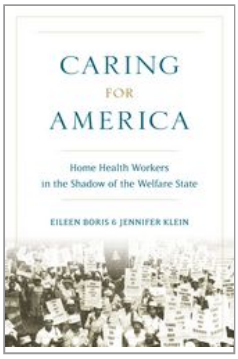

Caring for America: Home Health Workers in the Shadow of the Welfare State
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Introduction

Making the Private Public

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Abstract and Keywords

As personal attendant and home health aides, poor African American and immigrant women have enabled elderly and disabled people to live decent lives at home. Their workplaces might be private and isolated, their work excluded from the nation's labor laws, but how they do their jobs is a story of political economy, one that reflects the major shifts in work and welfare that define contemporary America. This introduction lays out the economic, political, and social changes that have made home care one of the fastest growing occupations of the 21st century and placed women of color at the center of the labor movement. The emerging carework economy, in turn, has called for new organizing strategies to meet the state structuring of the labor and the relational character of the work. To understand the struggles of home care workers, then, we must reflect on meanings attached to care, its association with women's unpaid and women of color's underpaid labor, and its place within the welfare state.

Keywords: home care, carework economy, unions, dependency, welfare state, feminist theory

These are the faces of home care. For 47 years, single mother Evelyn Hawks looked after her developmentally disabled daughter, Hester Brown. A former data entry operator, Hawks, an African American, was paid to care for her daughter through California's In-Home Supportive Services program. The work was hard, the income just enough to rent a tiny one-bedroom apartment in

central Los Angeles. But Hawks judged the sacrifice to be worth keeping her daughter out of an institution. Shortly after taking office in 2003, Governor Arnold Schwarzenegger sought to eliminate personal attendant services for children like Hester when a parent performs the labor of care. A coalition of disability rights activists, organized seniors, and trade unionists beat back his assault.[1]

After bathing, shaving, and cooking for Hector Bertull for seven hours a day in San Ysidro, California, 62-year-old Mexican American Rosa Perez went home. But she treated the 93-year-old as if he were a member of her own family: “I’ve grown so attached to him that I sometimes take him home with me.” Bertull returned the affection: “I love Rosa … like I loved my own mother.” Such attachments blur the boundaries between family and work.[2]

On the tenth anniversary of “welfare reform” in August 2006, Philadelphian Mysheda Autry, a 25-year-old African American high school dropout, faced the loss of her welfare benefits. “Sooner or later she’ll have to get a job,” admitted the head of the social service agency whose help Autry sought. The administrator pointed her to work as a home health aide.[3]

Evelyn Coke, a 73-year-old Jamaican immigrant from Queens, had spent 20 years cooking for, cleaning up after, and bathing clients on Long Island, sometimes working 24-hour shifts, though she was rarely paid for overtime. Infirm from a car accident and undergoing kidney dialysis, she relied on her computer technician son for personal assistance. “I loved my work, but the money was not good at all,” she recalled. “The job didn’t even give us health insurance.”[4] She **(p.5)** became the plaintiff in a high-profile lawsuit demanding overtime compensation for all those extra hours of work, but in June 2007, the Supreme Court ruled that Coke and 1.4 million other aides at the time fell outside the Fair Labor Standards Act, even when employed by a for-profit agency.[5]

Women like Hawks, Perez, Autry, and Coke perform intimate daily tasks—such as bathing bodies, brushing teeth, and putting on clothes—that enable people to live decent lives at home. They labor in private spaces meeting individual and family needs. But how they do their jobs is anything but private: theirs is a story of political economy, one that reflects the major shifts in work and welfare that define contemporary America. Home care aides compose a vast workforce—much larger than that of the iconic auto and steel industries. Their lives tell us much about the shifting relations between home and market, state and family. Their fate links together some of our most challenging social issues: an aging society and an inadequate national long-term care policy, the rise of a vast medical-industrial complex, the neoliberal restructuring of public services, the need for disability rights, the crisis of domestic labor and decline of family

income, new immigration and systemic racial inequality, the expansion of the service economy, and the precariousness of the American labor movement.

For decades they labored in the shadow of a welfare state that shaped the very conditions of their occupation. They rarely earned a living wage. But during the last third of the twentieth century, these previously invisible workers, disproportionately women of color, organized to demand rights and recognition. They surged into unions, making claims on the state despite a market fundamentalism that sought to deny any right to care; over 400,000 had joined unions by 2010. They made unions relevant by defending and valorizing relations of dependence and interdependence. Still, their modest gains and continual struggles also underscored the formidable obstacles to social justice with the unraveling of the New Deal order.

