversely affected by immigration restrictions and other limits on labor mobility. Manufactured goods can be more easily imported. William Baumol famously called attention to what he called the “cost disease of the service sector.”³

The prediction that relative prices would increase did not come true for the service sector as a whole. 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. Measures of output per worker are hard to come by in these occupations, because they cannot be easily converted to physical units such as widgets produced per hour. But these jobs are information intensive, and the relative cost of processing information has clearly declined. Limits on labor mobility also proved a less serious obstacle than once anticipated. The growth of overseas call centers provides a striking example. Basic question-and-answer functions that initially seemed to require geographic proximity are now untethered and automation in this area continues apace. This example dramatizes the potential for offshoring other customer services.

Most jobs in care services, however, are both less information intensive and more person oriented. They require types of physical and personal interaction that cannot easily be conducted over the phone or the Internet. Nursing, teaching, child care, and elder care in particular involve

direct supervision and empathetic contact. Potential for substituting capital for labor is limited, and the consumers—in this case, patients, students, toddlers, and the elderly—cannot easily be relocated.⁴ The uneven pace of technological change alone helps explain why the relative price of care is increasing.

Improvements in women’s bargaining power in the labor market and the home have also played a role. Many forms of overt discrimination against women that once helped keep a cap on care costs are now illegal. Jobs that involve provision of care are still predominantly filled by women, and they still pay less than compara-

ble jobs (even if men perform them).⁵ But between 1975 and 2004 the earnings of full-time women employees have increased from a little over 60 percent to almost 80 percent of what full-time men employees earn.⁶ Over time, however, the same forces that have increased the relative pay of full-time women wage earners from about 65 percent to about 80 percent of what full-time men earn have increased the relative costs of care.

The increased labor force participation of wives and mothers has reduced time available for nonmarket work, contributing to what might be termed a “care deficit” and increasing the demand for paid care services.⁷ The reduction of barriers to professional careers has reduced overcrowding of women in paid care jobs. Teaching and nursing, once among the most lucrative jobs available to women, now pay considerably less than jobs in management, banking, and finance. Women are also moving into more credentialed jobs within the care sector. The number of women applying to medical school in the U.S. has been increasing for some time; in 2003–2004, for the first time, it exceeded the number of men applying.⁸ 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 near future.

The escalation of costs has been particularly extreme in health care. Between 1994 and 2004, the overall Consumer Price Index for urban consumers in the U.S. increased 27 percent, while the index for medical services increased 51 percent.⁹ Health care is a classic example of an industry that does not conform to the logic of supply and demand. Those who need services are not those who pay for them, because most bills are paid by third parties—insurance companies and the government. The bureaucratic yet decentralized structure of the industry contributes to an exceptionally high level of administrative costs.

Many factors have contributed to the escalation of health care costs, including the development of effective but expensive new health technologies. If the true benefits of improved health were adequately measured, we might consider the prices we pay for them a bargain. Nonetheless, high costs leave many unable to pay for the insurance needed to guarantee their access to those benefits. The number of individuals younger than age sixty-five lacking health insurance in the U.S. has now reached about 15 percent.¹⁰ Medicaid rolls are expanding rapidly, imposing ever more pressure on state budgets.¹¹ The cost of Medicare entitlements continues to grow.

While other care costs may not be rising as quickly, they are nonetheless taking painful bites out of family budgets. The 1997 National Survey of America’s families showed that 48 percent of working families with children younger than age thirteen had child care expenses; of those families who paid for care, the average monthly expense was \$286 per month, or an average of 9 percent of earnings.¹² In 2002 estimates for approximately full-time child care (corresponding to a forty-hours-per-week employment schedule for a parent) for one year ran from \$3,600

to \$7,800 in a family child-care home to \$6,000 to \$9,000 in a child-care center. The cost of a live-in nanny ranged from \$18,000 to \$30,000.¹³ In recent years, costs have risen considerably faster than the rate of inflation.¹⁴ Out-of-pocket expenses are lower because most working parents juggle their schedules and benefit from the assistance of relatives and friends, and some public subsidies are available to those with low incomes. As Meyers and Durfee show in their article in this volume, the donated time that many families rely on may be “invisible,” but it still exacts a price.

