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Valuing Home and Child Care Workers

Policies and Strategies that Support Organizing, Empowerment, and Prosperity

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Introduction and Context

The COVID-19 pandemic has shined a light on just how essential care workers are to our economy and society. Not only do they care for our loved ones, they also make it possible for others to hold jobs outside the home. A strong, stable, and high-quality care workforce is a critical element of a competitive and inclusive economy in which everyone who wants to work is able.

These jobs make up a significant portion of our workforce. There are currently 2.3 million home care workers (personal care aides, home health aides, and nursing assistants) serving seniors and people with disabilities. More than one million more home care workers will be needed by 2028.[1] There are over 1.1 million child care workers[2] in the United States.[3]

Despite the essential nature of their work, both home care workers and child care workers are underpaid and undervalued. Care workers, the vast majority of whom are women and largely women of color, earn low wages and rarely have access to basic benefits like paid sick days or health care. State median wages for home care workers range from $9.05 to $16.66 per hour, with a national median of $13.02.[4] In 12 states, workers earn $11 or less.[5] Child care workers continue to earn poverty-level wages, ranging from $8.94 in Mississippi to $15.36 in the District of Columbia, with a median wage of $11.65 per hour across settings.[6] More than half (53 percent) of child care workers rely on some form of public assistance to get by.[7] Care workers also face barriers to training and further education, lack viable career advancement opportunities, and often do not have access to a union and collective bargaining power. Poor working conditions not only impact care workers' well-being and turnover, but also jeopardize their ability to provide high-quality care.

The American Rescue Plan, signed into law in March, included more than $12 billion for Medicaid home and community based services (HCBS) and $39 billion in child care relief funding. But supporting these care workers means more than rescuing them from hardships faced during the pandemic: they need long-term investment to permanently improve compensation and job quality.

In the Biden administration's American Jobs Plan, released in late March, home care and child care were elevated to the level of infrastructure. The plan includes $400 billion for high-quality, affordable home- and community-based care for people who are aging or disabled. The administration specifically calls for caregivers to receive better compensation and the opportunity to join a union. The plan also calls for $25 billion to help upgrade child care facilities and increase the supply of child care. However, the bulk of Biden's child care plan is laid out in the American Families Plan, which calls for $225 billion in funding to make child care more affordable, improve the quality of care, and invest in the workforce.

These workers hold up our nation's fragile care economy, but they are not given the support they need to keep it standing. Care workers have a long history of organizing and unionizing, but the nature of their employment—the fact that they are often independent providers—means they are not protected under federal discrimination and worker protection laws. This report explores effective strategies for organizing home care workers and family child care providers in pursuit of improved wages, benefits, training, and career advancement opportunities. We have chosen to pair these sectors because, as Ai-Jen Poo, the CEO of the National Domestic Workers Alliance, explains, these workers make all other work possible. They are also both funded at least partially by tax dollars, indicating that public policy has a large role to play in determining the working conditions of these workers. Additionally, both sectors of workers have had some success with collective bargaining in recent years but have struggled to expand beyond specific locations or subsets of workers. Our goal is to identify factors driving successful organizing and improved job quality and to offer policy recommendations to build on existing models.

From February to April, New America conducted over 30 interviews with experts, care providers, and union representatives, focusing on three states. This report outlines key considerations for improving care worker job quality through organizing. We also include case studies on care worker organizing in California, Illinois, Washington, and the Cooperative Home Care Associates (CHCA) in New York City, selected based on the effectiveness of organizing strategies in each.

Home Care Funding in the United States

Home care services are paid for using a mix of federal and state funding. Medicaid, which involves a federal-state funding partnership, is the primary source of long-term home care funding for the elderly and individuals with disabilities. Federal Medicare dollars also cover the cost of short-term in-home care.

States decide how to structure their Medicaid service delivery and payment systems. The structure of a state's home care system could have advantages and drawbacks for both consumers and home care providers. Traditionally, fee-for-service (FFS) models, where state Medicaid offices pay service providers for each covered service a beneficiary receives, have been most common. FFS models are most beneficial to independent home care workers, who see a direct correlation between Medicaid service reimbursement rates and their wages. Yet, FFS models are generally more costly to operate, and some have attributed duplicative or inefficient services for consumers to this structure. While FFS delivery systems still exist, more states have been implementing other service delivery and payment systems with the goal of improving the quality of care, streamlining the consumer experience, reducing spending, and paying for health outcomes instead of services.

Managed care is now the most prevalent structure, with nearly every state operating a comprehensive risk-based managed care and/or primary care case management (PCCM) program.[8] Through a risk-based managed care system, a state Medicaid agency contracts with managed care organizations (MCOs) to deliver Medicaid and other health benefits for a set payment per person per month, or capitation payment. PCCM is a managed system in which beneficiaries are enrolled with a primary care provider who is paid a small monthly fee to provide case management services in addition to primary care.[9] FFS payments are still used for some health care and support offered within managed care models, particularly through PCCM.

Many states rely on managed care systems to support consumers that are dually eligible for both Medicaid and Medicare. The managed care model has some advantages, including more incentives built into the system to address holistic and preventative care needs for consumers. However, it does present a profit incentive for providers, involves more administrative costs for home care agencies that must contract with multiple plans, and introduces a lack of funding transparency less present with pure FFS models. For consumers, the managed care model can translate into a more streamlined health care experience and greater access to resources to address holistic care needs, including investments in home care support that prevent more costly and severe medical interventions in the future. Yet some consumers may encounter restrictions on what services are available and where. For home care workers, some managed care providers determine worker compensation, at times with little state oversight or enforcement. This lack of transparency, coupled with a profit incentive on the part of the managed care providers, could eat into workers' wages.

Increasingly, states have been building home- and community-based long-term services and supports (LTSS) into their managed care models as an alternative to costly institutional care. This trend corresponds with a growing interest from older people and individuals with disabilities in receiving care in the comfort of their own homes. Consumer-directed home care models, through which Medicaid beneficiaries hire a home care worker of their choice, offer consumers more decision-making authority and management of home care services. Yet the amount of support a consumer receives to find a home care worker depends on the state. Workers' access to training and support depends on the infrastructure in their state or region. Independent home care providers could be more isolated and unsupported, especially if they have no attachment to a union, making it challenging to receive professional development and training aimed at improving the quality of care.

Child Care Funding in the United States

Access to high-quality and reliable child care is essential because it is both a workforce support for parents and an important component of children's growth

and development. Child care costs can take a substantial part of some family's budgets in the United States and the majority of families with young children pay for child care out of pocket. However, over 1.3 million children from families with lower incomes receive assistance through the Child Care and Development Block Grant (CCDBG) each year.[10] CCDBG is the primary source of federal funding to improve child care access. States have significant flexibility in implementation: they set child care subsidy eligibility guidelines, determine which providers are eligible for CCDBG subsidies, and determine reimbursement rates for providers. This report focuses on child care programs that receive public funding.

Our nation's child care landscape is complex, with a mixed delivery system of center-based programs, family child care homes, and informal care arrangements (FFN, or family, friend, and neighbor care). Providers can be subject to state licensing standards and more recently, quality rating and improvement systems (QRIS) that award ratings to programs that meet a set of defined standards. In many states, providers caring for children receiving subsidies are paid retroactively based on child attendance, rather than enrollment, hindering their ability to plan for and sustain wage increases.

