

Organizing Home Care: Low-Waged Workers in the Welfare State

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Unionization of home care has depended on the state location of the occupation. Government social policies and funding created home care, shaping the structure of the industry and the conditions of work. The welfare nexus, linking old age, disability, health, and welfare policies, however, also transformed care hidden in the home into a public service. Through case studies of California and Oregon, leaders in deinstitutionalizing care of the elderly and disabled, we explore the social struggles that forced the state to recognize its invisible workforce. The home location of personal attendants and other health aides has entailed not only organizing challenges but policy innovation as well. Using the welfare state location of the labor, workers allied with consumers to develop the public authority as a new structure of representation. The history of home care shows that social welfare and health policy have long been entangled with labor policy.

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Commemorating the death of Martin Luther King Jr. on April 4, 1988, a hundred Los Angeles home care workers marched to demand union recognition. "This is Memphis all over again," civil rights leaders addressed the mostly female and minority crowd. "We are saying again today, 'We are somebody.' We're men and women who deserve to be treated with dignity."¹ For over a decade, all across the nation, these caretakers of the frail elderly and the disabled had been asking for "respect, dignity and an increase in our wages."² They were a hidden workforce, located in the home and confused with both the labor of domestic servants and the care work of wives and mothers.³ After 74,000 entered the Service Employees International Union (SEIU) in 1999, media celebrated these

minimum-waged, predominantly Latina, Black, and immigrant women, who pulled off the largest gain in union membership since the sit-down strikes of the 1930s.⁴ This organizing, however, depended on the welfare state location of the labor—that is, on the prior organizing of home care through law and social policy during the last quarter of the twentieth century.

These front-line care workers enable aged, blind, and disabled individuals to remain in their own homes by performing a range of duties, depending on the needs of clients, such as assisting with personal hygiene, cooking, cleaning, and shopping and helping with medication.⁵ Despite such socially necessary labor, their average hourly wage is lower than that of all other jobs in health care with the exception of janitors. In 2000, hourly rates ranged from \$5.74 to \$10.13, with nearly half at \$7.50 an hour or less.⁶ Workers in nursing homes received 30–60 percent more for identical labor, while the annual earnings of hospital aides and orderlies were 70 percent greater. Thus, despite earning wages, home care workers remain poor, with one-quarter having family incomes below \$10,000 year and a third at the poverty line. Rarely employed full time, they also have lacked health insurance, paid sick leave, paid vacations, or even workers' compensation.⁷ Most have been middle-age women of color or immigrants, though the exact mix of race, ethnicity, and citizenship status has depended on the region of the country.⁸ Both the state and the long-term care industry have shared the presumption that “women would always be willing to provide care and companionship for our loved ones—despite jobs that kept them working but poor.”⁹

Since the 1980s, home care has emerged as one of the fastest growing sectors of the health care industry. It can be secured through public and private social welfare agencies, county welfare departments, Medicare-certified home health agencies, private employment agencies, and independent workers directly hired by clients, or through families. These workers may labor in “private homes” and perhaps for a nongovernmental agency, but in most cases the public sector provides or pays for their services. By the 1990s, Medicaid accounted for 43% of all long-term care expenditures, a percentage that persisted into the next century. While spending for institutional services predominated, government payments made up over half of all monies for home care. Over two million people receive

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home and community-based care through Medicaid.¹⁰ State and local governments additionally have drawn on other federal, state, and county funds. Consequently, government social policies and reimbursement rates directly have shaped the structure of the industry and the terms and conditions of work. Indeed, the contracting out of labor and services by states maximized the uncertainties of the work, the employment status of home care workers, and hence, the service itself.¹¹

The history of home health care allows us to trace how social welfare policy and health policy are entangled with labor policy. Broad transformations in old-age policy occurred as prevailing notions of public assistance began to shift toward fostering wage work. Together the 1962 Public Welfare Amendments, the Older Americans Act, and Medicare/Medicaid established a foundation for a social services labor market within the welfare state. Developments in poverty policy and public assistance both helped to create a low-wage labor force but also, by the 1990s, offered a political opening to transform the conditions and status of such labor. In the broadest sense, then, we argue that state policy and funding created the labor market for home care.

In this article, we first consider the welfare nexus—the connection between disability, old age, and welfare policies—in the national context. While home care exploded as a new occupation, the status of home care workers remained ambiguous in law and social policy. We then chart the process by which particular intersections between health policy and labor policy finally forced the state to recognize its invisible workforce. Our analysis requires state-level case studies, since home care provision varies by locality. We thus look at California and Oregon, two innovative states, to illuminate the political response of consumers and providers of home care.

There are several reasons why we have focused on these two states. Possessing strong county-level governments, California and Oregon had a viable political infrastructure in place to carry out deinstitutionalization of long-term care. Moreover, while most states continued to emphasize institutional care through the 1980s, these were among the few that quickly used federal resources to build and sustain community-based and home-based care. What set them apart? As our case studies reveal, social movements, workers' mobilizations, and welfare-to-work programs appear to be distinguishing factors. Finally, in each state, mobilized workers joined with consumers of care to use the domain of the welfare state to force changes in labor as well as social policy.

Because personal attendants and other health aides have labored in homes, for individual or small employers, performing the work of family members, their struggle for recognition and dignity, for better working conditions and pay, has required unusual creativity. It was not sufficient simply to lobby for augmented welfare state funding; workers and their unions also had to compel innovations in labor law and labor policy. Public sector and health care workers often have turned to political remedies to win bargaining rights.¹² Those who work in homes, at the perpetually clouded boundary of public and private, created a new round of

labor policy innovations, suited to promote the unionization of a growing “flexible” service workforce. The public authority, which made the local or state government into an employer to bargain with, became the mechanism to end the fiction of the home care worker as independent contractor and cut through obfuscations stemming from home care’s place within the welfare state.

THE WELFARE NEXUS

The policy origins of contemporary home care can be found in state-funded domestic or homemaker assistance programs, and thus the work has continued to appear more as domestic service than health care. The New Deal initially sponsored a visiting housekeeper program that paid unemployed women to care for other poor families or households where the primary parent or caretaker was ill or incapacitated. The homemaker-home health aide services that developed in both public and voluntary social agencies in subsequent decades followed this model, specifically intending to send such workers into homes to undertake household chores as well as personal assistance. In the 1960s, as in the 1930s, such jobs were assigned to women on welfare and black and immigrant women of color. In turn, consumers, their families, and health professionals perceived the home care worker as a “cleaning lady.”¹³

This interpellation is hardly surprising; New Deal labor law refused to recognize the home as a workplace. Nurse-companions and other in-home care workers hired directly by clients became classified as domestic servants. Excluded from coverage in 1935, only in 1951 did Social Security cover some domestics. With the second wave of feminism, an alliance of professional women, civil rights activists, and trade unionists fought for amendments that finally in 1974 brought household workers under the Fair Labor Standards Act (FLSA), thereby making them eligible for minimum wage, maximum hours, and overtime compensation. But the 1974 amendments identified home care workers with casual babysitters rather than domestics. Subsequent Wage and Hour regulations actually excluded home care labor from FLSA, even if hired by a third party, like a health care agency. More than sustaining invisibility, this sleight of hand opened the door for localities treating home carers as independent contractors rather than employees, thus denying the status of worker and their own responsibility for working conditions and compensation.¹⁴

