

# **The Current Budget Proposal and its Implications for the In-Home Supportive Services (IHSS) Program**

Briefing for California State Legislative Staff, 2007

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Supportive Services (IHSS) Program**  
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**2007**

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**I. Introduction – Linda Delp**

- This briefing will
  - Give an overview of the nation's problems with long term care explaining that the demand for LTC is expanding as the baby boom ages, as our population is living longer and as technologies make it possible for people with disabilities to live productive lives in their communities;
    - But at the same time, our ability to provide that care is being undermined by our failure to recognize that the traditional long term care workforce is shrinking; the current budget proposal reflects a failure to understand that the success of California's long term care system depends on retaining an adequate IHSS workforce to maintain the strength and quality of the IHSS program;
  - We will provide a history of the IHSS program and the compact that it was meant to reflect between consumers and the state;
  - We will then explain how the funding for the program works and why the program is so often targeted in proposed budget cuts, threatening to undermine the compact between the state and its frail elderly and disabled population;
  - We will then explain what the actual impact of the proposed budget would be, in particular the impact of freezing wages for IHSS workers.
  
- Who are IHSS consumers and workers?
  - Currently about 375,000 consumers receive IHSS services which are provided by about 309,000 providers
  - The population of consumers and providers is highly ethnically diverse; as of 2004, it was comprised of Latinos, white native-born, African-American, Chinese, Russians and Armenians and other Asians (see Table 1)
  - Because consumers are eligible for the program only if their income is less than about \$1000 per month, the consumer population is poor. But the provider population is also very poor; 52 percent of population surveyed in 2004 had household incomes of less than

- \$24,000 per year despite the fact that 37 percent had other employment in addition to their IHSS job;<sup>1</sup>
- Only 65 percent have health insurance, 30 percent of those have insurance through their IHSS job; were it not for the IHSS insurance available to them, only 35 percent would have health insurance;
  - 79 percent were female; their average age was 46
  - 68 percent were caring for a family member and 43 percent were living with their consumer
  - So IHSS providers, the workers whose wages will likely be frozen as a consequence of this proposed budget, are largely people caring for their family members and friends, but who – as this briefing will show - need to be paid adequately for their work and provided with health insurance if they are going to be able to provide the quality care that consumers require.

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<sup>1</sup> Survey conducted as part of the project “Wages, Benefits and Flexibility Matter: Building a High Quality Homecare Workforce” (Candace Howes, P.I.), under the auspices of the Better Jobs, Better Care program funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies ([www.bjbc.com](http://www.bjbc.com)).

**Table 1. Demographics of IHSS Workforce by County, 2004,**  
(based on survey conducted by Howes, et al.)

	<b>Total</b>	<b>Los Angeles</b>	<b>San Francisco</b>	<b>Yuba-Sutter</b>	<b>Yolo</b>	<b>Sierra-Nevada</b>
<b>Total</b>	100%	88%	9%	1%	1%	1%
<b>Race/ethnicity of caregiver</b>						
Latino	24%	26%	9%	10%	19%	10%
Chinese	8%	5%	36%	0%	1%	0%
Russian	4%	2%	18%	0%	11%	0%
Armenian	10%	12%	0%	5%	4%	2%
African American	18%	19%	12%	2%	4%	0%
White	21%	20%	13%	69%	52%	81%
<b>% Foreign born</b>	58%	58%	76%	17%	27%	4%
<b>% Caring for family</b>	68%	70%	56%	61%	52%	55%
<b>fam/friend as 1<sup>st</sup> client</b>	84%	86%	72%	68%	71%	84%
<b>fam/friend as current</b>	84%	86%	73%	68%	71%	76%
<b>% Living with client</b>	43%	45%	28%	40%	34%	56%
<b>% Female</b>	79%	79%	71%	86%	83%	89%
<b>Marital status</b>						
Married / Cohabiting	52%	51%	60%	58%	60%	51%
Widowed/Separated/Div	27%	27%	21%	29%	20%	25%
Never married	21%	22%	20%	12%	19%	24%
<b>Educational attainment</b>						
less than high school	25%	25%	27%	24%	22%	13%
High school	29%	29%	29%	35%	26%	34%
Some college/tech sch	30%	31%	22%	37%	35%	45%
College grad	10%	10%	15%	3%	11%	3%
Grad school +	5%	5%	7%	2%	7%	5%
<b>% With other job</b>	37%	37%	41%	27%	45%	52%
<b>Total paid hours per week in all jobs</b>						
less than 20 hours	15%	15%	18%	19%	11%	22%
20 to 40 hours	38%	39%	36%	40%	35%	36%
more than 40 hours	46%	46%	47%	40%	54%	42%
<b>Annual household income</b>						
< \$12 K	19%	20%	14%	21%	14%	10%
\$12 - 24K	33%	34%	27%	32%	26%	30%
\$24 - 36K	23%	23%	28%	24%	20%	23%
\$36 - 48K	14%	14%	18%	14%	21%	19%
\$48K+	11%	11%	14%	8%	13%	16%
<b>Satisfaction with job</b>						
Satisfied / Very satisfied	86%	85%	92%	77%	94%	86%
<b>Wages (08/2004)</b>						
Health Insurance Elig req (hrs/mo)		\$7.50 80/2	\$10.28 25/2	\$6.75 none	\$9.60 80/3	\$7.11 none