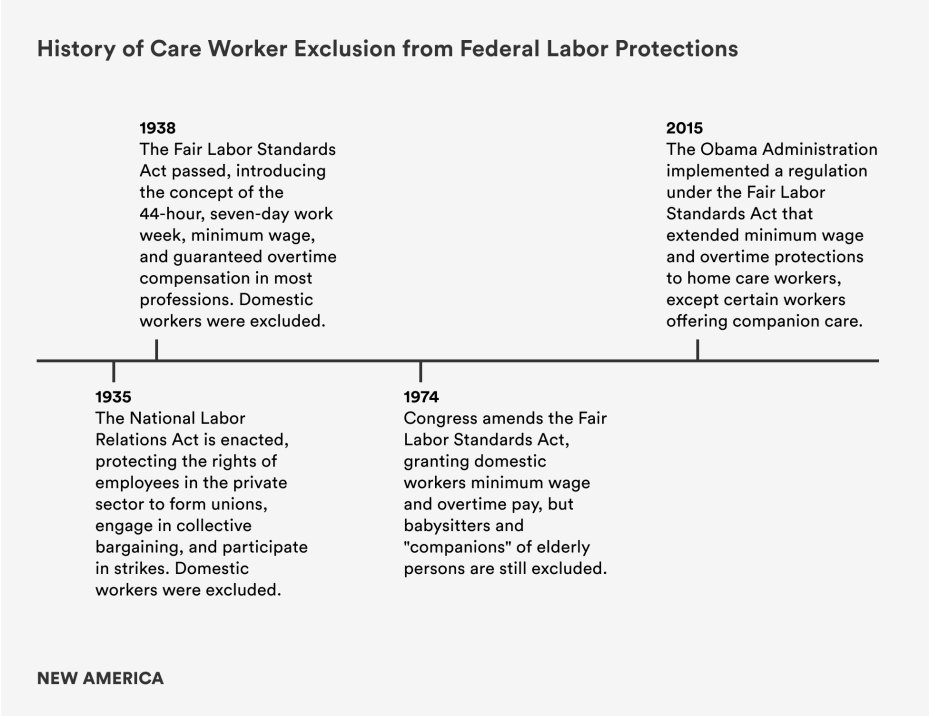
Child care worker earnings usually come from a combination of out-of-pocket parent tuition payments and public funds. Low reimbursement rates for providers accepting CCDBG barely cover the cost of providing care. The quality of care that children receive depends directly on the quality of the workforce. Low wages, minimal benefits, and poor working conditions are major causes of stress for child care workers and impact their mental and physical health. This can inhibit how they engage with children, whose learning depends on the quality of interactions with adults.

Policy: A Roadblock and Pathway to Securing Care Worker Rights

> "Taking care of children or elders or people with disabilities…[has been] historically undervalued…It just wasn't even treated as real work, and in many cases it's still not—largely because of who is doing this work." - Terri Harkin, Healthcare Career Advancement Program

> "Back in the 80s, when I was very young, I tried to get into caregiving and it was very discouraging…we had no training whatsoever, the pay was very little, and I could not afford to pay my bills and support my two children. I ended up leaving my job but when my mother got very ill ten years ago, I became her caregiver…It was amazing to see how things have changed from then to now." - A home care worker and member of SEIU 775

Home care, child care, and other forms of domestic work have been historically undervalued, in no small part because of who comprises the workforce. Disregard for these workers in America is rooted in the legacy of slavery and Jim Crow, and perceptions that care work—traditionally performed by women, particularly Black women—is not real work. Federal policy, dating back to the 1930s, has reinforced labor market structures that contribute to low wages, lack of benefits, and limited worker protections for independent home care and family child care providers. The New Deal era ushered in a series of legislative reforms aimed at protecting vulnerable workers from unsafe and predatory working conditions but largely excluded domestic workers.



For instance, the Fair Labor Standards Act of 1938 (FLSA) established minimum wage and overtime pay standards affecting full-time and part-time workers in the public and private sector, but domestic workers were considered exempt from the FLSA's requirements for decades. A 1974 amendment to the FLSA granted domestic workers minimum wage and overtime pay protections, yet those who worked with the elderly or children were still excluded. It was only in 2015, when the U.S. Department of Labor (DOL) implemented a regulation under the FLSA, known as the Home Care Rule, that minimum wage and overtime protections were extended to most home care workers.[12] However, family child care providers still do not have protections under FLSA, in part because they are considered self-employed.

Home care workers and family child care providers have had a long history of organizing and forming unions to advocate and lobby for better wages and benefits. However, this activity is not protected at the federal level. The 1935 National Labor Relations Act (NLRA), which applies to most private sector employers and grants employees the right to form or join unions and engage in protected, concerted activities to advocate for improved working conditions, explicitly excludes workers "in the domestic service of any family or person at his home." And because the NLRA only applies to employees, self-employed family child care providers are not covered. The NLRA also elevates enterprise-level over sectoral bargaining approaches by establishing a single worksite/single employer as the default unit for bargaining. However, home care workers and family child care providers do not work together at a single job site and instead

work from their own or others' homes, and do not have a traditional employer with whom they can collectively bargain for improved wages, benefits, and training. Without the right to collectively bargain, these workers have struggled to make significant inroads.

Recent Supreme Court decisions have made worker organizing more challenging by limiting the ability of unions to collect dues or agency fees from non-union members covered under collective bargaining agreements. In 2014, the Supreme Court ruled in *Harris v. Quinn* that the First Amendment prohibits the collection of an agency fee from home health care providers who do not wish to join or support a public sector union. The ruling created a distinction between partial public employees (like Medicaid-funded health workers) and fully public employees whose direct employer is the government and who under *Abood v. Detroit Board of Education* (1977) can be required to fund union activities that benefit all workers. The Supreme Court went on to eliminate the agency fee requirements with its ruling in the 2018 *Janus v. American Federation of State, County and Municipal Employees* (AFSCME) case. The court held that requiring public employees to pay agency fees is unconstitutional under the First Amendment. These rulings have limited financial resources for unions in recent years.

Nonetheless, home care workers in eight states[13] and family child care providers in about a dozen states[14] have managed to secure the right to collectively bargain via executive action, legislative reform, or ballot measures. What distinguishes these workers from other independent providers is that much of their work is publicly funded: Medicaid in the case of home care workers and state child care subsidies for family child care providers serving low-income families. In several states, these workers have succeeded in securing sectoral bargaining power by leveraging the publicly funded nature of their work to establish a common employer with whom to negotiate.

Public Authorities and Job Quality

> "If you don't have a connection back to a funding source, what changes are [family child care providers] really going to make?" - Kursten Holabird, executive director of the SEIU Education and Support Fund

The nature of home care funding has made way for workers in seven states to establish an employment relationship with public entities created by a state or county government, also known as public authorities or home care authorities (HCAs).[15] Establishing HCAs as the employer of record for home care workers has positioned workers to collectively bargain for improved wages, benefits, and training opportunities. The Service Employees International Union (SEIU) first succeeded in implementing this organizing model in California, where counties receive federal and state dollars to manage and partially support their local home

care systems. In the 1990s, SEIU advocated for legislation that required counties to establish local public authorities with which home care workers could collectively bargain. A coalition including the disability rights community, families, advocates for the elderly, and workers came together to ensure the sustainability of this workforce through better wages and benefits.

California's decentralized approach to home care public authorities, through which the union negotiates individual contracts with each of the state's 58 counties, is unique and has resulted in a wide range of compensation and benefits for workers. The HCA model has since been implemented in Connecticut, Oregon, Illinois, Massachusetts, Minnesota, and Washington, all of which operate statewide public authorities. In the seven states with HCAs, home care workers earn more than the average national wage, and all are on track to reach or are already above $15/hour in their current contracts. Home care unions have also managed to secure health care, paid time off, retirement, and other benefits through negotiations with HCAs. In addition to improving job quality for home care workers, HCAs have the benefit of increasing access to quality care by arranging and managing HCBS for Medicaid beneficiaries, setting standards for home care worker training, and maintaining a registry to match home care providers with clients to preserve consumer choice. These authorities align the interests of workers and families needing services around the common goal of high-quality home-based care.

Case Study: California's Home Care Workers

Organizing History

California's In-Home Supportive Services (IHSS) program, created in 1973, provides personal care services, including house cleaning, meal preparation, and grocery shopping to more than 600,000 low-income consumers who are unable to live safely at home without assistance.[16] By the early 1990s, consumers were struggling to find adequate care. Due to low wages and difficult working conditions, turnover was very high, and when a care provider quit, it was difficult to find and screen a new aide. Some individuals needing assistance were forced into nursing homes because they could not find care in the community.[17] In 1992, consumers, organized labor, workers, and state and local officials came together to propose legislation that would authorize the creation of county-level public authorities to manage the IHSS program and act as the employer of record. In total, seven counties chose to create this structure, and the workforces unionized soon after. In 1999, workers pushed for additional legislation to direct additional dollars to the program. More counties joined, and today, 58 counties have home care authorities that serve as the employer of record.

Facilitating Conditions that Led to Worker Organizing

A crucial component of success in California passing the initial legislation in the early 1990s was that the campaign was narratively driven by consumer needs and concerns.[18] The consumer was centered as the main beneficiary early in the process, and thus higher wages were cast as a benefit to the consumer, neutralizing the argument that higher costs could lead to less service.[19]

More recently, the SEIU has been pushing for increased training of workers. Initially, the disability community was skeptical, as there were concerns that increased training requirements would decrease consumer choice. However, by positioning training as an important step towards higher quality care and partnering with specific training groups, this concern was overcome.[20] There are still insufficient resources to meet all training needs, but there have been significant investments in this area.