By then, the liberal welfare state had connected provision of services for the needy with removing poor women from welfare. Beginning with the Public Welfare Amendments of 1962, federal funds encouraged the states to reduce “dependency” through services—like training, education, childcare, therapy, and personal assistance—promoting “self-support and self-care,” a policy known as “rehabilitation.”¹⁵ The disabled could be “restored to useful and productive lives . . . rather than merely being recipients of cash benefits,” Assistant Secretary of Health, Education, and Welfare (HEW) Roswell Perkins explained, and fami-

lies on welfare—who increasingly were never married, divorced, and minority—could become independent through maternal employment; that is, they could keep “other needy people . . . from living in an institution.”¹⁶ Under the War on Poverty, the Office of Economic Opportunity (OEO) supported training projects to meet labor shortages in service occupations, particularly health and child aides, home attendants, and homemaker aides.¹⁷ Workfare amendments to Aid to Families with Dependent Children (AFDC), intensifying after the Work Incentive Program (WIN) of 1967, offered a labor force.¹⁸

The War on Poverty incorporated the elderly through the Older Americans Act of 1965 (OAA); the newly created Administration on Aging (AOA) distributed grants directly to state governments. Local Units on Aging would identify and coordinate services that might help elderly persons with transportation, housing, legal advocacy, recreation, or cultural activities. “Independence” became defined not through income or economic security, but through access to services in the community.¹⁹ Such sweeping rhetorical goals, however, were only minimally funded.²⁰

1965 amendments to Social Security, establishing Medicare and Medicaid under Title XIX, were particularly important in shaping home care. Medicare, available to those who had paid into old-age insurance, created a medicalized definition, since only a physician or other health professional could authorize part-time in-home services, such as skilled nursing or physical therapy, following hospitalization.²¹ Medicaid, in contrast, introduced an antipoverty service strategy into long-term care. For those identified as “functionally disabled elderly individuals,” this program offered medical assistance through community health or welfare agencies. Physicians could prescribe in-home health services to those eligible for nursing homes. For indigent and low-income elders, Medicaid handed the states a funding stream for support services, such as homemakers, personal attendants, and choremakers.²²

The availability of public reimbursement under Title XIX and the requirement that a licensed group deliver in-home services quickly led to the formation of local home health agencies. Public welfare or health departments organized separate programs, while nonprofits and a handful of for-profit proprietary agencies developed to carry out the new social service mandates of the welfare state. After 1967, public welfare agencies could purchase services from private sources. Social services grants—made available by the 1967 Social Security amendments—quadrupled between 1969 and 1972, with California receiving a disproportionate share (25 percent) of all funding. Oregon also spent these grants at several times the national rate.²³

Certification required home care agencies to have skilled nurses and therapists on staff, but custodial and daily support services generated the significant boom in labor demand. With Medicare and Medicaid, “personal care” entered into the definition of homemaker services, with a single person, the “homemaker-home

health aide," available for both tasks.²⁴ Despite calls for employee or civil service status, "a living wage," and differentiation from "domestic service," classification of homemaker labor as social, not medical, undermined attempts at occupational upgrading.²⁵

Under Nixon's new federalism, state and local governments gained more discretion over such public grants. Amendments to the OAA in 1973 established Area Agencies on Aging (AAAs) as vehicles that would plan, coordinate, and implement programs for older persons in the community. Decentralization would generate an accessible, visible public institution around which elders could organize and mobilize demands. But services increasingly became privatized. Forbidden from direct service provision, AAAs established "contractual arrangements with public and private non-profit agencies."²⁶ While the federal government would pay cash assistance for the disabled and elderly, the states had to finance 90 percent of the social services for public assistance recipients, deinstitutionalize elder and disability care, and expand allotments for homemaker and chore services.²⁷

Since social services funds under recent public welfare amendments had no annual ceiling, local and state governments continued to apply for federal grants. Shifting discretion to the states thus failed to achieve fiscal reductions, leading Nixon and HEW to fund only services that led to "self-support" and "self-sufficiency." As the politics of budget control hardened in the mid-1970s, the goal of ending dependency became explicitly hitched to cost cutting and devolution. Further ceilings came with Title XX of Social Security in 1974, which consolidated federal social services. The states could choose what services to offer, where, how, and to whom, as long as they were targeted at elimination of dependency, including replacing institutional care with community-based or home care. For states that had been using their entire federal allotment, Title XX offered no new funding. Thus new services meant removing existing ones. This hit California and New York, the other major receiver of funds, particularly hard.²⁸

The Reagan administration sharpened these imperatives. It turned Title XX into a general block grant, with an overall lower appropriation, for the states to use as they wished for deinstitutionalization and self-sufficiency. This did not automatically initiate a major move toward home and community-based care because Medicaid, which during the previous decade unexpectedly had become the major source of funding for nursing homes, guaranteed an unlimited federal match. Most states would not begin significant deinstitutionalization until the fiscal crunch of the mid-1980s.²⁹

States still faced constraints. Funding sources were woefully inadequate in the context of growing elderly populations, increased life spans, and more women in the labor force unavailable for unpaid carework. With less than a third of OAA funds actually available for services, states turned to "demonstration projects," as the New Deal and OEO had done before them. From the mid-1970s to the mid-1980s, such small-scale and limited projects allowed the states to patch together

monies from OAA, Title XX, the Health Care Financing Administration (which ran Medicaid), and AFDC to lay institutional foundations for the shift to home care within the community.³⁰

As policy makers sought to promote community-based care, they eased reimbursement rules and deregulated entry into the home health market. After 1976, the home health care sector entered a phase of significant growth that has continued unabated. The number of agencies certified to deliver Medicare or Medicaid home health services rose from about 2,000 in the mid-1970s to approximately 6,000 by 1986, and Medicare reimbursements tripled. Also proliferating were unlicensed agencies that contracted with certified ones to provide homemaker and personal care services. By the time Title XX funds arrived, subcontractors offering only homemaker, chore, and personal care services composed over 25 percent of all agencies. With this growth, the home health sector became the home health industry. For-profit proprietary home care agencies, about fifty prior to Title XX, jumped tenfold in the first half of the eighties, capturing 30 percent of the market by 1986. Visiting Nurse Associations simultaneously declined. The number of paid homemaker, personal care attendant, and home health aide positions had grown from under 2,000 positions in 1958 to 60,000 in 1975, to over 350,000 in the late 1980s. This did not include many of the aides employed as independent providers. The whole enterprise depended on expanding their numbers: without an aide helping with daily living, most clients could not remain at home.³¹

As the industry grew, policy makers, welfare advocates, and county administrators still viewed the welfare poor as a reserve pool of labor, especially for those tasks most closely resembling domestic chores. Parallel to, and sometimes even bound up with the demonstration projects in long-term care, were "demonstration" projects for moving welfare recipients into wage work. Drawing on OEO and WIN precedents, local and county governments, nonprofit health and welfare groups, and community service organizations secured federal grants to "experiment" with placing welfare recipients and the unemployed in home health care jobs. Typically Leah Glass of the State Communities Aid Association, which ran one such project in New York City, proposed "to prepare the workers for the unsubsidized job market." Her nonprofit agency organized a consortium of six home care providers that applied to train welfare recipients as homemaker and home care attendants who subsequently would work for the six agencies. These providers took their cue from President Carter, who had announced his Better Jobs and Income Act in 1977, promising 4,000,000 jobs, including 200,000 in elder home care, for employable welfare recipients. This New York City project created a modest number of entry-level positions, 275 in all. While evaluators praised the "training," participants described the labor as "helping clients with personal hygiene" and with moving about or "cleaning" the house and helping "with shopping."³² Again poor women found themselves slotted for minimum-waged domestic labor.