## II. IHSS History/Overview

### A. What is the Crisis of Long Term Care and how does the budget proposal threaten to worsen the problem? - Candace Howes<sup>2</sup>

- People in all advanced industrial countries, including the United States, are living longer; elderly and disabled are able to live more productive lives in the community; but for people to live productive and comfortable lives we as a society will need to dedicate more resources to the provision of long term care;
- Over next 40 years the number of people over age 65 needing LTC is expected to double while the number of women between age of 45 and 65 who provide most of that care will increase by only 46 percent, leaving a huge LTC gap and crisis, unless we can identify innovative approaches to providing care;
- Majority of care recipients prefer alternatives to institutionalization, including home- and community-based care which on average costs a fraction of facility based care;
- Other advanced industrial countries provide long term care services as an entitlement for all; Japan, for example, funds its program from a social security-like tax. But the US funds most long term care through the Medicaid program; thus, rather than recognizing LTC as an investment in keeping our frail elderly and disabled population in the community and living productive lives, the US tries to slow the growth of spending on LTC by limiting the growth of home and community-based care; the hope is that the care gap will be filled by unpaid family caregivers who are unwilling to put their family members in LTC facilities (see Fig 2 and 3);
- The gap cannot be filled by family caregivers as women and other family members enter the workforce to close the growing household income gap for middle and lower income families; many would gladly care for their family members if they could be paid wages comparable to what they can receive in alternative employment, but increasingly families cannot afford to give up outside income to provide all of the care that is needed by their family members;
- If family providers are to continue to provide care for their elderly and disabled relatives, rather than taking better paid jobs, many of them will need to be paid for their work, or to be paid better wages and benefits than they are currently receiving; if consumers are to find providers who can be reliable and long term, they must be able to offer wages comparable to what those providers could get in alternative jobs;
- Compared to other states, CA has a forward-looking consumer-directed model that recognizes the need for unique solutions to fill this care gap, including allowing family members to care for their disabled relatives and in some counties paying decent wages and health insurance benefits; as a

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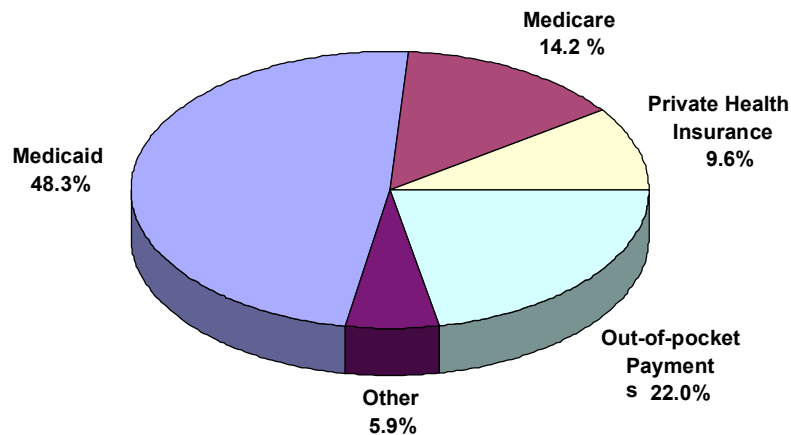
<sup>2</sup> The source for most of this section is Howes (forthcoming)

consequence CA is able to offer long term care to large proportion of those who need it; thus CA has the most cost effective and humane long term care coverage in the US;