Many of those who need care services find it difficult to pay for them. Yet care often represents a necessity rather than a luxury. As a result, the elasticity of demand for it is low: a large percentage increase in prices does not lead to a large percentage increase in consumption. Rising prices often exacerbate preexisting inequalities in living standards or shift the burden to the public sector.¹⁵ The demands of paid employment limit the flexibility that families have to meet their own care needs. As conservative coalitions cut taxes to block increases in spending on health, education, child care, and elder care, distributional struggle intensifies. 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

Paid care services resist the automation and geographic relocation that have lowered costs in other services, but they are not invulnerable to them. Their resistance depends, in large part, on standards of quality that many workers and consumers value but find difficult to measure. 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.¹⁶ 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.¹⁷ Automation also has disquieting implications. Distance learning over the web is a poor substitute for the back-and-forth of a small classroom. Automatic sensors can take our pulse, but they cannot 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 poses inherent threats. They become problematic when they take place within an institutional context that leads to “over-commodification.” Any time a service is bought or sold it becomes, in technical terms, a “commodity.”¹⁸ The *American Heritage Dictionary* defines a commodity as “something useful that can be turned to commercial advantage.” I define

overcommodification as what happens when the pursuit of commercial advantage itself undermines the efficiency of market exchange through reductions in product or service quality.

There are good economic as well as philosophical reasons why not everything should be for sale.¹⁹ 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. Feminist philosopher Virginia Held applies this reasoning to paid care when she argues that there is a distinction between work that is paid and work that is done under “market norms.”²⁰ The pursuit of individual self-interest and principle of *caveat emptor* (“let the buyer beware”) can lead to perverse outcomes when consumers are vulnerable or poorly informed.

In the idealized world of economic textbooks, overcommodification 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 (i.e., the more competition, the better!). The more choices consumers have, the better off they are. I love my plastic, often shop online, 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 are not sure what we are buying, get locked into deals that are difficult to modify, and feel that genuine choices lie beyond our grasp.

Marx’s concept of commodity fetishism describes our tendency to be mesmerized by commercial transactions that conceal the underlying process of production.²¹ Robert Reich modernizes the concept when he notes that many people can see the low prices that Wal-Mart offers much more clearly than the employment practices that generate them, even when they are adversely affected by those practices.²² Harry Braverman’s *Labor and Monopoly Capital* explains how regimentation and deskilling of jobs reduces the intrinsic satisfaction that might otherwise be derived from work.²³ Arlie Hochschild explains the burdens of emotional labor, as when airline stewardesses are trained to fake solicitous smiles.²⁴

The new institutional economics, which emphasizes the difficulties of obtaining perfect information and monitoring effort, puts more emphasis on how consumers may be affected. In a classic article, George Akerlof explains why the market for used cars may result in a large number of “lemons” changing hands.²⁵ Institutional arrangements that encourage workers to donate effort lead to better-quality output at a lower price. Susan Rose-Ackerman notes that nonprofits may provide better services than for-profit firms because workers believe that clients or patients will benefit directly from their effort.²⁶ Patrick Francois builds on efficiency wage models to explain why high wages and reducing monitoring can lead to improved service quality.²⁷

Ecological economists put more emphasis on spillovers and externalities that are not captured by market exchange. Thomas Princen 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.²⁸ “Shading and distancing” of problems is easier when they are diffuse and difficult to measure.