This book gives home care a history. We address the development of long-term care and the intertwined efforts of workers and clients to win dignity, self-determination, security, and personal and social worth. We rethink the history of the American welfare state from the perspective of care work. Social policies are not just income transfer programs. They also depend on a particular configuration of labor that facilitates support on a daily basis. Government has had a central role in creating labor markets in human and social services. Broad trends in U.S. social policy over the latter half of the twentieth century fostered the creation of new occupations, funded by the state, and actively channeled particular workers into these jobs, especially poor and minority women, deploying and perpetuating gender and racial inequality.

The term “home care” includes a variety of skills and occupations, ranging from visiting nurse to physical therapist to housekeeper. This study focuses on personal attendants, in-home support workers, homemaker-housekeepers, and **(p.6)** home health aides. Though not officially classified as health workers, they are part of health systems and health care unions and have taken to calling themselves “home health workers.” These essential workers are America’s front-line caregivers. More than social workers or nurses, they enable people to remain home by providing personal care and maintaining a safe and clean environment. They earn average hourly wages lower than that of all other jobs in health care and historically have labored without security of employment, social benefits, or even workers’ compensation.[6]

Once considered economically marginal, home care has moved to the center of the economy. By the end of the twentieth century, it was among the fastest growing occupations. While manufacturing shed jobs, long-term care and the “health care support” sector added hundreds of thousands of positions at a steady clip.[7] Not only did the number of jobs increase, but the percentage of the nation’s workforce employed in these fields rose. At the start of the Great Recession in 2008, over 1.7 million people across the nation worked as home

health or personal care aides. Nor did the U.S. Department of Labor expect the recession to reverse this trend. Citing technological advances and the growing number of older people, the Bureau of Labor Statistics projected rapid employment growth in home health aide jobs, second only to registered nurses.[8]

This statistical story points to fundamental changes over the last few decades. Low-waged workers stand at the core of a new care work economy, defined, on the one hand, through the long shift of household labor into commercialized and public service sectors and the now permanent participation of married white women in the workforce. Families increasingly sought other women to take up the slack. They hired immigrant and U.S.-born women of color not only to clean their houses and care for children but to assist elderly and ill people, tasks associated with the unpaid labor of mothers and wives within families. On the other hand, with the development of more outpatient services, the rapid discharge of sicker patients from hospitals, and the increasing emphasis on deinstitutionalization in the last quarter of the twentieth century, care work also began to move back into the home. The workers, as well as their patients, clients, or consumers (names variously used to refer to recipients of care), also traveled a continuum between care in nursing homes, hospitals, and homes. The care work economy includes a host of other jobs: child care providers, preschool teachers, school lunchroom and teacher's aides, mental health and substance abuse counselors, social and human services assistants and specialists, and occupational therapists. Under an entirely separate job category, "personal care" occupations, the Department of Labor registers an additional 3.5 million workers.[9]

Such numbers signal the reason that these jobs define the future: they cannot be offshored. Wherever capital may migrate globally to produce goods or provide technical services, care work stays home. Moreover, as had been the case **(p.7)** with manufacturing a century earlier, waves of new immigrants continually replenish these workforces. The demographics reflect the migrant flows of this era's global economy: home care aides are Latin American, Chinese, Vietnamese, Hmong, Eastern European, African, and Caribbean. As a *New York Times* journalist observed, "Home care aides are the garment workers of the modern New York economy"—immigrants caught in a new sweating system. Nonetheless, among those counted in this workforce by the U.S. Department of Labor, blacks still represent over a third of the workforce, with "Hispanics" hovering around 15 percent.[10]

Consequently, women's labors—once considered outside the market or at the periphery of economic life—have now become the strategic sites for worker struggle and the direction and character of the American labor movement. For nearly 40 years, the real growth in organized labor has been in health care, public employment, food service and hotels, and education. These workers joined the Service Employees International Union (SEIU), American Federation

of State, County, and Municipal Employees (AFSCME), National Education Association, American Federation of Teachers, Hotel Employees and Restaurant Employees Union, and California Nurses Association. In the late twentieth century, SEIU claimed the place that the United Automobile Workers occupied during the mid-twentieth century as the major organizing and political force among wage earners. These new union members also shifted the profile of organized labor. At the end of the first decade of the twenty-first century, when only one in ten labored in manufacturing and about half were in the public sector, women composed 45 percent of unionized workers. The percentage of Latinos in the unionized workforce had more than doubled. One in eight union workers was an immigrant.[11]