Additionally, while county supervisors were often perceived to be a barrier, many had experienced the difficulties in accessing care themselves. This highlights an opportunity in this space: so many people know firsthand how important this work is, and how hard it is to access. The coalition for these initiatives is therefore very broad with the correct messaging.

Workforce Demographics

According to **PHI**, in California, this workforce is 85 percent female, 70 percent workers of color, 48 percent foreign-born, and 53 percent have a high school diploma or less.

Success/Benefits for Workers

Overall, there is large variation across the state due to the county-level model. The first benefit to workers under this model has been increased wages. In the 1990s, after the initial legislation, workers in counties with home care authorities earned up to two dollars more per hour than their counterparts in counties without the public authority. This is in part what drove the broader state-wide effort.

In terms of other benefits, only one county offers retirement benefits. The state legislated that workers have access to sick days, so in all counties, workers have access to three sick days off. Additionally, working with external partners such as the University of California San Francisco, the union has been able to implement widespread training for workers to increase access to career advancement and improve the quality of care.

Continued Challenges

The most challenging aspect of increasing standards for care workers that is specific to California is the fragmentation of the system. Contracts need to be

negotiated in each county, and each time new coalitions need to be built to push for change. This is unique to the California system.

Much like with independent home care workers, family child care providers' success in securing collective bargaining rights has hinged on the ability to establish a state government entity with which to negotiate. Under federal labor laws, state or local governments are under no obligation to recognize or negotiate with family child care unions. As self-employed individuals, family child care providers face additional hurdles to collective bargaining because they are subject to state and federal antitrust laws that prevent them from engaging in anticompetitive activities, such as negotiating wage rates. The way around antitrust laws is to secure a legal exemption via legislative reform or executive action. Following in the footsteps of home care workers, family child care providers in multiple states have pushed for the establishment of the state as the employer of record as well as the authority to unionize and collectively bargain. In Illinois and Washington, this statewide organizing has not only led to increased subsidy rates for family child care providers but also state contributions to a health insurance plan for workers.

Independent home care workers and family child care providers that have managed to establish a state or county agency as their employer of record are generally not considered public sector employees. While legislation giving Illinois family child care providers the right to collective bargaining determined they were public employees, it was only for the limited purposes of collective bargaining. By not designating home care workers and family child care providers as public sector employees, state or county governments are under no obligation to automatically extend costly health care, retirement, paid leave, and unemployment insurance benefits traditionally afforded to government workers.

Prioritizing Worker Power and Voice

Outside of negotiating contracts with state or local governmental entities, care workers have reaped benefits from broader worker advocacy campaigns. State and regional efforts to increase the minimum wage to $15/hour have buoyed home care provider efforts to improve worker wages in California, Washington, and other states. Home care providers in some states have also seen an increase in compensation through wage minimums under publicly funded state care systems. Home care services are paid for using a mix of federal and state funding, with Medicaid serving as the primary source of long-term home care funding for the elderly and individuals with disabilities, and Medicare covering the cost of short-term in-home care. Generally, public funding is allocated for services and not specifically designated for the wages of service providers. However, more than half of states have at some point implemented a Medicaid wage pass-through, requiring that a certain amount of Medicaid resources flow directly to care workers. For example, one year after introducing a wage pass-through in

Kansas for care workers in skilled nursing facilities and home care, annual turnover dropped by 10 percentage points.[21]

The development of worker cooperatives, which are owned and democratically controlled by employees, have also emerged as a strategy for promoting better working conditions and benefits for home care providers. Evidence from Cooperative Home Care Associates, the largest and longest-operating home care worker co-op, suggests that the annual turnover in home care cooperatives is less than half the industry average, which may lead to better quality care.[22]

To date, there are roughly a dozen home care worker cooperatives in operation and another dozen or so in development in the United States.[23] Worker cooperatives are less common in the early child care space, however. As of 2019, fewer than 10 worker cooperatives in child care were operating, with another dozen or so known to be in the planning or conversion process.[24] There are two family child care provider cooperatives operating in Illinois and Pennsylvania, banding together to more effectively manage business operations and facilitate training.[25] This business model has great potential to democratize child care work through business conversions as center owners retire. However, despite the benefits of cooperatives to workers and consumers, the fact that they require significant financial and capacity-building resources to stand up has limited their ability to expand.

In 2018 Congress passed the Main Street Employee Ownership Act, which encourages lending to small businesses interested in converting to an employee stock ownership plan (ESOP) or a co-op. But workers, particularly those in low-paying occupations, often struggle to produce the collateral required by most financial institutions, including the Small Business Administration (SBA), to obtain a loan. The low wages in home care and child care, combined with the historic marginalization of the workers who typically occupy these roles, makes traditional loans an unsuitable vehicle for funding worker-owned cooperatives. The racial wealth gap and gender wealth gap mean that this workforce is less likely to have access to the capital required to start a business.[26] Therefore, rethinking loan eligibility requirements is key to ensuring that federal cooperative development resources and strategies help dismantle long-standing barriers to worker ownership. The USDA Cooperative Development Grant program, which offers technical assistance to support cooperative development in rural areas in addition to loans, presents a promising federal investment in worker cooperatives.

Case Study: Cooperative Home Care Associates

History

Cooperative Home Care Associates (CHCA) was founded in 1985 in the Bronx with just 12 home health workers. In 2003, CHCA workers unionized with SEIU 1199 after the union had secured significant pay increases for Medicaid-funded personal care workers across the state. One of only a handful of home care cooperatives in the United States, and by far the largest, CHCA is a promising model of care worker empowerment and improved job quality.

Workforce Demographics

Currently, nearly 1,700 individuals work for CHCA, making it the largest worker-owned cooperative in the United States: approximately half are owners. Nearly all workers—95 percent—are women of color.[27]

Facilitating Conditions that Led to Worker Organizing

Community development leaders in New York City with the Community Service Society were interested in connecting local residents with quality jobs that benefited the community.[28] Home care, a field with low wages, unreliable hours, and lack of benefits (just as today), was seen as an occupation that could be improved for the sake of workers and the community.

CHCA began operating its own training within its first few years. Finding that training through higher education and local nonprofits did not fit worker needs, CHCA founded the Paraprofessional Health Institute (PHI) in 1991 to provide training. PHI and CHCA still partner to offer four-week courses for aspiring home care workers, with a guaranteed CHCA job at the end. Approximately 600 New Yorkers per year complete the training and begin a career with CHCA.

Benefits for Workers

CHCA workers and worker-owners benefit from a number of job quality improvements, both due to the cooperative model and workers' representation by SEIU 1199. First, the structure of a worker cooperative means that worker priorities like training, better wages, health benefits, and stable scheduling are the business's priorities. As of 2002, approximately 80 cents of every dollar of CHCA income went to worker wages or benefits; at other home care agencies in New York City, only about 70 cents per dollar went to wages and benefits.[29] Furthermore, turnover at CHCA is less than one-third of the national average.[30] Finally, experienced CHCA aides benefit from guaranteed paid hours, which stabilizes income and reduces turnover. Over its 35 years, CHCA workers have seen significant wage increases. Most wage increases are due to the role of the employee union, though CHCA workers do earn slightly more than other home care workers in New York City who are also unionized.

Continued Challenges

While CHCA is well established and the cooperative model has much to offer the home care profession, creating new cooperatives often comes with significant challenges. Home health workers wishing to form a cooperative may confront difficulties in securing sufficient startup capital, with similar challenges in converting conventional home health agencies to worker-owned cooperatives. Once these initial financial hurdles are cleared, cooperatives—like other home health agencies—experience extremely tight profit margins. Though worker-owned cooperatives prioritize workers' well-being, pay, and benefits, there may be little profit to reinvest in workers.

Practice: Uniting a Largely Independent Workforce

The independent nature of working in home care or running a family child care program has impacted why care workers organize and been instrumental in determining how they organize.

In addition to the desire for better pay and benefits, the desire to organize partially stems from the independent and sometimes isolating nature of this work. Working from either a client's home or their own home, home care workers and family child care providers do not necessarily have contact with other care workers. Pamela Franks, a family child care provider in Springfield, Ill. who has led her program for more than 20 years, explained the toll this work can take: "Just imagine day-to-day being isolated. ... Some providers are isolated because it's just them. Being away from people and trying to provide all of these services. ... It makes you burn out. People don't understand that this job is stressful."