Although allegedly entering the health care field, these women were kept on the bottom rung of a hierarchy defined as much by the professionalization agenda of nurses as by race, ethnicity, and class. For much of the twentieth century, registered nurses had maintained labor control through training schools and state boards. The latter regulated licensing, staffing, specialty certification, and standards of practice. Attempts during the late 1970s and 1980s to contain rising health care costs, rationalize the health care industry, and change Medicare policy challenged nurses' control over direct care. In 1983, for example, Medicare's new prospective payment system impelled hospitals to discharge patients earlier than before, so not only was there greater reliance on home care and outpatient services, but patients came home sicker and weaker. Nurses feared that cost-cutting behind these shifts also would fuel deskilling and casualization, with "nurses' aides . . . performing an increasing amount of" their care work. As Medicare and Medicaid tightened reimbursements in the 1980s, home health agencies sought to preserve their profit margins by substituting low-skilled, low-paid, and part-time employees to perform some jobs previously done by highly skilled, better-paid ones. State departments of health began allowing any kind of facility, including home health agencies, to train and certify aides. Nurses responded by asserting jurisdictional prerogatives, insisting that "nurses need to reclaim nurses' aides as members of the profession's hierarchy" and strengthen, as Susan Reinhard of Rutgers' College of Nursing argued, their "chain of command."³³

Nurses included within their "chain" aides and personal care attendants to distinguish such laborers from skilled nursing. They prohibited aides, for example, from operating the high-tech equipment then entering homes just as they earlier had taken away the giving of injections.³⁴ Where state nursing regulatory boards won jurisdictional control of aide and home care certification, they designated the aide's work as domestic. Thus, even after the North Carolina Board of Nursing created a "nurses aide I" category and a formal registry, the labor remained so poorly remunerated that most of those certified eventually left for restaurants, retail sales, and manufacturing. Indeed, Oregon and North Carolina continued to classify home care workers as domestic workers outside state employment law, locking in their inclusion at the very bottom of the nursing hierarchy.³⁵

TRANSFORMING LABOR LAW: THE CALIFORNIA CASE STUDY

California became a recognized leader in consumer-directed home care services, but only after a political struggle that involved a coalition of unions, seniors, and the disabled. From the start, the state had one of the largest home care caseloads from a combination of demographic and political factors, including a large elderly population and a robust social movement of the disabled that created Centers for Independent Living in the 1970s. It was well poised, as we have argued, to take advantage of federal funding. Its solution to the ambig-

ous status of the workforce became the public authority, an old form used for new purposes.³⁶

Created in 1973, In-Home Supportive Services (IHSS) developed out of previous attendant and homemaker/chore programs that often sought to employ those on welfare to care for others on public assistance. Over the years the program experienced underfunding (from state, federal, and county sources) relative to the demand, uneven administration, local financial shortfalls, and bureaucratic red tape. Charges of fraud and abuse periodically accompanied calls for reorganization. With the poor elderly and disabled as its clients, and a minimum-wage workforce, Republican governors especially attempted to balance budgets by cutting appropriations, despite the fact that those eligible were entitled to the service.³⁷

Trying to provide “on the cheap” exacerbated the already confused employment status of the workforce. County attempts to have other levels of government pay for the service joined with denials of employer responsibility. Beginning in 1960, under the state attendant care program for severely disabled persons on public assistance, the consumer of services—the client—acted as the employer. After social workers assessed their needs and ability to supervise aides, consumers received state monies to pay for attendants. When funding and levels of expenditures increased in the mid-1970s, attendants earned enough to qualify for Social Security, but consumers lacked the income to pay the employer share of taxes, as mandated by the California Department of Social Welfare.³⁸

The fiction nevertheless developed that the home aide was an independent contractor working for the consumer/client. After passage of MediCal, California’s equivalent of Medicaid, in 1966, home health aides joined homemakers and attendant care workers among the services offered to the poor. The expectation was that the MediCal would cover most attendant care cases, displacing costs to the federal level. Meanwhile, while the legislature directed the State Department of Social Welfare to recruit and train women on AFDC for home care, county welfare departments in 1969 gained the ability to contract with proprietary as well as voluntary agencies to provide services. Such contracts specified that for-profit contractors give preference to welfare recipients. Still, certain conditions encouraged the retention of individual providers, such as isolated location, relative availability, or a preexisting long-term caregiver relationship. In 1973, with IHSS, the method of reimbursement changed again when the state paid the home care provider rather than their clients, most of who continued to hire attendants directly.³⁹ Rarely were deductions taken for Social Security or taxes, since such payments came out of the overall IHSS appropriation, indirectly lessening the number of care hours funded.⁴⁰

Under IHSS, counties could organize the service in one of three ways. The Individual Provider or IP mode emphasized consumer direction. Under this option, the consumer hired, trained, supervised, and terminated the attendant and

the worker was considered an independent contractor. While this option met demands of independent living activists to control their own care, it obscured the role of government in service provision since the state cut the check and issued payment of an hourly wage to providers of care, the County Department of Social Services ran the program and its social workers allocated hours. But not all consumers were capable of acting like employers. Other options more clearly defined the employment relationship. Under the County mode, the care provider became a government employee, but most counties, concerned with keeping costs down, hired few workers directly. With the Contract mode, the county contracted with a for-profit or nonprofit company, which became the employer.⁴¹

Disability rights activists wanted more control over their arrangements; others wanted to hire family members, which was more difficult to do when having to go through a contractor. Counties sometimes reimbursed relatives only for tasks beyond expected routines and sometimes they would pay only relatives who left other employment to engage in home care. Investigating one minimum-waged rural county, the Western Center on Law and Poverty found that "when the worker came to the premises and saw what had to be done, she put in extra hours which would lower her low minimum wage even worse."⁴² Contractors thus took advantage of the relational and intimate nature of carework, which rarely could be dropped in the middle of a task just because compensated time ran out.⁴³