In turn, these workers transformed organizing strategy, union demands, and the very nature of collective bargaining. Home care became a pivotal sector in which unions experimented with new tactics. Since the job stood outside New Deal labor laws, unionization ultimately had to take shape apart from that framework. Just as industrial unionism emerged in the 1930s as the structural response to mass production, an expanding care work economy compelled a reawakening labor movement to reconsider questions of strategy and structure, “industry” and the state, labor value, and the employment relation. Organizing low-waged workers in dispersed locations, many of whom lacked the legal status of employee, required unions to think outside the box of the National Labor Relations Act—with its format of signing up members, holding an election for representation, gaining certification, and then bargaining with an employer. Furthermore, the location of home care, straddled between welfare and a state-subsidized medical sector, forced unions like SEIU to confront a fundamental strategic question: how to build a labor movement of poor people in a service so dependent on state funding. As workers and their organizations reformulated who constituted their movement, **(p.8)** they also had to take account of the complex interpersonal relations essential to care work. They had to enter into alliances with the receivers of care.

To understand the struggles of home care workers, then, we must reflect on the nature of care and its place within the welfare state. For some feminist ethicists, the notion of a care work economy represents an oxymoron. Care and market just don’t mix; just like love and money, they exist apart in hostile worlds. Caring for dependents, usually defined as the frail, ill, and young, should defy the cash nexus. Caring represents a special kind of work involving personal relationship and emotional attachment so that, as economist Susan Himmelweit has claimed, “much of the quality of our lives would be lost if the imposition of inappropriate forms of market rationality turned such work into mere labor.”[12] In the popular imagination as well, care stands in its own special place. It is only most genuine —that is, caring—if undertaken freely, not for pecuniary reward. Such

assumptions repackage the ideology of separate spheres: women give care, men earn money.[13]

Care work as employment, in contrast, no longer appears as a labor of love, but becomes unskilled work that allegedly any woman could perform. Cleaning bodies as well as rooms, home care workers engage in intimate labor, a kind of toil that is at once essential and highly stigmatized, as if the mere touching of dirt or bodily fluids degrades the handler. This devaluation thesis assumes the unworthiness of the labor because of the race, class, and gender of the workers. Black, immigrant, and poor white women long have undertaken these jobs; indeed, men who engage in them usually earn less than other men, experiencing the costs of racialized feminization.[14] This labor is devalued, however, not just because of its ascribed racial or gendered meanings but because of the way the state chooses to structure it. This outcome, we show, is historical rather than epiphenomenal; devaluation is not only structural and ideological, but a product of conflict and accommodation between experts, state authorities, workers, care receivers, and institutions since the New Deal.

Care also has been low paid because it is justified in terms of the paramount needs of the recipients: they need care no matter what. That is, our society thinks about care in terms of its consumers and their condition rather than the providers of care, the workers. In response to Evelyn Coke's appeal, Supreme Court Justice Stephen Breyer insisted that millions of people would not be able to afford home care if they had to abide by the nation's wage and hour law, so government was acting in the public interest by divorcing such workers from the larger fair labor standards regime.[15] This understanding grants additional moral license to expropriate their labor on the cheap. It implies that denial and self-sacrifice are essential to the "ethic of care." Hence, instead of regarding this work as a form of paid employment, some name it "caregiving." These formulations further mystify the relations of class exploitation.

(p.9) Policy analyst Deborah Stone suggests that the rules and regulations of caring in the public or commercial sphere "promote disengagement, distance, and impartiality," discounting the love, partiality, and attachment that many develop toward those cared for. Most caregivers, she concludes, feel demeaned by the label "worker," for that implies managed, bureaucratic concepts in contrast to their own "relational and personal concepts of care."[16] Indeed, home care workers describe themselves as caregivers and view "their work more as service than as employment," a calling infused with spirituality.[17] They end up working longer than scheduled, even weekends without pay, because clients need them.[18] Their sense of vocation tells them that this is right. At the same time, philosopher Eva Kittay argues that if care for dependents is to be valued at all, providers of care must themselves be cared for—valued—in material ways.[19]