With limited support networks, care workers are often left to navigate complex systems and demanding jobs on their own. This can be especially daunting for family child care providers as small business owners. They provide care and education to children of different ages, run the business, support families, and navigate state and federal regulations, all while working very long hours. Franks said, "I wear a lot of hats. I'm the cook, I'm the teacher, I'm the nurse, I'm the social worker, and I'm the administrator." Franks recalls that before family child care providers were unionized, she was unsure of where to go for support. She said there was "no one to talk to when the payments from the state didn't come on time." Connecting with others in their field has allowed care workers to support and learn from each other, and to form a collective voice to address their grievances. Franks said, "If I went down to the capitol and I'm yelling, 'we need raises,' they'll look at me like I'm crazy. But if I have 30 or 100 more providers with me, they're going to say, 'yeah!'" Franks currently serves as an executive board member for SEIU Healthcare Illinois Indiana (HCII) in Illinois.

To reach care workers across work sites, union organizers have departed from their traditional methods of workplace organizing (focused on single employers, etc.) and employed community organizing tactics. These workers differ significantly from the traditional notion of a factory-based union worker, both in demographics and also in the kind of work they undertake, and therefore union methods had to evolve to meet their needs.

One of the first unions to do this was SEIU 880 Illinois (now SEIU HCII), which represents both home care workers and family child care providers. Beginning in the 1990s, union leaders who had previously worked at ACORN (Association of Community Organizations for Reform Now) brought their knowledge of community organizing to the fledgling union. They focused on strengthening

workers' voices and building political power. Myra Glassman, one of the original SEIU 880 organizers, recalls her early days organizing home care workers in Illinois: "Part of the strategy was figuring out who people were. … We needed to knock on the doors of 40 houses a day."

With home care workers, union organizers knocked on every door and considered it a success if they reached 10 workers in a day and signed up one person to join the union. SEIU 880 organizers built on what they learned in the home care space and employed similar tactics to reach family child care providers. However, for family child care providers, organizers were able to access lists of people because running a child care program is a matter of public record.[31] Glassman recalls that "in child care it was more successful and we were able to get up to a couple thousand workers paying dues regularly."

Case Study: Illinois Home Care Workers and Family Child Care Providers

SEIU Local 880, which represents both home care workers and family child care providers in Illinois, was the first in the nation to organize home care workers and the first to secure collective bargaining rights for family child care providers that receive public funds. SEIU 880 organizers relied heavily on lessons learned from their experience with home care workers to organize family child care providers. SEIU 880 merged with two other local unions in 2008 and is now called SEIU Healthcare Illinois Indiana (or SEIU HCII). The union currently represents over 50,000 home care workers in Illinois, Indiana, Missouri, and Kansas and 15,000 Illinois family child care providers who participate in that state's child care assistance program.[32]

Workforce Demographics

In Illinois, 39 percent of home care workers are Black, 38 percent are white, 11 percent are Latinx, and another 11 percent are Asian or Pacific Islander. Eighty-nine percent are women, and the median age of these workers is 49. Nearly one in four (22 percent) are immigrants.[33] The median hourly wage for home health workers in Illinois is $12.25.[34]

The demographics of family child care providers in Illinois are similar to other states. Approximately 96 percent of licensed family child care providers are women and their mean age is 48.[35] Just over 42 percent of family child care providers are white, 37.9 percent are Black, and 16.7 are Latinx. The greatest racial diversity is in the city of Chicago. The state's child care workforce speaks over 20 languages, most commonly English and Spanish. More than half of family child care providers' highest level of education is a high school diploma or

GED. The median wage for child care workers in Illinois was $11.16 in 2019, across all settings.[36]

Home Care History

SEIU 880 used an organizing model for home care workers based on its experience as community organizers for the Association of Community Organizations for Reform Now (ACORN).[37] A few staff members with SEIU 880 from its beginnings in 1983 had previously worked for ACORN.[38] This meant that in its early days, SEIU 880 was less concerned about recognition and collective bargaining rights than building political power to strengthen workers' voices and improve job quality. The home care workers in the union did not shy away from traditional community organizing methods to collectively exert political influence, while they did not yet have the right to collectively bargain. Illinois organizers view the density of the home care worker population in legislative districts across the state as instrumental to their early success.[39]

Without yet having won union recognition and the right to collectively bargain, the 880 political action committee and other arms of SEIU pushed for Rod Blagojevich, a Democrat, to be elected governor. Gov. Rod Blagojevich (D-Ill.) was the only candidate that committed to granting an executive order recognizing the right of independent provider home care workers to have a union and collectively bargain with the state. Illinois had not elected a Democrat in almost 30 years, and Blagojevich was likely to create a better environment for care workers and for organized labor in Illinois. Blagojevich won that election, and in 2003, he became the first U.S. governor to issue an executive order and then sign legislation granting home care workers collective bargaining rights.

Successes/Benefits for Home Care Workers

From its early days in 1985 to 2005, SEIU 880 was able to win 13 pay increases for DORS (Illinois Department of Rehabilitation) independent provider personal assistants through legislative fights that resulted in budget increases to the DORS home care program to fund those pay raises.[40] The union also won a 34 percent wage increase in its first contract with the state of Illinois in 2003.

In 2011, the union successfully won a training fund to support workers' initial and continuing learning. The classes, which consist of a combination of required and voluntary training, are free and participants often receive stipends. In early 2020, SEIU HCII finalized another collective bargaining cycle with independent provider home care workers through the state's DORS and Home Services Program that will increase their minimum hourly wage to $17.25 by December 2022,[41] as well as additional resources to expand worker training programs through the union's training fund.

Family Child Care Provider History

The work to unionize child care workers began in the summer of 1996. Following successes in the home care space, SEIU 880 was interested in organizing more low-wage workers. SEIU organizers saw that family child care was a common source of employment in the neighborhoods they served.[42] Several 880 members had family or friends who were family child care providers, and some 880 members had left the home care space to work in child care.[43] This was also around the time that President Clinton enacted welfare reform, and Temporary Assistance for Needy Families (TANF) work requirements led more parents to go into the labor force and rely on child care providers.

There were numerous similarities between the home care and child care workforces, both in terms of demographics and working conditions. Family child care providers who relied on public subsidies from the state Child Care Assistance Program (CCAP) wanted to address two main issues: late payments from the state and the low reimbursement rate for services.[44] In 1999, under pressure from Local 880, Gov. George Ryan (R-Ill.) increased reimbursement rates for licensed child care providers by 50 percent.[45] In 2000, family child care providers "won an informal grievance system through which child care providers could get their problem with the state addressed more formally."[46]

Family child care providers were officially granted the right to organize and collectively bargain over wages, hours, and working conditions in 2005 when Gov. Blagojevich issued an executive order. Legislation was signed soon after, stating that publicly subsidized family child care providers are state employees for the limited purposes of collective bargaining.[47] According to the legislation, "Any contract negotiated by the providers is both self-executing and enforceable by the right to strike."[48] Unlike other states, agreements negotiated by the union that require additional funds, like child care subsidy rate increases, do not rely on legislative approval to be implemented.[49]

Successes/Benefits for Family Child Care Providers

Relative to other states, the union in Illinois has been successful in securing benefits for family child care providers. The union has negotiated four collective bargaining agreements since achieving recognition.

The first contract in 2006 included a 26 to 30 percent reimbursement rate increase over three years for family child care providers.[50] The governor's budget included funding to cover the first year rate increase.[51] And while only family child care providers were covered under the contract, the state's child care advocates successfully used the family child care provider rate increase as leverage to lobby for rate increases for child care centers. The contract also included health insurance in its third year and pay incentives for training. Illinois family child care providers can access health insurance through the SEIU IL Home Care & Child Care Fund. Illinois remains one of the only states to have secured health insurance for this workforce.

In 2009, the union and state agreed to another three-year contract. This contract included a 22 percent rate increase over three and a half years, continued state funding for the labor-management partnership overseeing health insurance, incentives for providers to participate in trainings, and changes to make payment procedures more efficient for providers.[52] The training fund is peer-driven, with experienced child care providers leading many of the courses.[53] All of the trainings are free and many offer a stipend for participants. The state requires educators in licensed settings to complete at least 15 contact hours of training per year, and providers can access these trainings for free through SEIU HCII.