Located in isolated homes, IHSS workers had no mechanism to bring themselves together to challenge the conditions of their labor. Defining this labor became crucial to who would organize this workforce. Were they public sector employees and therefore under the jurisdiction of a union such as AFSCME (American Federation of State, County, and Municipal Employees)? Were they domestic service workers, thus the constituency of United Domestic Workers of America (UDW), or movements of household employees? Did they belong to the service workforce, rapidly being organized by the growing SEIU in commercial and non-profit sectors? Policy changes, especially Medicare and its subsequent amendments, had pushed home attendants and aides into the expanding health care sector, and so some unions began to see them as health care workers. Indeed, given both the structural ambiguities and the blurred nature of the labor itself, union activists spent well over a decade experimenting with organizing strategies, navigating the shifting legal terrain and modes of service delivery, and competing with each other to define a viable unionism for home care. In every case, no matter the union, organizers found their task complicated by the service provider–client relationship, not just by the worker–boss relationship—particularly in California, where consumers were already well organized themselves. To succeed, unionization of home care workers would have to rally all those impacted by the welfare nexus and create a viable base of employment within the state itself. Union strategy hinged on emphasizing the welfare state location of IHSS labor.⁴⁴

The San Diego–based UDW, now affiliated with AFSCME, initially promoted contract home care. Founded under the influence of Cesar Chavez, this black and

Latino union discovered in home care providers a type of domestic worker they could locate. SEIU had been engaged with organizing health care workers in more traditional workplaces and saw the expanding home care labor force a logical extension of its activity. Both SEIU and AFSCME had benefited from earlier changes in labor law that facilitated public sector unionism, while SEIU mobilized immigrant workers through direct action militancy. UDW began to focus on the county contracts with proprietary firms; such contracting concentrated the workforce, facilitating organization and providing a terrain of struggle. In April 1980 UDW blocked the San Diego County Board of Supervisors from awarding the IHSS contract to a firm that “promised no improvements” in wages or working conditions.⁴⁵ Instead, San Diego gave its \$7.2 million contract to Remedy Home and Health Care Corporation, which signed a union agreement two months later, covering over 2,000 attendants. Workers gained a small hourly raise, paid vacation, sick leave, and their own health plan as well as a grievance procedure system and union security.⁴⁶ Nearly a decade later, Remedy would be the site of a Ford Foundation demonstration project on improving the conditions of home care workers. Guaranteed hours, subsidized health insurance, and increased training, this project revealed, facilitated worker retention. But soon afterward, the county moved its contract to a lower bidder.⁴⁷ UDW, however, became committed to the county mode of service delivery, which also put the union in the position of supporting privatized corporate management of IHSS. Through the California In-Home Care Council, UDW worked closely with contractors. This collusion did not sit well with prominent consumer groups, deeply opposed to the contract mode.

In other parts of the state, SEIU locals chose a different tack: they sought to reach the more numerous independent providers. This focus entailed the additional legal challenge of defining the employment relationship. The Ninth Circuit court in 1983 held the state and counties liable for purposes of the FLSA—that is, for wage and hour regulations. For the Department of Social Services and county welfare agencies “controlled the rate and method payment, and . . . maintained employment records.” Particularly important was their assignment of hours, even though consumers supervised home workers on a day-by-day basis. The court noted that “these services have been traditionally performed by domestic employees in the private sector,” but as a federally funded and regulated program, administered by the state, home care was not immune from FLSA.⁴⁸ Similarly, the California Court of Appeal two years later said of the direct payment option, in which the county gave funds to the recipient, that the county’s “*sufficient control* over the IHSS provider” made the State an employer.⁴⁹

In 1985, California’s attorney general determined that IHSS attendants came under state workers’ compensation and other labor laws. “For purposes of collective bargaining . . . the IHSS workers (under the IP mode) may be considered the employees of the counties,” but not of the state because they were not civil service employees. This ruling worried counties, which sought to end liability by con-

tracting out services. SEIU Local 250, in fact, had joined with UDW to push for legislation favoring the contract mode. It convinced San Francisco County to move all of its caseload to the unionized Remedy over a three-year period. In this situation, support of community groups dissatisfied with the IP mode was crucial.⁵⁰ By 1987, when SEIU began its "massive campaign" to organize home care in Los Angeles, in which it poured \$285,000 for nine months in 1988 alone and hired over twenty full-time workers, legal rulings existed that claimed government as the employer of IHSS workers, rather than the thousands of program recipients.⁵¹

Yet SEIU's Los Angeles Homecare Organizing Committee faced a number of hurdles, including which "employer definition . . . suits our organizing needs." Primarily it had to identify the workers. Elsewhere it had obtained lists of names "through co-opting an inside source of the targeted company" or it had circulated a petition on "a popular issue (e.g., minimum-wage increase)" at the site where workers picked up paychecks. In Los Angeles, it planned to use its members in other government employee locals: caseworkers could get names from microfiche, and data and payroll processors could compile a list, while other county contacts could pilfer the program's "referral list." So, even when counties formally refused to hand over the names of workers, the sectoral strength of SEIU provided alternative routes.⁵² That social workers and home care workers belonged to the same union, although usually in separate locals, proved a benefit for organizing. This advantage UDW used to attack the ability of SEIU to truly represent the best interest of attendants, since social workers supervised them, in contrast to its unitary focus on home care.⁵³

Los Angeles County initially opted for designating itself as the employer. SEIU built a citywide organizing committee through home visits and direct mail, trying in the mid-1980s to reach 40,000 attendants, whose numbers kept on growing even as individuals dropped out of the work. Based on its experience in Boston and Chicago, it believed on-the-ground organizing would look like a political canvass. No matter if the employer was public or private, organizers concluded "that the more the organizing is based on public events and grounded in public issues, the better our chances of winning and the stronger the organization will be at the other end."⁵⁴

This strategizing assumed that the employer question soon would "be resolved in ways that will allow for successful organizing."⁵⁵ SEIU launched its campaign in October 1987, but by December was requesting the courts to determine whether in fact Los Angeles County was the employer under the Meyers-Milias-Brown Act, the law governing collective bargaining for government employees. Apparently the Deputy Director of Labor Relations Services had advised that Los Angeles County reject this reasoning. The union argued that if the county was not the employer, IHSS workers would have "no legally-sanctioned opportunity for collective representation." They did not meet the requirements for state employees and the National Labor Relations Act excluded those "in the domestic

service of any family or person at his home” from the definition of “employee,” thus make it impossible to have recipients serve as employers for collective bargaining—even if that was logistically possible.⁵⁶ As International President John Sweeney told a rally of 1,500 home care workers in 1988, “When these officials won’t even acknowledge they are your employer, they bring dishonor on this county,” especially since “if it were not for you, 83 percent of your clients would have to be placed in an institution at an astronomical financial cost.”⁵⁷

When the State Court of Appeals ruled two years later, the union met legal defeat. In *Service Employees International Union, Local 434 v. County of Los Angeles*, the court found IHSS workers to be “independent contractors” because the counties did not control their activities on the job. Yet, as SEIU later argued in defense of the public authorities, “Even under a common law test, these unskilled workers, with no capital, who have their tasks detailed in work plans specifying the number of minutes they may spend on each task, and who are paid an hourly wage—are not independent contractors, but employees jointly employed by the recipients and the public authorities.”⁵⁸