Our collective reliance on Mother Nature offers some insights into our collective reliance on Mother Care. Both metaphorical mothers provide services that are not motivated by the pursuit of individual self-interest. In the short run, the supply curve for many natural and social services is not a function of price. We do not pay for nonmarket care services out of pocket, and as a result, we tend to take them for granted. High levels of intrinsic motivation and moral commitment increase the supply of paid care effort far beyond what a mere wage would buy. This “extra” supply of labor to the market is also taken for granted.

But in the long run, pollution, overexploitation and plain old disrespect can reduce the supply of both ecological and care services. They can hamper the replenishment of positive motivation and capacity in complicated, disruptive, and virtually irreversible ways. If you think global warming might cause serious problems, consider the possible consequences of social chilling. Many convergent problems in our natural and social environment cannot be analyzed in terms of market forces. For instance, a recent study of the Inuit of Greenland discovered toxic levels of hazardous waste (PCBs and mercury) in breast milk. 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. Among the Inuit, mother’s milk is now hazardous to children’s health.²⁹

The social environment can also become hazardous. Extreme levels of economic inequality are associated with higher levels of crime and lower levels of trust.³⁰ Despite high average income the U.S. ranks poorly compared to Europe on most measures of public health. Infant mortality rates among African American infants in the U.S. are higher than in many poor countries.³¹ And even consumption of mothers’ milk is affected. A statistical analysis of the impact of welfare reforms implemented in 1996 suggests that they reduced breastfeeding at six months after birth by over 5 percent.³²

The current institutional structure of the paid care sector often generates problems with quality. 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.”³³ 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.

A similar trend has been observed in education. 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 do not compete by offering better quality services, but by attracting a student body with high average test scores. 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.”³⁴

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 commercial establishments. In most states it is far more difficult to obtain credentials as a hairdresser than as 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 do not 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 students’ scores on multiple choice exams are often misleading.³⁵
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.³⁶

These problems are not unique to the care sector. Coke versus 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.³⁷ 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?)³⁸

Some level of intrinsic motivation is 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.³⁹ 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 CEOs to misreport profits.⁴⁰

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 call for a “new care movement” has found a wide audience among academics.⁴¹ 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*, contrasting “unrationalized labor-intensive work systems” with “high-skill autonomous work systems.”⁴² 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 these authors apply with special force to the care sector: increase the minimum wage, establish equivalent compensation for nonstandard 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.⁴³ 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.

A more specific list of high-priority strategies for the care sector should include the following: 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) Reconceptualize the role of the public sector; 6) Publicize and encourage “best practices” management.

Build Links Among Care Sector Workers

The term “care sector” is scarcely used outside feminist circles within the academy. Yet it has the potential to forge a stronger collective identity among the predominantly women workers employed in human services. Sociologists Kim Weeden and David Grusky advocate a new “class map” that puts less emphasis on “big classes” and more on the “institutionalized social categories that develop at the detailed occupational level.”⁴⁴ The care occupations represent a case in point.

Women dominate care sector employment for a number of reasons. Occupational segregation plays a role. But women may select care jobs for important positive reasons—they value both the process and product of care. 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 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.⁴⁵ Female immigrants often land in pink-collar jobs that involve emotional labor in body-related service provision such as hair and nail salons.⁴⁶ 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 may not be natural allies in every respect, but they share a common interest in quality of care. Adult care recipients, like workers, are disproportionately female. Organizing efforts need to emphasize and strengthen this commonality by educating the public about threats to care 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.”⁴⁷ Pressures to cut health care costs have led to institutional changes that have significantly decreased nurses’ ability to perform this aspect of 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 once 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.⁴⁸ 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.⁴⁹ A survey of over 7,500 nurses released in 1996 reported that 73 percent felt they had less time to comfort and educate patients.⁵⁰ Deborah Stone describes her interviews with home health care workers as follows: “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.”⁵¹