From 2015–2019, Gov. Bruce Rauner (R-III.) was hostile to unions. During Rauner's tenure, the Illinois General Assembly included a rate increase for CCAP child care providers in the budget but he did not implement it. The union sued the state for failure to implement the rate increase to home child care providers. Soon after Gov.Pritzker (D-III.) took office in 2019, he agreed to wage increases for both home care and child care workers and agreed to pay about $44 million in back pay for the time that Rauner had not implemented the rate increase. This impacted 14,000 child care providers.[54]

Continued Challenges

While not unique to Illinois, the primary challenge for care workers is that there is not enough public investment in the system. Even with increases in reimbursement rates, many home care and child care workers struggle to make ends meet. Providing quality care is expensive, and rate increases rarely translate to family child care providers paying themselves more. Home care workers also have a long way to go before they can reliably earn a living wage. More public funding is needed for reimbursement rates to truly cover the cost of providing high-quality care.

Another challenge is that child care worker reimbursement rates remain at the whims of the governor to some degree, as exemplified above. The state has not consistently elected officials who are friendly to the union or to care work. Illinois child care workers are still fighting for key benefits, particularly a retirement fund, compensation based on years of experience, a pool of substitute educators, and a set "payday" each month where they can reliably expect to receive their reimbursements from the state.[55]

Care worker organizers in Illinois face tough obstacles, including powerful anti-union political forces in the state legislature and recent Supreme Court decisions that make it harder to build and sustain unions within the fragmented home care and child care sectors. Nevertheless, SEIU HCII has been able to successfully sign up workers as full members and enlist them in the ongoing fight to pass worker-friendly policies at the city, state, and national level.

A basic principle of organizing is that there is power in numbers, and these community organizing tactics lend themselves to more densely populated areas. SEIU 880 pursued organizing in the areas with denser populations where it was easier to more quickly reach more workers in an effort to impact state legislators with a large number of care workers in their district. They started with Chicago, and then opened offices and directed their efforts to other metropolitan areas in the state. State legislative champions can arise when a sufficient number of workers in their district come together. Glassman shared the example of a young state senator, Barack Obama, who sponsored legislation on home care workers in the Illinois Senate and championed this issue. Population density also played a role in California, where both home care and child care organizing efforts began at the county level and grew county by county for many years before there was a successful statewide effort.

The importance of the worksite in this strategy's effectiveness is especially evident when comparing organizing success of different types of child care workers. While organizing efforts have been most successful among family child care providers, a majority of child care workers work in center-based programs. Like family child care providers, those working in centers receiving subsidies are subject to low reimbursement rates and are usually compensated poorly. Center-based child care teachers are afforded federal protections as traditional employees, but achieving collective bargaining rights has proven more challenging for these workers because the center-based child care industry is less centralized.[56] They may receive the same subsidies as family child care providers, but their employer is the center director or owner. When attempting to organize at the individual center level, employees have a traditional employer with whom they can bargain, but their numbers are likely small and high turnover rates make it hard to form a collective bargaining unit. Any gains secured at the center level do not automatically extend to other center-based workers. Having varied employers can make it difficult to organize across worksites when pursuing sector-wide organizing, and the high turnover rate at centers can make it difficult to get enough employees on board.[57] By the time organizers get to a vote, a substantial percentage of the workforce has often changed.[58] Marcy Whitebook, director emerita of the Center for the Study of Child Care Employment at the University of California-Berkeley, explained, "The center-based teachers are essentially invisible. There's no independent list of them and they're often not certified. ... It makes doing research really hard and makes organizing really hard."

Partnerships and Politics

> "When you fight in numbers, you win." - Pamela Franks, Illinois home child care provider

Cultivating and exercising political power has taken a number of forms for care workers over the past 40 years. Other than the centrality of community organizing strategies described above, partnerships with other allied constituencies help build worker power and momentum for change. Likewise, identifying those in office or pursuing political office who could be persuaded to champion care workers' priorities can facilitate improved working conditions and job quality.

While gaining union recognition and collective bargaining rights constitutes the gold standard for improving job quality, workers have been able to make strides before or without such status with community organizing strategies which helped improve conditions for workers even without union recognition or collective bargaining rights. As an example, home care workers across Illinois had joined SEIU 880 and organized direct actions and solidarity campaigns to push state policymakers to raise their pay in the 1980s and 1990s. Using community organizing principles focusing on personal connection, breadth of outreach, and coordinated action, Illinois home health workers garnered approximately ten pay raises before their union was officially recognized in 2003.

A more recent example, Organizers in the Land of Enchantment and partner organizations in New Mexico won, through long, concerted community organizing efforts, hazard pay for child care teachers early in the COVID-19 pandemic, and passage of a bill allocating a share of the state's permanent land grant fund to early care and education.[59] Given that a lack of public investment is the greatest barrier to improved wages and benefits for child care workers, this additional, codified funding stream has the potential to improve job quality for child care workers across the state.[60]

Forming Alliances and Partnerships

Forming alliances with key constituencies, particularly those receiving care from these essential workers, is critical to providing high-quality care and fighting for improved job quality for workers.

Older adults and people with disabilities in states that use consumer-directed Medicaid home care models have considerable power and can make strong partners for care workers. These groups can coalesce around shared goals of improving and expanding quality home care through higher public investment. In California, seniors and disability rights groups became critical partners in the

early days of organizing home care workers, partly because both constituencies were already well organized, with advocacy groups operating across the state. While the disability rights community's perspective is often aligned with that of care workers, tension may occasionally arise around issues such as requiring or incentivizing health care training for care workers. This can be perceived as medicalizing clients' disabilities and as removing clients' ability to train their own caregivers in the type and manner of care they require.

Care workers and organizers should prioritize building close and early relationships with the disability rights community and working together to further shared interests around quality and stability of care. Rebecca Gutman of SEIU 1199 United Healthcare Workers East (UHW-East) in Massachusetts pointed to close partnerships with the disability rights community as a means of building and amplifying each other's power. She said, "I think there is a shared narrative that some of the wins that we have had over time … neither community would have won without the other." Forming relationships with senior groups can also be useful in working to improve home care. Partnerships with care worker unions or other organizations around pushing for increased funding can be particularly useful.

In the child care sector, different alliances between workers and other constituencies have elevated worker power and efforts to improve care. Parents can be organized as powerful allies of child care workers. In Seattle, child care providers partnered with parents throughout the mid-late 1990s to push for increased wages.[61] In 1999, Gov. Gary Locke (D-Wash,) funded a pilot program with improved wages after pressure from this coalition.[62] Partnerships among unions have proven indispensable for family child care worker organizing in California. SEIU, United Domestic Workers of America (UDW), and AFSCME partnered to push for collective bargaining rights for family child care providers rather than separately working to pursue this aim. The resulting union, Child Care Providers United, is now officially recognized in the state and is currently in the collective bargaining process for its first contract.

Case Study: Washington Child Care Workers

History

In 2005, the Governor of Washington issued an executive directive allowing all home-based child care providers to organize. By November of that year, over 90 percent of family child care providers had voted to join SEIU Local 925. One year later, the 925 won legislation granting explicit collective bargaining rights to subsidized family child care and family, friend, and neighbor providers, designating them as state employees for the purposes of collective bargaining.[63] Additionally, the providers who do not participate in the subsidy program were

granted the right to union representation for the purposes of shaping the regulatory requirements that apply to them. The first contract was approved in November 2006, which included subsidy rate increases (10 percent over two years) and additional financial incentives to care for infants and to provide care after hours. Starting in 2008, subsidized family child care providers received health insurance. However, none received the right to strike.

Facilitating Conditions

Unionization efforts in Washington were led by a **coalition** of parents, workers, and labor. Workers were able to organize parents to effectively advocate for their children and those who cared for them, resulting in increased wages for workers.[64]

Although workers had been unionized in many areas in Washington state before 2005, it was only when workers were granted explicit collective bargaining rights from the legislature that they were able to bargain at the state level. This closed the gap in wages between places like Seattle, which had been more active in the union before state recognition, and more rural areas of the state.

Demographics

According to the **Migration Policy Institute**, in Washington, this workforce is 96 percent female. As far as the racial and ethnic composition of the child care workforce, 72 percent identify as white, 14 percent as Latinx, 8 percent as Asian, and 5 percent as Black.

Successes and Benefits for Workers

Overall, workers have won access to higher wages, retirement benefits, better training, and overall better working conditions.

Since workers have organized through SEIU 925, rates for family child care providers have gone up by over **one-third**. The 925 also recently helped create a substitute provider pool and achieved significant wage gains of up to 20 percent for some providers.[65] However, wages are still very low, and the pandemic has been extraordinarily difficult for these workers.