- Problem of LTC – as other nations have recognized – is best solved by supporting consumer-directed care as in the IHSS model and allowing friends and family to provide paid care when feasible;
- But for there to be a sufficient workforce to meet needs of consumers, workers must be paid livable wages and most importantly have access to affordable health insurance even if they are working part-time
- Yet year after year including this year, IHSS budget proposals threaten to undermine this cost effective, critical program at the very moment when other states, following California’s example, are experimenting with how to expand consumer-directed care;
- The current budget proposal threatens to exacerbate the long term care crisis and pushback some of the gains that have been made, even in the short term;
- While the budget proposal has provided funding for caseload growth, in recognition of the fact that the state has long made a commitment to care for its elderly and disabled population, the proposed budget would most likely have the effect of freezing the growth of wages and benefits; the Governor’s proposal, while acknowledging the long term commitment, fails to understand that that commitment can only be realized if consumers are able to pay their care givers decent wages and benefits; as we will discuss later in this briefing, retention of IHSS workers is closely linked to paying adequate wages and health insurance benefits.

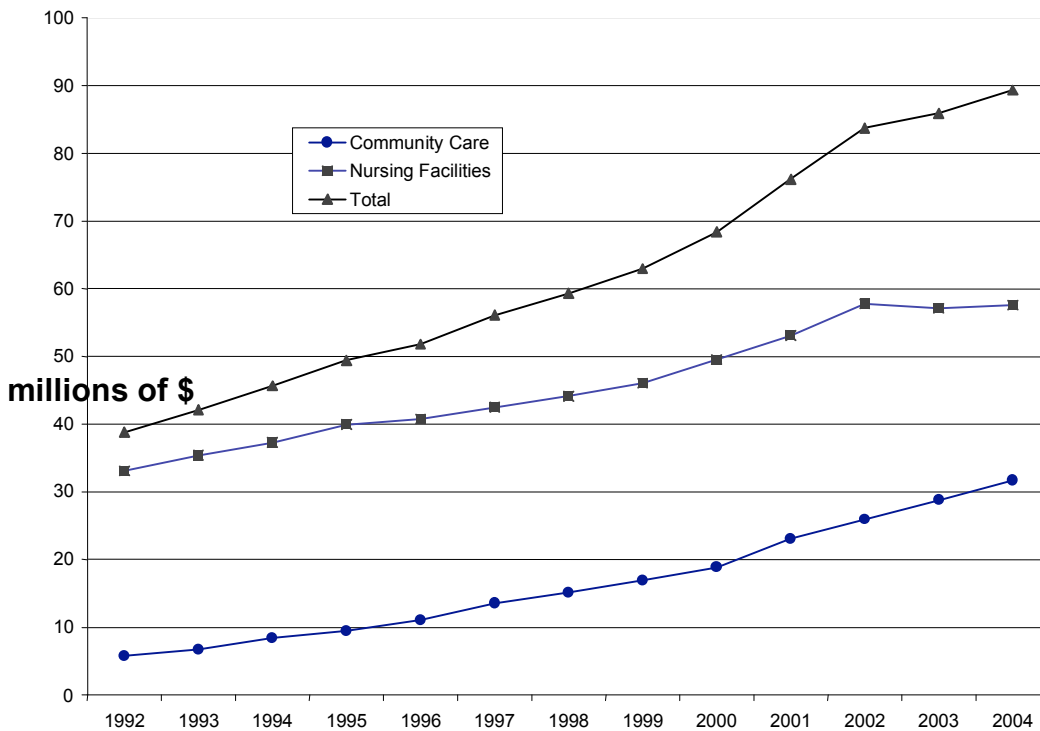
**Fig 1. Sources of Long-Term Care Spending, 2001**

Total Long-Term Care Spending = \$151.2 Billion



Source: House Committee on Ways and Means (2004)