Los Angeles County would not negotiate with the union because it claimed that it was not the employer. But neither was the state Department of Social Services, the IHSS program, MediCal, or individual clients. This uncertain legal status led SEIU to develop the public authority, for someone to bargain with, as the state already had granted voluntary dues check off, thus providing a stable financial base for future campaigns.⁵⁹ By Fall 1990, a task force within the union, led by its chief representative in Sacramento Maury Kealey and with UCLA Law Professor Craig Becker, began sketching the contours of such an authority, its legal basis and political effectiveness. SEIU envisioned that representatives from the local area and disability entities would have seats on the authority’s advisory committee. Equally important for the disabled community, recipients would “retain the authority to hire, fire, and direct the personnel.” In crafting the legislation, SEIU sought to place IHSS workers within the meaning of public employee without defining them as civil servants both to maximize flexibility for bargaining and ease enactment.⁶⁰

SEIU’s chief lobbyist then joined with others from organized groups of seniors and the disabled to spearhead the effort to amend the state welfare code governing IHSS. The California Senior Legislature went on record for the public authority concept in 1991, the year when the union initially tried to have its bill passed as a rider to the state budget. In the midst of proposed cuts by Governor Pete Wilson and public outcry over elder abuse and fraud documented by the Little Hoover Commission, in 1992 the legislature permitted counties to develop authorities. The next year Assemblywoman Gwen Moore (D-Los Angeles), whose election the union had supported, introduced further legislation that saved IHSS from a 12 percent reduction by transferring some services to Medicaid’s personal care option. Other amendments provided start-up funds for the authorities. Alameda, San Francisco, and other Bay Area counties immediately created mechanisms to

reclassify home care workers as employees; Los Angeles only followed after a five-year struggle. This legal change, gained from political lobbying by the union, the Congress of California Seniors, the California Senior Assembly, the California Foundation of Independent Living Centers, and various local disability groups and commissions, created an employer to bargain with—as well as a central registry to locate the home care workforce. At least half of the members of the authorities were mandated to be current or past IHSS recipients.⁶¹

The union alliance with disability activists was not necessarily a natural one. The union had approached the Oakland-based World Institute on Disability, an activist think tank, as early as 1986. The Institute's 1987 report, "Attending to America: Personal Assistance for Independent Living," had endorsed unionization to enhance attendant wages. The organized independent living centers by the summer of 1992 agreed to support collective bargaining for the union if disabled people would retain consumer control over the authorities. Indeed, the centers and the union apparently shared the same lobbyist for a time. This cooperation came out of an informal group that worked closely together in Sacramento on legislative issues.⁶² Even though SEIU gained credit for opposing an attempted managed care "takeover" of attendant programs, other militant activists feared that the interests between the two groups conflicted and subsequently sought to slow down implementation of the authorities, especially in Los Angeles.⁶³

In 2000, the legislature provided additional monies for pay raises and training, while mandating that all counties establish public authorities by 2003. This followed the U.S. Supreme Court's *Olmstead* Decision, which upheld community-based treatment over institutionalization under the Americans with Disability Act.⁶⁴ Mobilization to pass these laws has helped to organize workers; in turn, these political victories provided institutional spaces for union organizing. As public sector employees, then, IHSS workers have found collective bargaining projected into the political arena.⁶⁵ By 2005, some 360,000 people received IHSS monthly, costing \$3 billion annually.⁶⁶

Despite this new recognition, most IHSS workers still earn less than a livable wage (though the unions have increased wages into the \$8 per hour range.) IHSS worker Amanda Figueroa explained their plight before the Los Angeles County Board of Supervisors in March 2001 "as that of a 'ping-pong ball,' tossed between the state and county with neither willing to accept fiscal responsibility for wage increases or benefit coverage," as labor educators Linda Delp and Katie Quan observe.⁶⁷ Before Los Angeles County raised wages in 2004, SEIU Local 434B only could deliver on services for members, such as aid with immigration issues, housing, health care, and training. UDW long had run food banks and training centers. Dignity depended, then, on legislative victories. But, after the gubernatorial recall of union supporter Gray Davis in 2003, the political terrain became newly perilous with Republican Governor Arnold Schwarzenegger yearly proposing cutbacks.

SEIU and UDW also decided to end their rivalry. Plagued by jurisdictional disputes throughout the 1990s, the two unions agreed to divide up the counties so that only one would work in a given location. They formed the California Homecare Council in 2000 as a joint lobbying and organizing effort.⁶⁸ But, with SEIU leaving the AFL-CIO and AFSCME putting UDW into receivership for diverting dues to SEIU, among other charges, raiding each other began again during the summer of 2005. In late September, however, AFSCME and SEIU entered into a two-year pact, agreeing to form the California United Homecare Workers Union, to be affiliated with both, while maintaining their existing jurisdictions. The new entity would organize the twenty-six mostly rural counties that lacked bargaining agreements. Some viewed this as a first step toward one home care union in California.⁶⁹

THE OREGON MODEL: OLD AGE MOVEMENTS AND WORKER RIGHTS

In contemporary policy discussions, Oregon appears as a pioneering state in long-term care policy, spending more on home and community-based care and far less on nursing homes. Since 1981, the state deliberately has used federal and state funds to develop alternatives to institutionalization, which it officially declared as an option of last resort. This commitment extended even to those who lack economic resources. Oregon currently spends 73 percent of its Medicaid long-term care budget on home care. According to proponents, the "Oregon Model" began when the state became the first to apply for a Medicaid Home and Community-Based Services waiver in 1981—a strategy subsequently followed by just about every other state in the nation.⁷⁰ This starting point, however, ignores the evolving history of the service provider state and its links to constituencies of consumers and workers.

Oregon's home and community-based programs also originated in homemaker and chore services. In response to the 1962 Public Welfare Amendments, counties, like populous Multnomah and Lane, implemented homemaker services with the express goal of "helping elderly persons live in their own homes instead of institutions."⁷¹ After 1965, public agencies also drew on OAA funds to reach several thousand recipients. Even private organizations, such as the Portland-area Kaiser Permanente Health Plan, applied for a Public Health Service grant to train "home health aides."⁷² Oregonians also formed viable AAAs at the county level to deliver home and community center meals to elderly Japanese, Jews, Hispanics, and Native Americans. Senior centers provided legal counseling, shopping assistance, and chore and homemaker services.⁷³ The state's Office of Elderly Affairs, however, was small, underfunded, and ineffectual. As the decade wore on, an extraordinarily high percentage of elders were institutionalized.