Continued Challenges

There is simply not enough money for child care. There is only room for 17 percent of eligible children in state programs, and it continues to be extremely difficult to find workers to go into this field. Demand far outpaces the state's ability to provide care.

The Politics of State Leadership

State political leadership can empower or stymie worker organizing. It is critical for workers and allied constituencies to identify and engage federal, state, and local candidates and politicians currently in office who could be convinced to champion key policy goals of organized care workers. SEIU workers in Illinois, still not recognized or able to collectively bargain in the early 2000s, realized they would make little additional progress in securing better quality work without political leadership that was friendlier to organized labor. Therefore, they devoted their energy to electing Democrat Rod Blagojevich governor. Shortly thereafter, Blagojevich followed through on a campaign promise, and the state recognized SEIU 880 and began the collective bargaining process for home care workers.

While workers in California, Illinois, and Washington have all benefited from Democratic governors' executive orders to gain collective bargaining rights, a governor alone may not be able to maintain or improve wages and benefits for these workers. Even with a generally supportive state legislature, Illinois child care providers remain reliant on the support of the governor. Bruce Rauner, in office 2015–2019, was hostile to organized labor and failed to implement child care reimbursement rate increases passed by the General Assembly.[66] SEIU HCII sued the state. Rauner's successor, J. B. Pritzker, implemented the rate increases previously passed by the state legislature under Rauner, with back pay for workers in the most recent contract, in effect until 2023.

While Democrats are typically more likely to facilitate improved job quality for care workers than Republicans, Democratic party affiliation is no guarantee of labor-friendly policymaking. California child care providers had been organizing for years, but were not granted the right to collectively bargain until Gov. Gavin Newsom (D-Calif.) signed the legislation. His predecessor, Democrat Jerry Brown, was not a strong proponent of child care and in fact quelled workers' efforts to win collective bargaining rights, as had Republican Arnold Schwarzenegger. Strategic connection with political candidates and attempts to secure their support, with the combined voices of care workers, care recipients, and other allied groups, can have significant implications for the future.

Case Study: California Family Child Care

History

Family child care providers in California who care for children receiving subsidies have been fighting for the right to have a union negotiate with the state on their behalf for over 17 years. Gov. Arnold Schwarzenegger (R-Calif.) vetoed bills that would have authorized statewide bargaining for family child care providers in 2004, 2006, 2007, and 2008, citing concerns over higher costs that could reduce the number of children receiving care. Gov. Jerry Brown (D-Calif.)

vetoed a similar bill in 2011, pointing to concerns over the bill's impact on the state budget.[67] Finally, in September 2019, Gov. Newsom signed legislation that granted the approximately 40,000 family child care providers in the state who receive subsidies the right to collectively bargain and organize. In July 2020, about 10,000 providers overwhelmingly voted to join Child Care Providers United, a partnership of the SEIU and the AFSCME. For the first time, California's family child care providers have a union empowered to negotiate with the state for higher pay and better training.

What Facilitating Conditions in this State Led to Worker Organizing?

A crucial component of the successful effort to gain collective bargaining rights was the collaboration between unions. While it was Newsom who signed the bill finally giving family child care providers the right to collectively bargain, providers had been working with their local unions for over a decade to win significant victories, such as payment rate increases that followed successful union efforts to raise the minimum wage. Due to the fact that so many decisions affecting family child care providers serving subsidized families occur at the state level, SEIU and AFSCME member leaders and staff realized early that collaborating around joint decisions and creating a unified state strategy would make the greatest impact on behalf of providers. The union that formed to represent providers in their newly won right to collectively bargain is a partnership between SEIU and AFSCME.

Demographics

Precise demographics of the California child care workforce are notoriously difficult to obtain due to the lack of a statewide workforce registry or an updated statewide survey. According to the Center for the Study of Child Care Employment, there were approximately 116,800 people as of 2019 that made up the state's early childhood educator workforce, not including self-employed workers such as family child care providers. The average wage for a child care worker in 2019 was $13.43/hour[68] and nearly 60 percent of the state's early educators live in families that rely on public support.[69] The workforce is overwhelmingly female: While gender data is not available for family child care providers, 97 percent of center-based child care providers in California were women in 2012 and over two-thirds of family child care providers were people of color.[70]

Success/Benefits for Workers

The newly formed Child Care Providers United union has already secured tangible benefits for its members. In the union's first major victory, the legislature approved $144 million in federal funds to provide financial relief to providers in the wake of COVID-19. The funds will be used to give providers one-time stipends of $525 per child in subsidized care as of November 2020, allow 16

additional paid non-operational days for COVID-19 closures, and form a working group of union and state representatives to review how to provide additional financial relief for providers through the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.[71] In April 2021, the union secured a second COVID-19 funding agreement which, if approved by the legislature, will provide family child care providers hundreds of thousands of dollars of financial support to address economic hardships caused by the pandemic.[72] The union is currently in negotiations with the state to finalize its first master contract that will include details about reimbursement rates, training and professional development opportunities, benefits, and grievance arbitration.

Continued Challenges

Insufficient public funding at both the federal and state level is an ongoing challenge in the early care and education field. Family child care providers in California and elsewhere operate on very thin margins, resulting in low earnings which make it unlikely they will earn health benefits or accrue savings for retirement. Reimbursement rates paid to providers who accept subsidies are not tied to the true cost of care, so even when these rates are raised, they still might not be high enough to significantly increase the earnings of family child care providers to a livable level or allow them to pay their assistants a livable wage.

Not All Benefits Are Equal

> "I became a caregiver in 2005 after my sister became disabled from an accident and needed someone to take care of her. I went through classes and got my license, not expecting to be a caregiver for very long ... but then the union came along and it just became a really good career, it's been a good foundation for my family ... We have medical, dental, optical, and retirement [benefits]. We get paid time off, we just won paid holidays. ... I make $21.52 an hour. It's not great but it is enough to keep a roof over my family and food in my kids' bellies." - Rhonda, home care worker and member of SEIU 775

Workers in Illinois, California, and Washington came together with their unions to fight for higher wages and better benefits. Overall, organizing led to far more favorable policies, particularly among home care workers. "There are so many things the union fought for and provided caregivers in the state of Washington," said an SEIU home care worker there. "The list just goes on and on. It's heartbreaking to hear of people doing the same work in other states and not being respected on the same level." Indeed, we found significant variation in benefits, and less significant wins for family child care providers.

Wages

Unionization combined with collective bargaining led to increased wages for home care workers across the board. However, there remains significant variation across contracts. The wage in Illinois is significantly lower than in Washington, and in California, wages vary from county to county. As Brandi Wolf, policy and research director, Local 2015, explained, many places in California that are more conservative have refused to raise wages, leading to lower wages for those workers.

While child care workers have also won increased reimbursement rates when they unionized, this money does not necessarily translate into higher wages due to the significant overhead required to run a child care program. As family child care provider Pamela Franks said, "I don't even make $12 an hour," which is what she pays her employees. After paying for rent, supplies, and other expenses, there is very little left over. Moreover, because providers are often reimbursed by attendance instead of enrollment, if children are absent, providers are not paid. Finally, unpredictable paydays (being paid a different day each month) means that it is difficult for family child care providers to plan.

Retirement Benefits

Many workers have sought retirement benefits in their contracts to ensure economic stability for themselves and their families. However, few contracts have included these benefits. Of the XX states with home care authorities, only home care workers in Washington state have also been able to win retirement benefits.

Child care workers have been unable to win retirement benefits in any of the three states we studied. Nationally, **fewer than 10 percent** of child care workers have access to retirement benefits, indicating that this is a problem that goes far beyond these three states. Even though workers collectively bargain with the state, they are not state employees. This was intentional in places like Illinois and Washington because the financial cost of making workers state employees overnight was too great, in large part due to the generous retirement benefits state workers receive.

Paid Time Off

In our case studies, home care workers in Illinois and Washington receive paid sick days (and in other states, workers in Massachusetts and Minnesota have also won paid time off). Although these are limited in number, this is an important victory. During the COVID-19 pandemic, many other **states** have followed suit, indicating a potentially positive development in this area as these workers are recognized as essential.

As business owners, family child care providers often do not receive paid time off. As Illinois family child care provider Pamela Franks explained, if she does not work, she does not get paid, and she cannot afford to pay for a substitute. Though the union in Illinois is fighting for a substitute pool, and the union in Washington has won substitutes for workers, this benefit has yet to materialize. California was the exception in this area, with child care workers receiving guaranteed days off, which were actually **increased** during the pandemic.