**Fig 2. Medicaid Expenditures for Long-Term Care Services: 1992-2004**



Source: Burwell, et al. (2004)

**B. Brief History of IHSS and its relevance for issues of the day - Eileen Boris<sup>3</sup>**

- What can we learn from history of IHSS that can help us understand what has made the program successful and provide guidance for how to improve the program to meet the growing needs for long-term care? History tells us that this is a program that has always had bi-partisan support, that bi-partisan support developed because of a widespread understanding that the program had very broad popular support as reflected in the diverse coalition that has coalesced around IHSS; that this program long reflected a commitment on the part of the state to provide support and services for the elderly and disabled; but that it works only if there is a high quality workforce; but the odd nature of the funding for the program, combined with a tradition of devaluing the job, has made it difficult to ensure the funding necessary to ensure adequate wages and benefits for the workers;

<sup>3</sup> Sources for this section are in Delp and Quan (2002), Heinritz-Canterbury (2002), Boris and Klein (2006), Boris and Klein (2007), and Boris and Klein (forthcoming).

- Why is it that IHSS jobs (as well as homecare workers nation-wide) are paid as poorly as they are? Why is it that the Governor can consider freezing wages of already low paid workers? This is a job that has been devalued historically because of its origins:
  - Located in the home, which most of us think of as a place apart from work. It is associated with domestic and family labor, performed by women for their own families without pay or by poor minority and immigrant women for low wages for other people's families.
  - Funding came mostly from federal social assistance and child welfare funds that were needs based, rather than being funded through Medicare
  
- Despite devaluing the job, CA over the years has developed a model program with bipartisan commitment to provide care for elderly and disabled
  - Beginning in 1950's attendant care program began for polio survivors;
  - Reagan expanded the program beginning in 1968
  - IHSS authorized in 1973 as commitment to care for aging and disabled population, as part of state compliance with SSI. Consumer directed model built into the program, as well as state commitment to make up any shortfalls from inadequate federal financing
  - Major advances over the years under both Republican and Democratic administrations such as Reagan, Wilson, Davis (see Handout for history of program)
  
- Contract/commitment by state to its elderly and disabled population
  - The legislative history of IHSS suggests that it was a compact with the state's citizens who require home support to maintain their independence. Then State Assemblyman John L. Burton (Democrat-SF) boasted in 1973, "We have given them [the old and disabled] a measure of economic security . . . that may help them for the rest of their lives."
  - This long standing commitment to provide long term care was influenced by Olmstead supreme court decision of 1999 which expanded right to receive community-based care; Aging with Dignity initiative of 2000-2001 reaffirmed that right

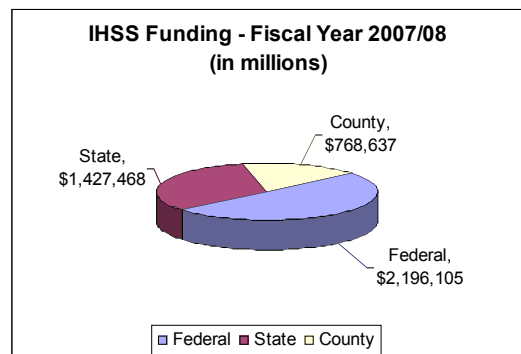
- Support from broad coalition underlies bipartisanship and was critical to building, shaping and sustaining the program historically and up to the present day
  - Who's in coalition – consumers, providers, advocacy groups –19 groups pushed the governor and legislature for the 1973 legislation including CA League of Senior Citizens, Committee for Rights of Disabled, the California Legislative Council for Older Americans, Disabled and Blind Action Committee of California [connected to Independent Living Movement]. Over the years this coalition identified shared values to improve quality of program. Support from broad coalition had two key impacts – on structure of program and on potential to obtain additional funds
  - Structure of program today reflects those shared values:
    - Consumer-directed critical – where consumer has right to choose the person who will care for them, including family members
    - Consumers and workers both have a voice in improving the program – consumers through majority consumer advisory boards; workers through union representation
    - Established employment relations model appropriate to caring for vulnerable population– workers agreed not to strike; workers and consumers work together
    - Codified in 1992 legislation which allowed for development of public authorities and creation of an employer for collective bargaining purposes at the county level
    - Legislation in 1999 (AB 1682) mandated the creation of an employer for collective bargaining purposes in all counties by 2003; Public authorities, which reinforce consumer-direction, have emerged as the preferred model
  - Coalition efforts helped bring in additional federal funds, allowing for program expansion –
    - In 1992 Governor Pete Wilson signs AB 1773 (sponsored by Assemblywoman Gwen Moore) which established the Personal Care Services Option with Medi-Cal (California's Medicaid) funds now paying for many of the services provided by IHSS.
    - Because the legislation also allowed for the creation of Public Authorities, many were established in counties such as San Francisco, Santa Clara; then some counties, frequently, though not always, following unionization, began to bargain to bring wages above the minimum level and add benefits
      - SF is a good example
    - 2000 Aging with Dignity Act includes funding for increased wages, under the trigger mechanism, for home care workers working in counties with public authorities.