Frustrated seniors began organizing through OAA centers and AAAs, demanding that policy makers curb this nursing home expansion, where caseloads had grown at twice the rate of population for those over age seventy-five. The leg-

islature responded with a Special Committee on Aging in 1973, which toured the state to hear out the seniors. To its surprise, the Committee found seniors incredibly well mobilized at the community level, knowledgeable with "their own lists of bills" and prepared to lobby. Seniors urged the Committee to recognize that many were institutionalized unnecessarily and in-home services were a viable option.⁷⁴ Out of this initiative came Oregon Project Independence (OPI), enacted in 1975 as Title XX funds became available, which provided people over sixty with a modest amount of housekeeping, bathing assistance, meal preparation, and personal care. It covered low-income seniors not on Medicaid through a sliding fee schedule.

Two years later, activists kept their movement going by forming the United Seniors Cooperative. This brought together the Gray Panthers, Retired Teachers' Association, NOW's Older Women's Task Force, National Council of Senior Citizens in Salem, AAA volunteers, retired union members, and retired government staffers. With economic recession, United Seniors' political demands for aging in place and reduced reliance on nursing homes started to look fiscally attractive. Certainly, OPI was cheaper than nursing home confinement since it depended on both low-paid workers and volunteers subsidized by the OAA. AAAs and senior centers further relied on private and charitable donations to fund services. Lacking the institutional and financial capacity to develop these services more systematically, in the late 1970s Oregon obtained two demonstration project grants from the federal government to run "experiments" in community-based care in four counties. With this seed money, the state Medicaid office tried to consolidate services run out of welfare departments, health departments, AAAs, and senior centers. While the demonstration project did nothing to lessen poverty among either elderly women or workers, it apparently proved that community-based care offered tremendous savings over nursing homes.⁷⁵

Based on these findings, the Department of Human Resources (DHR) proposed a new state-level division consolidating the Office of Elderly Affairs, Medicaid, Welfare, Adult and Family Services, and the Senior Employment Division. Not only was United Seniors excluded entirely from this planning process but also the proposal called for limiting the autonomy and activity of the AAAs. The irate seniors went straight to the Governor, who quickly handed the proposal over to them for revision.⁷⁶

The infrastructure of the social service welfare state became their political base of power. Through open, participatory meetings at senior centers and AAAs, continuous lobbying of legislators, and conferences with DHR, the old-age movement developed the Oregon Plan. During 1981, AAA captains led the lobbying effort and, by the end of the summer, the legislature passed two landmark bills. The first established a new state agency, the Oregon Senior Services Division, combining all funding streams. The second, the State Policy on Aging, called for the state to support elders in the least restrictive setting possible and to reserve

nursing homes as the placement of last resort. The State Policy would maximize in-home, community-based, self-care, and independent living to promote "independence, dignity, privacy, and appreciation of individuality." To avoid a simple privatization measure, it required cost savings be reinvested into community-based care. New applicants would be diverted into community alternatives, while nursing home residents capable of living elsewhere would be relocated.⁷⁷ As Lela Humiston, chair of an AAA citizens' advisory committee, testified, "Oregon's elderly have made clear their preference . . . Seniors were very much involved in the articulation of that policy."⁷⁸

Oregon then applied to HEW for the first Medicaid Home and Community-Based waiver in order to fund a wide variety of alternatives to nursing homes. AAAs, the seniors' community base of power, became the single point of entry at the local level for all recipients of government-sponsored care. Home care became a right; while relying on the same eligibility criteria as nursing homes, there would be no waiting list and anyone who applied and met the criteria would be enrolled. The majority of relocated clients, however, had no home to return to and could not live alone. Thus a new institution, the adult foster home, emerged to meet this need. Proprietors could develop a supervised living situation for up to five elderly persons in a private home. These proliferated rapidly throughout the 1980s.⁷⁹

For those who could stay home, the state offered two possibilities, both based on welfare state contracting. AAAs could contract with service providers, such as home care agencies licensed by the Senior Services Division (after 1989, Senior and Disabled Services Division). Oregon also established the "client-employed providers" system similar to California's IP mode in terms of client authority to hire, supervise, and fire. But here attendants had to turn in a voucher to the state to receive their pay. As with OPI, which continued serving low-income non-Medicaid clients, the state categorized the work as housekeeping or homemaker services. These caregivers, then, stood doubly outside the law. Despite receiving wages from the state, they were independent contractors, not state employees. Further, the state wage and hour code, following FLSA, and workers' compensation both exempted child care providers who worked in homes, domestic workers, and "companions to the elderly or disabled," with companionship services defined to include "fellowship, care, and protection" and "household work related to the care of the elderly or infirm person such as meal preparation, bed making, washing of clothes and other similar services."⁸⁰ In other words, the labor law exempted precisely those services the state had agreed to compensate through its long-term care policy. These labor laws also excluded resident managers and caregivers in adult foster homes. Not surprisingly, while demand for services rose dramatically throughout the next decade, the numbers of workers did not.

By the end of the 1980s, the state and the AAAs faced troubling labor shortages and high turnover rates. In 1989 the Oregon Association of Area Agencies on

Aging and the DHR secured a demonstration grant to focus on labor issues related to home care services. Proudly billed as “Who Will Care? A Model Collaborative Project,” fourteen counties launched “mini-projects” aimed at recruiting and retaining long-term care workers, increasing their “self-esteem,” standardizing “training,” and reducing turnover.⁸¹ Counties embraced these projects rather enthusiastically and generated a classic range of welfare capitalist and public relations remedies. Columbia County produced an “in-home care workbook,” while Malheur sponsored a public education campaign with “Careers in Caring” public service announcements. Several counties instituted the classic employee recognition ritual. These included years-of-service pins, special name tags, awards for meritorious service, training completion certificates, and, at the end, a statewide “employee of the year” luncheon. Final reports, which mostly boasted of success, made no mention of wages, health insurance, immigrant support services, labor policy, or political solutions—remedies that may have enabled low-wage workers to become more economically “independent.” All the emphasis was on the “caring” nature of the job but none on the employment aspect of it. Indeed, as if to devalue the labor even more, the Central Oregon Council on Aging established a volunteer program with unpaid students providing in-home care.⁸²

Unsurprisingly, the terms, conditions, and valuing of the labor remained unchanged in the 1990s. But now the workers got organized to change the situation. Demand for the services continued to rise, but the state held a lid on compensation. Some counties and agencies developed graduated career ladders, with titles such as “Care Provider I” and “Care Provider II,” but a worker continued to make the same low wage unprotected by labor law.⁸³ Other county AAAs sought federal job training programs, including Job Training Partnership Act funds, to push welfare recipients into homemaker jobs, but workers stayed poor. Buoyed by momentum in California, SEIU in 1997 formally launched a campaign among home care workers in Oregon.