The link between working conditions and service quality in child care has been successfully publicized by the Worthy Wages Campaign, a grassroots effort to build alliances between child care providers, teachers, and parents.⁵² 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 have any way of changing the structure of the child care industry. Low pay and the resulting high turnover among child care workers, averaging about 40 percent per year, reduce the consistency and quality of care children receive.⁵³ Many child care workers, especially those in informal family care settings, lack sufficient education and training.⁵⁴ Similar problems are evident even in state-funded prekindergarten programs for which high formal standards have seldom been effectively enforced.⁵⁵

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 percent of nursing homes are privately owned, though most are subsi-

dized with public dollars. Turnover rates among workers are high, amounting to almost 100 percent within the first three months. According to *Consumer Reports*, about 40 percent of nursing homes have repeatedly failed to pass the most basic health and safety inspections.⁵⁶ 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.⁵⁷

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.”⁵⁸ 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).⁵⁹

Challenge Claims That “Care Should Not Pay”

A care movement must challenge the notion that virtuous women should offer care “for free.”⁶⁰ 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.⁶¹ Yes, many care workers derive great satisfaction from their jobs. But that does not mean they should be paid less as a result. As Gabrielle Meagher points out in “What Can We Expect From Paid Carers” in this volume, familistic ideals of care are often deployed in inappropriate ways.

Neoclassical economists hypothesize that low-paid jobs are rewarded by a “compensating differential” of psychic satisfaction, but do not 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. Such models of “adverse selection” are more commonly applied to female than to male jobs, reflecting a longer intellectual tradition that applies a sexual double standard to the pursuit of individual self-interest.⁶²

In a recent article entitled “The Economics of Vocation or ‘Why is a Badly Paid Nurse a Good Nurse?’” Anthony Heyes argues that willingness to accept a lower wage, all else equal, distinguishes a “good” nurse from the “wrong sort.”⁶³ Raising nurses’ pay, he argues, would reduce the proportion of virtuously motivated nurses and decrease the quality of care. He does not apply the same reasoning to doctors or Chief Executive Officers. He also overlooks the empirical reality of a current nursing shortage in both the United States and the United Kingdom.⁶⁴ Adverse selection models in general ignore the impact of pay and working condi-

tions on employee morale and retention. Workers that enter a job with a strong intrinsic motivation can experience “burn-out.”

The need to challenge gender stereotypes that reinforce low pay is beautifully explained by the Center for Nursing Advocacy, whose Web site 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.⁶⁵

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. In their analysis of efforts to mobilize child-care workers, Cameron MacDonald and David Merrill insist on combining the vocabularies of virtue and skill.⁶⁶ 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.⁶⁷ 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.⁶⁸ Researchers need to develop more and better ways of documenting the connections between unionization and care quality. Research results should 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 percent 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.⁶⁹ 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. A heartening success story has unfolded with suc-

cessful unionization of home care workers in California and Oregon—an effort that began with the formation of a consumer-labor coalition that revised state laws (see Eileen Boris and Jennifer Klein’s “Home Care: Low Waged Workers in the Welfare State” in this volume). Unionization clearly improved wages and benefits, and also gave clients greater choice of caregivers.⁷⁰ 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.⁷¹ Living wage campaigns that set higher standards for state and municipal employees often specifically target workers in human services.⁷² We should look for opportunities to strengthen such efforts by building broader coalitions and improving communication across state lines.

H2Reconceptualize the Role of the Public Sector

Conservatives have developed a strong rhetorical attack on the public sector as a site of inefficiency and redistribution to the undeserving poor. This attack has been weakened by two recent events: Republican failure to win support for partial privatization of Social Security and widespread publicity of inadequate responses to the Hurricane Katrina disaster. Progressive policy makers should move beyond their defensive posture to articulate a positive agenda for public provision and social insurance with high-quality standards. We should reclaim the language of family values to articulate a vision for the care sector as a whole.