Health Insurance

In each of the states we examined, home care workers receive health insurance. However, in other states, even those with collective bargaining rights, workers have been less successful. For example, in Minnesota, Connecticut, and Massachusetts—states with similar models—workers must instead turn to the health care exchange to purchase insurance.

Family child care providers in Illinois and Washington have both successfully won health insurance in their contracts. However, they are the only ones: those in California have not, though current negotiations may include health insurance, and nationally, only 15 percent of child care workers have access to health insurance.

Worker Voice

Even if a union does not win everything its members might hope for, unions universally provide a seat at the negotiating table. This fundamentally changes the nature of their work. As Helen Blank, a longtime leader in the child care policy space explained, "It's important not to trivialize what they have done, because basic benefits for providers are a big deal." Franks agrees, explaining, "We have a voice, a seat at the table. That's the main thing the union brought us."

When workers engage in collective bargaining, they not only win benefits but become partners in determining their working conditions. It establishes a long-term relationship with the state, setting the groundwork for future negotiations and wins. As Terri Harkin, a senior program manager at H-CAP explained, one important improvement in working conditions that workers have achieved is getting paid properly and on time, as workers can demand solutions. Additionally, during the COVID-19 pandemic, workers were able to advocate for better personal protective equipment. The union therefore also allows workers to collectively address new issues and seek continuous improvement.

Home Care Cooperatives

Home care cooperatives have slim margins, but they provide broad benefits to workers. CHCA workers have access to health benefits, paid leave, and sick leave, largely thanks to the worker-ownership model that centers worker needs and concerns. However, while worker cooperatives like CHCA prioritize workers' needs and job quality, home care cooperatives are still operating under extremely slim profit margins, limiting the resources they can successfully reinvest in their workforce.

Standards and Training

> "Through our union we have really been able to negotiate contracts that help our caregivers make a decent living – if we go through training, we can earn a wage increase. But the training also helps us increase our wisdom and take better care of clients." - A home care worker and member of SEIU 775

Both home care workers and family child care providers lack clearly defined career pathways. In many states, a 20-year veteran of one of these jobs might earn the same or only marginally more than a new worker. While training is necessary for providing higher-quality care and education to clients and children, increased training does not necessarily translate to higher wages.

In California, for example, many providers of home care services have received extensive training for which multi-million dollar grants have provided the initial funding. There is no clear relationship between this level of training and additional pay or mobility for workers, however. The Center for Medicare and Medicaid Innovation set aside $11 million to provide additional training to home care workers in an effort to reduce rates of hospitalization and emergency room use. Despite the importance of this training, workers who participated in the training received only a $1 per hour stipend during the training and no ongoing wage increase.[73] Similarly, the Center for Caregiver Advancement in California received funding to provide three months of training to home care workers in Los Angeles County. While workers who completed it received a certificate and were deemed eligible to make a bit more money providing backup care if other workers are not available, the only immediate financial benefit was a $300 stipend per worker, which translates to about $1 per training hour completed; there was no change to the base hourly wage of the workers.[74]

Despite the general lack of connection between training and wages among care workers, Washington's home care workers succeeded in connecting increased training to higher wages. Washington home care workers were able to elevate training standards as a means to support career progression, secure increased wages for advanced home care workers, and improve quality of care.

Case Study: Washington Home Care Workers

History of Home Care in Washington

The elderly population in Washington, as throughout the United States, has been increasing and so has the demand for care services. In response, Washington

embarked on reforming its long-term care system to maximize consumer choice and flexibility, improve the qualifications and compensation of home care workers, and reduce long-term care costs, beginning in the late 1990s. In line with recommendations from the elderly and disability communities, Washington shifted to a consumer-directed model to support aging in place. Individuals who would ordinarily be cared for in a skilled nursing facility could access Medicaid and/or Medicare funding to acquire in-home care and support, a long-term care delivery approach that is far less costly.

The prioritization of in-home care presented several challenges for policymakers and implementers. To be successful, the state needed many more home care workers and an infrastructure for ensuring they were adequately trained to provide high-quality care. This was a challenge considering that home care was increasingly delivered in consumer homes rather than in care facilities like nursing homes, where workers had limited access to on-the-job training and mentorship.

The new long-term care model also presented a challenge to workers. The decentralization of home care services made it impossible for most workers, many of whom were independent providers, to organize and collectively bargain for improved wages and benefits. Beginning in the early 2000s, SEIU helped solve these problems by organizing workers, making them easy to find and contact, and by creating a training infrastructure and set of training standards to improve the quality of care.

Workforce Demographics

The home care workforce in Washington is 84 percent female, 62 percent white, 18 percent Asian/Pacific Islander, 9 percent Latinx, and 7 percent Black. The average home care worker is 48 years old. Two-thirds of the home care workforce has completed some college or more advanced education and training, while 34 percent have a high school diploma or less.

Facilitating Conditions for Worker Organizing

In 2001, home care workers affiliated with SEIU advocated for legislation that would establish the state as the employer of record for state-paid independent provider workers and allow them to form a collective bargaining unit for the purposes of union representation. When that failed, SEIU helped get Initiative 775 on the ballot later that year, which voters passed, giving independent home care workers the right to organize and collectively bargain with the newly created Home Care Quality Authority (HCQA). By 2002, 26,000 home care workers voted to form SEIU 775.

In Washington and other states in which independent home care providers have managed to form a union and collectively bargain, the presence of a Medicaid consumer-directed program has been the common thread. Before establishing

the state as the employer of record, these workers essentially functioned as independent contractors and therefore lacked protection under state and federal labor laws.

The unionization of home care workers in Washington laid the groundwork for a series of improvements to their compensation, benefits, and training.

In 2004, SEIU 775 negotiated its first contract with the state, which included health benefits for home care workers. By 2006, SEIU 775's second contract with the state included a wage scale with step increases for hours worked by home care aides, paid vacation time, workers' compensation, and mileage reimbursement.

Despite these gains, home care workers had few pathways for career advancement and were not valued or compensated as a professional workforce. Under the advice of PHI and SEIU 1199 New York Training and Upgrade Fund, SEIU 775 sought to improve home care worker qualifications and training standards as a means to secure better wages for workers. Prior to 2007, Washington had some of the most minimal licensing and training requirements for home care workers. That year, the legislature passed HB 2284, establishing a work group to recommend new training requirements and requiring that training for state-paid independent provider home care workers be provided through a joint labor-management training partnership. The SEIU Healthcare NW Training Partnership created a statewide training system, becoming the second-largest training provider in Washington. In 2010, voters passed Initiative 1163, which required most home care workers to complete 75 hours of entry-level training within 120 days of hiring; pass a certification exam through Washington's Department of Health within 200 days of hire; and complete a federal and state background check. Some caregivers are exempt or have lower training requirements because of their relationship with the client or other factors.

Successes

With increased training standards in place, SEIU 775 negotiated additional wage increases for home care workers who obtained advanced training. Currently, new home care workers earn between $16.72 and $18.25 an hour, above the state hourly minimum wage of $13.69.[75] However, individuals who earned a home care certification or Certified Nurse Assistant license are eligible for a $0.25 per hour wage increase, and those who complete advanced home care training earn an additional $0.75 an hour. Wage increases apply to both independent home care providers and those employed by Medicaid-contracted private agencies because of legislation passed that created parity within the Medicaid home care system. The universal applicability of home care worker benefits is unique to Washington.

Future of Home Care in Washington

Washington serves as a model for how to secure improved benefits, as well as training and career advancement opportunities for essential home care workers. Yet home care services, although critical, remain underfunded in Washington. In 2019, it became the first state to pass legislation to fund a long-term care insurance program.[76] Under the Long-Term Care Trust Act (LTCTA), employees must begin paying 0.58 percent of their wages into a fund that will help cover the cost of long-term care services for individuals who have met work history requirements starting in January 2022. SEIU, in collaboration with AARP, the Washington Health Care Association, and the Washington Association of Area Agencies on Aging, championed the LTCTA as a means to expand access to home care services and reduce the need for consumers to spend down into poverty to become eligible for Medicaid-funded long-term care. If successful, this initiative could set an example for how to adequately fund and expand access to long-term home care. What remains to be seen is how the new long-term care system will impact workers.