Again the public sector provided an arena for struggle. SEIU organizers from Local 503, Oregon Public Employees Union, convinced the governor’s office to give them the names and addresses of all “independent contractors” providing state-funded home care services. Organizers and home care workers made 22,000 house visits over the next four years, attempting to reach the approximately 13,000 workers paid by the state of Oregon. Yet the problem still remained of whom the union would bargain with even if the employees were organized. Here, the union developed a shrewd innovation. They decided to push for a ballot referendum that would establish a state-level Home Care Commission, one public authority for all home care workers. In Fall 2000, Measure 99 appeared on the Oregon ballot. This constitutional amendment called not only for the establishment of a Home Care Commission, with members appointed by the Governor, but specifically stated that “home care workers would have the right to form, join, and participate in the activities of labor organizations of their own choosing for the purpose of representation and collective bargaining with the commission . . .” and

that “home care workers could have public employees’ collective bargaining rights, [including] mediation and interest arbitration.” Finally, it made no bones about the nature of the work: “home care workers provide in-home services, including but not limited to housecleaning, shopping, meal preparation . . . personal care.” The state would formally recognize care work as employment. Measure 99 included a stipulation that while these workers would not be employees of the state of Oregon, it must pay unemployment insurance.⁸⁴ The amendment passed in November with 63 percent of the vote, creating a distinct innovation in labor policy. “It was the first time that collective bargaining rights were extended through a ballot measure,” said Steven Ward, Local 503’s organizing director.⁸⁵

The struggle was by no means complete, however. The voters may have expressed their will but the money still had to come from the state. This meant that yet another political campaign had to be launched—to convince the Republican legislature to appropriate funds for the new Home Care Commission. This time home care workers teamed up with disability activists and seniors groups to lobby legislators, district by district. Delegations of workers and the disabled visited every legislator in their home districts and the capitol. They organized thousands more to send letters. “It was so exciting,” said Karen Thompson, a worker who became president of the home care sublocal. “We got to pour out our stories. We weren’t isolated anymore.” The vote to approve funding was unanimous in the House and overwhelming in the Senate.⁸⁶ The legislature would recognize new employment rights for those who took care of others.

At the end of 2001, the organized workers got their union too. Through a state labor board election, home care workers won what *Northwest Labor Press* called the “largest public sector union victory in Oregon history.” 12,000 new members joined SEIU Local 503, forming Home Care Workers 99. The union has organized mainly the state-paid independent providers who serve Medicaid and OPI clients and not those in adult foster homes, assisted living facilities, or private agencies.⁸⁷ According to organizer Karla Spence, the membership is 85 percent female, with an average age of forty-seven. Several hundred are Russian and Romanian; many are of Asian descent. Enough of them are living at the poverty level that over a quarter were enrolled in the Oregon Health Insurance Plan. With initial bargaining in 2002, demands centered on designating the work formal employment. So in a state that helped launch antitax revolts, home care workers held a huge Tax Day Rally on April 15 to demand state and federal taxes be withheld from their paychecks. Subsequently, in its first year the union won inclusion in workers’ compensation, with the Home Care Commission paying the premium, paid leave, health and safety equipment provided by the state, a miniscule pay raise, and some of the things “employees” take for granted, like tax withholding, travel mileage reimbursement, and direct deposit. In 2004, the union won the Homecare Union Benefits Board, which offered health insurance to those who worked eighty hours a month for two consecutive months. The union continued to struggle for further wage raises and against cuts to clients.⁸⁸

CONCLUSION

The broad trends in old-age policy from the 1960s through the 1990s led to policies that fostered the creation of new occupations, funded by the state, and new opportunities for union organizing by formerly invisible workers. Not only did unions become active supporters of increased social spending, given that they had organized a labor market created within the welfare state; clients/consumers and workers, the two constituents of the service provider state, now seem joined in the same political struggle. "Twenty years of being unrecognized, underpaid, with no benefits, essentially an invisible workforce, has many of us frustrated and searching for solutions," said Herk Mertens, a home care worker in Waldport, Oregon. "I honestly feel the union is the only way home care workers and our clients have the ability to be visible."⁸⁹ The process of struggle—as well as the progress to date—has transformed the consciousness of care workers, along with recognizing the value of the work (even if the pay remains inadequate.) In these states, home care workers gave up the status of "independent contractors" in order to shake off the dependence of low-wage work that lacked the protections of labor law and the social recognition normally accorded to wage work in American society. A union staffer put it best when explaining, "The discrimination, the political and economic abuses facing both minimum wage workers and the most disadvantaged people in our society—the elderly and disabled—this created a bond, a human, sensitive relationship that developed between the workers and clients."⁹⁰ Their coalition offers a new path for envisioning the home as a place with dignity for workers and families.

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2. Charisse Jones, "Providers of Home Care in Budget Pinch," *Los Angeles Times*, March 22, 1989.

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6. Table D-3, "Personal and Home Care Aides Employment and Wages in 2000 by Industry Group," in National Center for Health Workforce Analyses, Bureau of Health Professions, Health Resources & Services Administration, *Nursing Aides, Home Health Aides, and Related Health Care Occupations: National and Local Workforce Shortages and Associated Data Needs*, February 2004, 92, available at <http://bhpr.hrsa.gov/healthworkforce/reports/nursinghomeaid/nursinghome.htm> (accessed October 9, 2005). Compare this with nursing aides, orderlies, and attendants whose average was over a dollar more, 91.

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11. Burbridge, "The Labor Market for Home Care Workers," 41, 44; Margaret MacAdam, "Home Care Reimbursement and Effects on Personnel," *The Gerontologist*, 33(1): 55–62.

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Caring about Caring Labor: An Introduction

DAN JACOBY

Caring labor has emerged as a wide-ranging field of study. Industrialized nations have experienced a significant increase in female labor participation, which has been both the cause and the result of changes in the way care is provided. In the United States, the New Deal legislation cared for the population with new measures intended to provide greater security. Because pension, health, and welfare benefits were tied to employment, the provision of care remained gendered. Scholarly study of caring labor examines such changes and considers the prospects for labor and social movements to provide quality care for all.

Keywords: *caring labor; gender; labor; social movements; social policy*

If the gender composition of the U.S. labor force had remained constant over the past fifty years, twenty-seven million women, or roughly 20 percent of all workers, would not be participants today. Among married women, the labor force participation rate has virtually doubled. Shifts of these proportions create dislocations that require institutional and other societal adjustments. Well over thirty million U.S. families now confront the difficulty of providing family care when married women work. This has led to both the expansion of governmental provision of care services and the emergence of industries that outsource work previously done within families. These changes in the overlapping labor markets and care institutions provide grist for an emerging new scholarship on “caring labor.”

The author acknowledges his deep appreciation to the scholars who participated in the Harry Bridges Center for Labor Studies Forum on Caring Labor and to the University of Washington faculty who have continued to work together to discuss and research the subject.

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Calling attention to the dilemma of nurses who are “ordered to care,” Reverby (1987) was among the first to make “care” a central focus.¹ Self-advocacy and collective bargaining, to say nothing of unionization, are widely imagined to be inconsistent with the responsibility to care for others. This, and competition with labor in the unpaid household sector, weakens prospects for improved working conditions. To the extent that some professions in health or education have become organized they appear better positioned to defend the interests of their members. Yet, low-status and nonprofessional home, child, and elder care aides—whose ranks have grown dramatically—face greater obstacles in improving their bargaining position.²

The definitions used to define care typically rely upon gendered conceptions such as “nurture” or “reproduction.” Women dominate the occupations that constitute caring labor, comprising nearly 80 percent of that workforce.³ Yet men too are involved in this sector, and the nature of care itself, as distinct from gender, constitutes an important axis for study.