- But funding has always been erratic, unstable, inadequate because of its link to state budget and Medicaid funding; constant struggle between state, counties and federal government to shift responsibility for funding, especially during budget shortfall years;
  - Since covered by Medicaid rather than Medicare, program became means tested and thus stigmatized. Many middle income elderly and disabled Californians have no help in obtaining quality home care, which they would prefer instead of the institutional solutions to Long Term Care;
  - Despite the fact that the adoption of PCS option in 1992 and waiver in 2005 brought new federal funding into the program, it has been difficult to fund at level which allows for adequate caseload growth as well as needed improvement in wages and benefits for workers;
  - The State's funding has generally acknowledged the need for caseload growth (indeed the enabling legislation mandates increased funding for caseload growth), but in too many proposed budgets over the last 20 years, the Governor has tried to cut funding for current or future wages and benefits for IHSS workers in order to save money without recognizing that an adequate workforce is a condition of providing a high quality service
  - Efforts to constrain cost growth through overly precise definition of tasks and time needed turns job into piece work, undermining the wage structure and threatening quality of care
- In the last decade, Public Authorities and unions also have sought to improve quality of care by beginning to focus on additional issues, some of which require additional state funding (like training)::
  - Registries to match workers and consumers,
  - Training for providers on home care services, first Aid & CPR, etc.
  - Respite care services for consumers if providers are ill.

### III. Financing the program – how does it work?

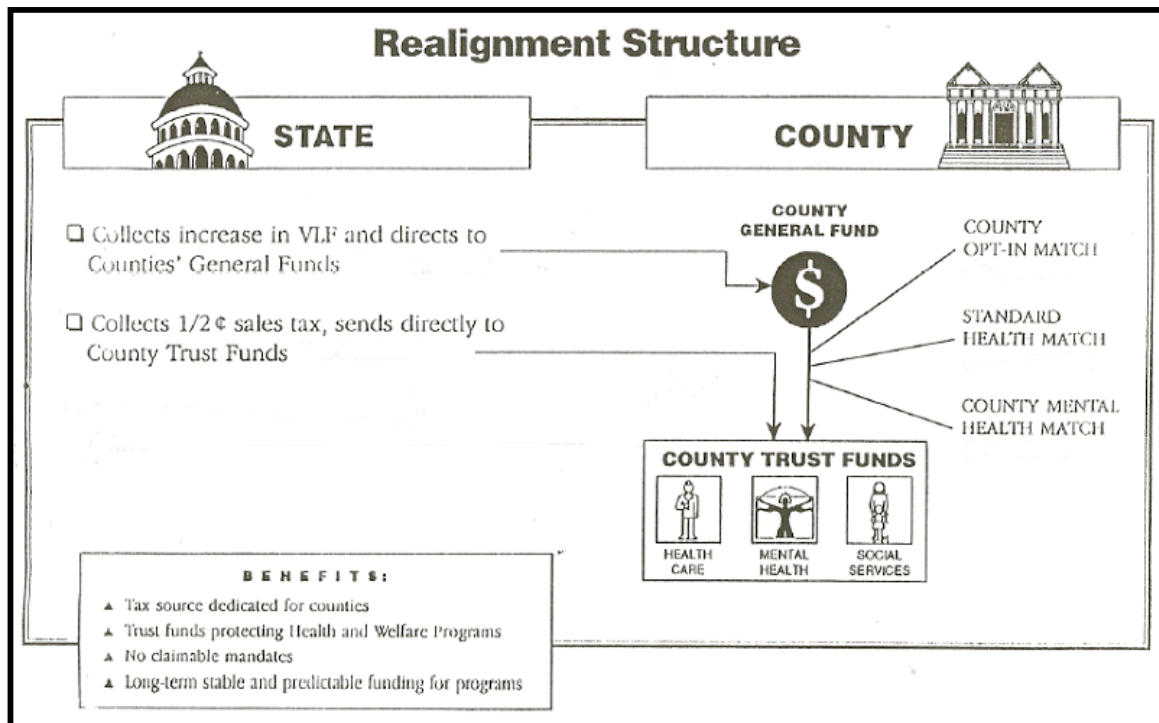
#### A. Brief overview of funding mechanisms (Karen Keeslar<sup>4</sup>)