Many progressive efforts to improve education, health, child care, and elder care are underway on both the state and federal level. Bringing representatives of these efforts together with social policy experts could yield viable new proposals. One need not fully endorse the “Third Way” approach developed by the British Labour Party to appreciate some of its modest successes. Social spending has been redefined as social investment in the capabilities of future citizens.⁷³ The campaign to end child poverty in the United Kingdom, now well underway, can point to significant achievements.⁷⁴

Regulatory standards for care quality need to be strengthened and extended. The minimum nurse-to-patient staffing ratios required by California law provide a stellar example.

In addition to improving care quality in the short run, such measures could also improve recruitment and retention of skilled nurses. In 2004 about thirty other state legislatures were considering such measures, but facing stiff resistance.⁷⁵ Were teachers, child care workers, and elder care workers in these states even aware of these legislative struggles, which have important implications for their own work environment?

Regulatory responses to nurse immigration also set the stage for policies relevant to the paid care sector as a whole. U.S. hospitals are increasing international recruitment (from the Philippines in particular) as way of avoiding the more costly solution of improving current working conditions.⁷⁶ In Great Britain

imported nurses (largely drawn from sub-Saharan Africa) supply more than half of all new nurses.⁷⁷ 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.⁷⁸ 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.⁷⁹

Child care also requires more effective regulation. Child care quality is low partly as a result of poor public oversight. Voluntary accreditation by the National Association for the Education of Young Children tends to improve quality. One California study rated 61 percent of accredited centers as good in 1997, compared to only 26 percent of those seeking accreditation the previous year. Nationwide, however, only 5,000 out of the nation’s 97,000 child care centers were accredited.⁸⁰ 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 can lead to exploitation of illegal immigrants.

Publicize and Encourage “Best Practices” Management

At first glance there may seem to be a conflict between a “craft” view of care, with an emphasis on giving workers the time and space they need to respond to individual needs, and a “best practices” approach that encourages more collective evaluation and standard-setting. But if care workers were given more voice in the development of management strategies, they could surely find a balance. Nurses are not averse to performance assessment; they are averse to methods of assessment that ignore those aspects of performance that are difficult to measure.

Teachers are not averse to standardized testing; they are averse to using test results in ways that undermine the large purpose of education.

Owners and managers have a greater incentive than front-line care workers to keep care costs low. They also have less opportunity to perceive and experience the results of speed-up or high turnover. As a result, they may be more tempted to reduce care quality. Steve Lopez provides eloquent testimony of this process in his essay in this volume, “Culture Change Management in Long-Term Care.”

Positive examples may not abound, but they do exist. Many state initiatives to improve pay and working conditions in the care sector provide institutional coun-

terbalance. The Kings County Career Development program for child care workers in Washington State shows how career ladders provide opportunities for personal development as well as higher pay.⁸¹ Recent studies by the Institute for Women's Policy Research and the Urban Institute study usefully compare efforts to get compensation for child care workers on the policy agenda in many states.⁸² A Nursing Home Quality Initiative passed in Massachusetts in 2000 included a wage pass-through, a scholarship fund, and a career ladders initiative. This initiative improved wages and increased retention of Certified Nursing Assistants.⁸³

Changes in management structure that give workers a stronger voice can have demonstrably positive effects in both public and the private arena. Some hospitals have experimented with greater nurse involvement.⁸⁴ Team management and interdisciplinary collaboration between doctors, nurses, and administrators can pay off.⁸⁵ The Pioneer Network has brought together a variety of constituents to improve the quality of elder care.⁸⁶ 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 Web site at <http://www.bjbc.org>). More concerted efforts to publicize such accomplishments could help raise the bar for all providers.

Conclusion

It takes a long time to build a high road, and sometimes it feels like tunneling through solid rock. A care movement cannot solve all our problems, and cannot be launched in isolation from other political efforts. But many women are involved in the care sector as both workers and consumers. The feminist economic analysis outlined here could help pull them together. It could also help care activists challenge conventional marketcentric economics. You do not need to obey the laws of supply and demand if they are not working. You need to write new laws.

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 an election.

NOTES

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