Recent works by Kessler-Harris and by Klein construct a history of caring labor that reinterprets the rise and decline of the New Deal. Kessler-Harris explores how Americans’ “gendered imagination” failed to anticipate or support economic dependence for women in their roles, not only as workers, but as wives and mothers.⁴ Klein considers the constraints on social movements during a period when labor and business constructed a new social order in which rights to health and security became employment based.⁵

U.S. experience reveals how caring labor challenges social institutions designed to facilitate family wage jobs for male breadwinners. The early implementation of New Deal policies for social security, labor standards, and organizing rights assumed and reinforced female dependence upon their husbands’ labor by denying protections and support for women working in households or domestic service. Federal Aid to Families with Dependent Children (AFDC) turned financially distressed family caregivers into wards of the state, setting off an ideological dialectic between support for family well-being and American understandings of freedom and independence. The issue of care became particularly visible as the expansion of labor force participation by women disturbed the functioning of existing institutions. Piecemeal adjustments involving income transfers and protective regulations were attacked by conservatives not only for their costs, but also because they challenged dominant understandings of liberty and contract.

Competing demands for new policies became a wedge separating organized labor from natural constituencies among minorities and women. Each group pursued their own disparate path toward economic independence, rendering New Deal reforms vulnerable and dimming prospects for a cohesive social agenda. One of the first arenas in which this became evident, as Boris and Klein point out (this volume), involved the increasing assault upon welfare that began in the 1950s. That attack recast perceptions of governmental support to families in need

by reframing it as a negative force that perpetuated economic dependence on women and minorities.

Where welfare had been designed to ensure the care of children in times of economic distress, welfare reform now gave primacy to female independence over family care. The state's unwillingness to create and finance options that would prevent poor women from the necessity to make desperate choices generally made increased labor participation the best, if not their only, solution. However, the state could not avoid the larger consequences inherent in the increasing labor force by women. Those effects varied by class. Middle-income women who entered paid work had only to self-finance the gaps in their families' care (child, senior, and health care) that went unmet by state provision. Keeping that cost manageable for middle-income families divided the interests of women along race and class lines, particularly as costs reliance upon low-waged care providers was a major factor in reducing costs. Serendipitously, with welfare reform, an increasing portion of the supply of child care, home care, elder care, nursing home aides, and orderlies could be recruited largely from women who either had been or would be on welfare. Even this supply, however, has been augmented by immigration of exploitable women from developing economies.

After a period of relative stability between 1900 and 1940, the percentage of U.S. workers employed in caring labor has nearly tripled from 4 percent to 12 percent over the last 50 years.⁶ The increasing costs of publicly provided care, fragment possibilities for class-based politics, particularly as the working poor are drawn in by anti-tax and anti-government rhetoric. Meyers and Durfee (this volume) produce estimates showing that the costs of care, just for children, are hardly trivial. Restricted solely to out-of-pocket expenses, New York families paid over \$2000 for childcare after subsidies, and that cost virtually doubles when the value of governmental assistance is included. These costs, which do not even include the controversial valuation of donated care, suggest how large may be the split between consumer and producer interests.

Several labor unions have taken up the cause of low-paid care workers, achieving relative success when considered against the backdrop of the dramatic decline in membership of organized labor. Insofar as care workers are designated public-sector workers whose rights to collective bargaining are determined by states rather than through the National Labor Relations Act, much of their success has required the active support of government. It is within this context that we need to understand calls for a caring labor movement, one intended to unite consumers and care providers.

The wider narrative of caring labor inevitably spills across national borders to encompass changes in the global division of reproductive labor.⁷ The demands for care workers by rich countries reverberate around the world, disturbing patterns of global employment as inexpensive caring labor emigrates from poor nations. Simultaneously, critiques of government-provided care rely heavily upon com-

parisons across nations to indicate the degree to which alternative policies are available. The wide scope within which caring labor operates suggests its importance with regard to the formulation of future social movements and policy.⁸

In 2004 the University of Washington's Harry Bridges Center for Labor Studies (HBCLS) received a substantial endowment to inaugurate the Martha Duggan Fellowship in Caring Labor. To herald this fellowship, the HBCLS convened a conference, cosponsored by *Politics & Society* to explore the subject of caring labor. Scholars from around the world expressed interest in participating, and a very lively and successful conference took place in May 2005. The deep commitments of the network of faculty who participated provide persuasive evidence of the importance of supporting continued scholarship on this topic. In publishing research generated through the Caring Labor Forum, both HBCLS and *Politics & Society* signal their continued interest in scholarship on caring labor.

Nancy Folbre keynoted the conference. Her provocative and challenging discussion locates the rationale for a care movement in the idiosyncratic conditions of care markets, a central feature of which is the three-party relationship between consumer, provider, and financier. Consumers often do not contract directly with providers, nor do they generally bear the costs or control the services provided. Even if they did, Folbre maintains that monitoring the performance of caregivers is inherently problematic and expensive. Cost pressures on government prod governments to reduce expenditures on care, rather than to raise quality. The result is evident in the numbers of low-paid, low-status workers who possess few options for upward mobility. Folbre offers the possibility for a coalition between consumers and workers that will unite in seeking a high-road strategy that produces quality care through well-paid, skilled, and motivated workers.

Given the difficulties inherent in administering caring labor, Gabrielle Meagher considers the normative resources of paid caregivers. Meagher does not idealize the bonds between clients and providers. Rather, she concludes that the model of duty in which professional sensitivities are trained or learned may promote "good enough" care. Meagher strips sentimentality from the argument and directs us instead to evaluate the realms of the possible.

Steve Lopez provides a firsthand account of the perversities involved in providing caring labor at one "well-run" nursing home. His nursing home proprietors adhere to up-to-date human resource management techniques that fail, largely because they are intended to. These paternalistic administrators create rigid and demanding schedules that ultimately impair care by shortchanging worker and patient needs. Quality care, suggests Lopez, would be better promoted through negotiations involving an independent union that gave voice to floor-providers' understandings.

Boris and Klein offer an account of homecare workers in California and Oregon over the past forty years. They document the legislation that continuously redefined the status of care work provided in the home. Women pushed toward paid labor were simultaneously denied fundamental labor rights until they began to organize. Union campaigns for collective bargaining, unemployment and other employee rights finally achieved a measure of success in the 1990s.

Finally, Meyers and Durfee offer a serious accounting of the costs of caring labor. Using data from New York City, they document the costs of care in a way that clearly indicates their impact on families, the state, and society.

Together these papers revise the ways we think about labor, the family, the state, and the market. In the 1970s, feminist writings often speculated on the value of women's household labor and the imperatives that an appropriate revaluation would create. At that time, there was little speculation that the economy had actually entered into a massive redeployment in which the majority of households would replace unpaid family care with purchased labor. Now that this process is in full motion, the scholarship of caring labor constitutes a reflection on this ongoing accommodation.

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