- IHSS program funded by federal ,state and county monies; the federal Medicaid program pays 50 percent of the cost of wages and benefits up to a maximum of twice the state minimum wage – or currently \$15.00 – and the



<sup>4</sup> This section was prepared by Karen Keeslar, lobbyist for the California Association of Public Authorities and President of Keeslar & Associates Government Relations.

state and counties combined pay 50 percent of the cost of county level wages and benefits up to a maximum of \$11.10 per hour, including \$0.60 for health insurance; the state pays 65 percent of the non-federal share from the General Fund and the county pays 35 percent of the non-federal share from the Realignment Funds.



- Counties receive funds from the state to pay for their share-of-cost in IHSS through a financing structure known as “Realignment.” The Realignment structure pays for increased costs associated with increases in wages and benefits through the Caseload Subaccount. The payments from the Caseload Subaccount are calculated based on annual changes in caseload costs, as well as IHSS worker wage and benefit increases, and made at least one year in arrears.
- There is a delay in the payment to the county from the Realignment Funds that can be 18 months or longer, thus some counties are wary of making a commitment that will not be reimbursed for some time.
- IHSS expenditure growth is eventually paid through the Realignment Caseload Account. However, counties are billed every month by the State Department of Social Services for the county share-of-cost in IHSS wages and benefits. The 18-24 month delay creates challenges for some counties to pay the bill on a monthly basis while they wait for their Realignment Funds to catch up.
- Funds owed to the Caseload Subaccount can carry over from year-to-year building obligations for Growth Fund distributions that deny growth revenues from going into Health and Mental Health.

- The California Association of Counties reports that counties are owed approximately \$60-80 million for caseload growth for fiscal year 2005-06, yet estimates for sales tax growth for the Caseload Subaccount are less than \$9 million.
- Nonetheless, every additional dollar that a county commits to IHSS worker wages and benefits up to \$11.10 an hour brings in an additional \$2 per hour in state money and \$3 an hour in federal money to IHSS workers income, and since many care for their relatives, can bring additional money into IHSS consumer households
- IHSS legislation has a funding mechanism built into it (part of the Aging with Dignity Initiative), referred to as the “trigger” which required the state to increase its participation in wage/benefit costs up to an additional \$1 of wages per hour for each year in which the General Fund revenue was projected to increase by 5%, up to a maximum wage of \$12.10 per hour; currently the trigger has raised the state commitment up to its share of \$11.10 per hour.

#### **IV. Response to current budget proposal/LAO - Candace Howes**

##### **A. Governor’s budget proposal**

- Budget proposes an increase of \$28 million or 1.9 percent in General Fund spending on IHSS;
- The increase covers only caseload growth and assumes that the caseload will be 374,999 for FY07 and 395,100 for FY08; although the Governor’s budget projects caseload growth of 5.4 percent over FY07, it also assumes that there will be a \$45 million savings from the quality assurance initiative that will offset some of the increased cost associated with caseload
- The LAO analysis argues that the Budget overstates the growth in caseload for both FY07 and FY08 and suggests that further reductions in funding for IHSS in FY 07 and FY08 of \$27 and \$34 million may be warranted; however, the LAO does hesitate to recommend such reductions at this time until an audit is completed for the May revision
- Budget proposes to limit state participation in provider wages and benefits to the level in effect in each county on the day that the wage freeze takes effect;
- Budget proposes to suspend the final trigger which is expected to fire in May, which would increase State mandated participation in wages and benefits to \$12.10; for those counties already paying more than \$12.10, the state participation would be frozen at \$11.10.