Child care providers, including family child care providers, face similar pressures to gain additional training without the reassurance that such training will lead to a higher wage. The Institute of Medicine and the National Research Council's 2015 report, *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation*, recommends a transition to a minimum bachelor's degree requirement for all lead educators working with children from birth to age eight. [77] But, while additional knowledge and skills for teachers would likely lead to higher quality care for young children, there is little evidence that this additional training leads to higher wages for the workforce. In fact, child care workers with a bachelor's degree earn about half as much as the average earnings of individuals with a bachelor's degree overall.[78] Child care workers who are able to complete coursework and earn a bachelor's degree are likely to consider leaving the field entirely, since they can earn a much higher wage teaching in the elementary school system.[79]

In theory, the quality rating and improvement systems (QRIS) put into place by many states should reward family child care providers who earn higher credentials. Partly to incentivize training, many states have instituted tiered reimbursement systems through which providers who meet specific quality standards, such as increased training for staff, receive higher reimbursement rates from the state. While this system connects provider training to higher subsidy rates from the state, moving up the levels of the tiered system is a time-intensive process that does not typically end up translating to higher pay for the provider because the extra money often goes straight back into the program to keep it running effectively.

New models for career preparation are emerging to provide workers with high-quality and affordable training options that lead to higher pay. Apprenticeship is a promising method for linking training to wage increases for entry-level workers

as well as incumbent workers looking to gain skills. Apprenticeships combine paid, on-the-job training with related classroom experience; apprentices complete their programs with work experience, higher skills, and no student debt. They also earn progressively higher wages as they advance through the program.

As of 2018, at least eight states have early childhood educator apprenticeship programs.[80] One of the leading organizations supporting these apprenticeships is Early Care & Education Pathways to Success (ECEPTS) in California. ECEPTS was developed in partnership with the SEIU Early Educator Training Center and intends to change entry-level early care and education jobs from being seen as dead-end jobs to being the first step towards a well-paid career in this field. ECEPTS has apprenticeship programs specifically designed for incumbent center-based and Head Start workers as well as licensed family child care providers.[81] By September 2021, ECEPTS will have enrolled over 600 apprentices. family child care providers who participate in the apprenticeship program participate in no-cost college coursework to help earn California Child Development Permits and receive wage enhancements throughout their time in the program.[82]

However, while apprenticeships are a promising method for linking training to wage increases for care workers, even the higher wages earned by apprentices who complete the ECEPTS program often fall short of a living wage, suggesting the need for more systemic change around the funding of jobs in early care and education in the United States

Policy Recommendations

This research suggests several routes for improving the working conditions and compensation of care workers. Policymakers at the federal and state levels could consider the following reforms to ensure that care work can become a path to economic security.

1. Increase federal funding for all care workers. Strategies to improve job quality for care workers can only go so far without significant public investment into home care and child care infrastructure. We applaud the Biden administration for calls to dramatically increase funding for home care and child care and recommend that Congress prioritize strong funding for these sectors to ensure the needs of consumers are met and that workers can be paid a family-sustaining wage. These jobs are essential to the public good, and require extensive public investment.

2. Reform federal labor laws to include care workers. Where home care and family child care providers have secured improved conditions correlates with the presence of unions and the right to collectively bargain. Updates to federal labor laws are needed to acknowledge the realities of today's independent and geographically dispersed care workforce by extending worker protections to independent home care and child care providers, and eliminating barriers to sectoral or industry wide bargaining. Reforms to the National Labor Relations Act, through the PRO Act, would extend the right to unionize and collectively bargain to independent workers, regardless of whether the state is their employer of record.

3. Establish state or county governments as the employers of record for home care and family child care providers in order to facilitate collective bargaining. Public authorities or HCAs provide a policy infrastructure for creating greater consistency in wages for independent home care workers and as the employer of record, serve as an entity with which home care workers can collectively bargain for wages, benefits, and training. Similarly, efforts to establish states, via executive or legislative action, as the employer of record for family child care providers have paved the way for negotiated subsidy increases and health insurance coverage. The federal government could award grants or offer increased HCBS and family child care matching funds to the states to incentivize the establishment of public authorities.

4. Promote higher compensation and greater benefits for home care and child care workers.

- **Raise the minimum wage**. A $15 federal minimum wage that applies to independent home care providers would go a long way to improve the compensation of workers across the country. In the absence of federal

action, however, states and local governments can push their own minimum wage increases.

- **Provide increased HCBS matching funds to incentivize wage increases**. During the COVID-19 pandemic, states were provided increased Medicaid matching funds, and 18 states, including conservative states like Arkansas and Texas, used these funds to provide increased wages for LTSS workers. This indicates that the federal government could effectively increase wages by providing an additional match if state dollars are used to increase wages.[83]

- **Explore Medicaid wage pass-throughs**. More than half of states have at some point required that a certain amount of Medicaid resources flow directly to care workers. The federal government should explore ways to incentivize states to enact and sustain Medicaid wage pass-throughs.

- **Encourage or require states to use a certain percentage of CCDBG funds for workforce compensation**. As the largest source of federal funding for child care, CCDBG could serve as a vehicle for improving family child care provider wages if the federal government were to designate a percentage of existing funds or new funding specifically for compensation.[84] Alternatively, the federal government could create a supplemental payment through CCDBG for providers that is reserved for wage increases.

- **Use enrollment instead of attendance to reimburse family child care providers accepting subsidies**. While the CCDBG Act already encourages states to reimburse providers based on child enrollment instead of attendance to support the fixed costs of providing services, many states continue to reimburse providers based on the number of days a child attends in a given month. This instability and unpredictability can make it difficult to plan ahead, which can compromise quality. Being able to predict how much money they earn each month allows providers to make more informed decisions around budgeting, staffing, and enrollment. Financial stability could make it possible to increase compensation for staff, likely improving employee retention and well-being. Predictable income also strengthens providers' applications for loans or grants to expand their business, enhance their facilities, or invest in quality improvement initiatives.

5. Increase access to career pathway opportunities that offer wage gains commensurate with skill gain.

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Invest in care apprenticeships. Apprenticeships combine paid on-the-job training under the supervision of a skilled mentor with coursework to prepare individuals for specific occupations and industry-recognized credentials. Apprenticeship is a particularly important training and employment model for care workers because it helps these individuals pursue postsecondary education at little or no cost, earn progressively higher wages as they build more skills, and obtain mentorship despite the isolated nature of their work. Federal and state policymakers can repurpose existing workforce investments to support the development and delivery of apprenticeships and/or appropriate new funding, such as through the Early Educators Apprenticeship Act.

- **Establish minimum and advanced training standards tied to compensation levels**. Given their financial stake and concern for residents of all ages, states have a vested interest in ensuring a qualified care workforce. As seen with home care providers in Washington State, establishing minimum training standards and associated compensation levels have the ability to raise the wages of workers while also raising the quality and consistency of care. More states should consider how to leverage their oversight and licensing authority to encourage wage increases tied to skill gain.

6. Support the development of worker cooperatives. There are several strategies at the state and national levels for encouraging the formation of worker cooperatives.

- **Provide seed funding/grants to support worker cooperatives**. Federal grants to facilitate worker cooperative development—particularly in care occupations—could reduce the significant barrier of accessing startup capital.

- **Ease financing requirements for worker cooperatives**. It is often difficult for cooperatives to secure business development loans, due to an unconventional business structure. The SBA should consider adopting cooperative loan policies and requirements successfully used by the USDA.

- **Offer technical assistance to prospective worker-owners**. Federal resources designated for technical assistance in cooperative development could help facilitate additional businesses in the home care space that prioritize reinvestment in workers. The USDA Rural Cooperative Development Grant provides a template for such an investment.[85]

Appendix: Summary of Care Worker Organizing Outcomes in Calif., Ill., and Wash.

	Illinois	Illinois	Washington	Washington	California	California
	Child care workers	Home care workers	Child care workers	Home care workers	Child care workers	Home care workers
What year bargaining rights won?	2005	2003	2006	2001	2019	1992
Who do workers bargain with?	Dept. of Central Management Services	Dept. of Central Management Services	Dept. of Social and Health Services	Home Care Quality Authority initially; latest **contract** signed by governor	Dept. of Human Resources or governor's designee	County board—varies
Increased wages?	Yes	Yes	Yes	Yes	N/A (still under negotiation)	Yes
Retirement benefits?	No	No	No	Yes	N/A (still under negotiation)	No
Health insurance?	Yes	Yes	Yes	Yes	N/A (still under negotiation)	Yes
Training opportunities?	Yes	Yes	Yes	Yes	N/A (still under negotiation)	Yes

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