##### **B. Implications of budget proposal**

- Fairness:

- As of January 10, 2007, only 13 counties will be paying \$11.10 per hour or more (including \$0.60 for benefits); there will still be 14 counties paying the state minimum wage to providers, and the remainder will be paying between \$7.50 and \$11.10 (LAO 07-08 analysis)
  - While the cost of living varies across counties, still the wages in many counties have not kept up with the cost of living; in other counties they have always been too low to sustain workers and their families and to encourage retention of IHSS workers;
  - IHSS workers are already quite poor; the average monthly individual income was \$1000 and household income was \$2,300 in 2004; the cost of housing and food alone averaged \$1,600 leaving less than \$700 for all other expenses;<sup>5</sup>
  - In counties where IHSS wages were still pegged at the state minimum wage level, the average individual income was much lower – less than \$700 in Yuba and Sutter counties and the household income averaged \$2000 per month. Housing costs were lower in those counties, but providers were not paying less on average for any of their other necessities, including food, transportation and healthcare costs;
  - Denying those workers whose wages have not yet risen to a level that is adequate to sustain them in the job, and denying others cost of living increases is unfair both to the workers and their consumers and may in fact violate consumers' right to receive long term care in the least restrictive mode.
- Workforce retention (and impact on quality of care):
- Research by Howes (2004, 2005) shows that wages and especially benefits have a significant impact on the retention of workers; in San Francisco when the wages increased from \$5 per hour to \$10 per hour and health insurance was added between 1997 and 2002, the one year retention rate for new providers increased from 33 percent to 61 percent;
  - As of Dec 2005, the San Francisco wage had only increased slightly above \$10 per hour and there had been little improvement in retention; for non-family providers retention increased only from 57 to 58 percent and that is only because of a huge increase in retention of Russian providers; for all other ethnic groups retention actually fell since 2002, especially for Latinos (9 points), African Americans (16 points) and native-born whites (7 points);
  - This suggests that the wage in San Francisco has not kept up with the cost of living and that if wages are frozen, retention will continue to decline;
  - The proposal to disallow the trigger mechanism promises to keep the wages in most counties well below what is necessary to maintain and increase the retention rate; even for counties with the highest wages,

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<sup>5</sup> See note 1 for reference.

there is evidence that the wage is not keeping up with the cost of living sufficiently to retain workers;

- The LAO analysis suggests that retention will not fall quickly but over the long run problems will arise with retaining quality workers and that there will be a negative impact on the consumer; the experience of San Francisco corroborates that view and suggests that the effect on retention may occur sooner rather than later;
  - Evidence from 2004 survey indicates that many providers feel they would have to leave their jobs if the wage does not increase and 19 percent of workers predict that their consumer would end up in a nursing home if they had to leave the job;
  - Some argue that counties will be able to make up the difference if the state withdraws its support; however, for the counties to make up for the state's reduced contribution could in some cases as much as double or triple the county's costs; if the county does not make up for the state's match, then every dollar the state withdraws will cost \$1.00 of federal monies as well, crippling the counties ability to pay decent wages and benefits;
  - LAO also argues that the budget assumes a higher rate of caseload growth than is justified by the evidence from 2005-06 caseload growth;
    - However, given that demand for IHSS services has been growing statewide at an average rate of 6 percent a year on for the past 10 years and given that all demographic predictions suggest that there will be a significant growth in demand due to growth in the population over the age of 65 for the next 30 years, it seems imprudent to adjust budget increases for caseload growth downward, based on the experience of a single year.
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- Budget proposal reneges on the State's promise to seniors and disabled to provide quality care that was made when the IHSS program was founded and that was renewed under the Aging with Dignity initiative;
  - Given the effect that higher wages and benefits have on the economic well-being of IHSS consumer and provider families and the effect that higher wages and especially decent health insurance has on workforce retention, this is a very good investment for the county, as well as the state; this should be a priority program for the state because of its historic commitment to provide long term care for its elderly and disabled population and because IHSS is so cost effective, compared to facility based care;
  - In fact, the last time the Governor proposed cutting IHSS wages, a survey of California voters showed that three-fourths of California voters opposed cutting IHSS wages; that is clear evidence that a broad, bi-partisan group of consumers, providers, their friends and relatives and all those who expect to need long term care in their lifetime all believe this is a program

that should be a priority for funding, including funding for adequate wages and benefits to sustain the workforce.

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The Hull Professor of Women's Studies at the University of California, Santa Barbara, **Eileen Boris** holds the only endowed chair in women's studies in the University of California system. She is affiliated with the Departments of History, Law and Society, and Black Studies and directs the Center for Research on Women and Social Justice. Among her books is the prize-winning *Home to Work: Motherhood and the Politics of Industrial Homework*. With Jennifer Klein of Yale University, she has forthcoming a history of home care: *Caring for America: How Home Health Workers Became the New Face of Labor*. She has authored policy reports on the feminization of poverty, the wages of care, and welfare reform.

**Linda Delp** is Director of the UCLA Labor Occupational Safety and Health Program (UCLA-LOSH), [www.losh.ucla.edu](http://www.losh.ucla.edu). She has a PhD from the UCLA School of Public Health where she researched the working conditions of home care providers in California's In-Home Supportive Services Program (IHSS). She convened the California Home Care Research Working Group in 2001 to bring together researchers and IHSS stakeholders to develop a research agenda and policies to improve consumer-directed homecare. She has published articles on the home care workforce and on the relationship between job conditions and worker health and has more than twenty years of experience developing innovative bilingual occupational health education programs. She is on the Advisory Board of Cal/OSHA and WORKSAFE (a statewide occupational health policy organization) and is a member of the American Public Health Association Occupational Health and Safety Council.

**Candace Howes** is the Barbara Hogate Ferrin '43 Associate Professor of Economics and Department Chair at Connecticut College. Her most recent book, *Competitiveness Matters: Industry and Economic Performance in the U.S.*, was published by the University of Michigan Press in 2000. Recently she has been investigating the problems that arise when very low wages are paid to service workers, especially those providing long term care to the elderly and disabled. As the Principal Investigator on a two year project, "Wages, Benefits and Flexibility Matter: Building a High Quality Homecare Workforce," conducted under the auspices of the Better Jobs, Better Care program ([www.bjbc.org](http://www.bjbc.org)) and funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies, she has conducted an extensive survey of the IHSS workforce and published several articles on recruitment and retention of homecare workers.

## RESOURCES

- Boris, Eileen and Jennifer Klein. 2006. "Organizing Home Care: Low-Waged Workers in the Welfare State." Politics and Society 34, no.1 (March 2006): 81-106
- . 2007. "We Were the Invisible Workers: Unionizing Home Care." In The Sex of Class: Women Transforming American Labor, edited by Dorothy Sue Cobble, 177-183. Ithaca: ILR Press.
- . Forthcoming. Caring for America: How Home Health Workers Became the New Face of Labor New York: Oxford University Press.
- California State Legislative Analyst's Office. 2007. 2007-08 Analysis of Proposed Budget.
- Delp, Linda and Katie Quan. 2002. "Homecare Worker Organizing in California: An Analysis of a Successful Strategy." Labor Studies Journal 27, no.1: 1-23.
- Heinritz-Canterbury, Janet. 2002. Collaborating to Improve In-Home Supportive Services: Stakeholder Perspectives on California's Public Authorities. New York: Paraprofessional Healthcare Institute.
- Howes, Candace. 2004 "Upgrading California's Home Care Workforce: the impact of political Action and Unionization," *The State of California Labor*, Vol. 4: 71 -105.
- Howes, Candace. 2005 "Living Wages and Retention of Homecare Workers in San Francisco," *Industrial Relations*, Vol. 44, No. 1, 139-163.
- Howes, Candace. 2006. "For Love, Money or Flexibility: Why people choose to work in consumer-directed homecare." Connecticut College, Dept of Economics.
- Howes, Candace. Forthcoming. "Who will care for the women: Medicaid budgets and long term care providers." In Hartmann, Heidi, ed. Women and Retirement Security, New York: Russell Sage Foundation.