Home care workers may not always regard themselves as workers, but their labor power is being extracted nevertheless. Within the larger system, the labor power of each individual worker is interchangeable; it is commodified. In order to control public budgets and intensify the labor, social workers and agency supervisors have tried to reduce the job to household maintenance and bodily care, in contrast to intangibles, like keeping company or chatting together about family and friends, which aides constantly remark as essential to work well done. To reduce what the state pays out, administrators have measured the work by tasks accomplished, creating Taylorized schedules: 15 minutes to move someone out of bed, 20 minutes to shower or bathe them, an hour for breakfast. If a person is in pain on a particular day or disoriented, none of these tasks may be completed within budgetary allotments. But workers will have to get the job done, even during the time when they are not being paid for the task.[20]

The very nature of the job, therefore, generates conflict and self-exploitation. Each client has his or her own unique needs. In spite of the commodification of the carer, the actual labor process is relational, creating interdependence. Essential to the job is emotional labor, affection, and building trust. The worker must make her own decisions, based on judgment and feeling. The expectation of the job is that one puts his or her personal, emotional self into it.[21] Workers do not simply go on strike and abandon clients who are unable to get out of bed. Because the work consists of more than tasks completed, because it doesn't produce something that can be quantitatively measured, or easily represented in the GNP, part of these workers' struggle involves establishing the legitimacy of what they "produce": human care and kindness, which itself defies our most taken-for-granted definitions of work as production.

The intimacy of the work and its home location therefore have posed unique hurdles for its rationalization and regulation, not to mention the possibility of unionization. These factors obscure care work as labor in multiple ways: through ideological and discursive dismissal of such labors as real or worthy work; **(p. 10)** through the service ethos of some care workers, which leads them to work beyond hours paid; and historically through legal classification that refuses to recognize the home as a workplace and the care worker as a worker. More ominously, those who have favored omitting these workers from labor standards present this exclusion as a positive good because recipients can then stretch their benefits to afford more hours of care.[22] How did this situation arise? How have home care aides come to define themselves as workers and articulate, from their perspective, what constitutes rewarding labor?

Public policy and professional expertise shaped home care as an occupation, thus setting the framework through which families could obtain help for their loved ones and unions would seek to organize this workforce. Care work resembles service labor, like restaurant work and retailing, because it involves what labor scholars call a third party—that is, the client or customer—in

addition to the relationship between employer and employee.[23] But the employment relation of home care is even more complicated, since fourth and fifth parties are central to the care work transaction as well: family members who hire and supervise the worker, and the state (represented by agencies, administrators, social workers, and others), which determines eligibility, cuts the check, and oversees care services either directly or through private agencies. Unions, worker centers, and other advocates have sought to change the terms of these interactions and the balance of power therein. While clients have chosen to call themselves consumers, they are not quite the same as customers. Rather than free market agents defined by an ability to pay, clients, constrained by meager finances and impaired or not yet developed capacities, do differ from shoppers of other goods. At times, we use the term “consumer”—instead of client or recipient—when discussing the independent living movement to reflect its self-identification and political impact, as seen in the social services concept of “consumer-directed” care and the adoption of this designation by policy makers in the last quarter of the twentieth century. Yet we also remain alert to the ways in which consumer terminology obfuscates political concepts of rights, obligations, and the ethics of human interconnectedness.[24]

Government social policies directly shaped the development of home care. By the 1990s, Medicaid made up over half of all monies for it. A decade later, Medicaid was the primary funding source for home health aide jobs.[25] The beneficiaries of the service, the structure of the industry, and the terms and conditions of the labor all were products of state intervention. As public work performed in private homes, home care illuminates the public-private configuration of the American welfare state, the workings of federalism, and the twisted logic of welfare reform. When taxpayers felt that the undeserving, or nonproductive, received special services, they sought to cut funding for care labors; when politicians needed to balance a budget, they eliminated services for those with less power. We cannot therefore **(p.11)** discuss home care without the state; low pay for care workers is integrally bound up with anxiety about public budgets.

Precisely because home health care unites public assistance with labor, old age, and disability policy, and because its value reflects the privileged position of medical models of care, it offers an opportunity to rethink the growth and devolution of the U.S. welfare state. This story complicates the narratives of America’s divided welfare state by challenging the separation of state, markets, and families and by shifting the emphasis from distinctions between different social programs to their connections. To understand both the political economy of home care and organizing by workers, we begin with home care’s hybrid structure: part domestic service, part health care. Though federal policies shaped its contours, implementation occurred on the local level and in light of state governments and their budget allocations. Given the workings of federalism, then, a national overview is not enough to understand home care. To

chart this history, we therefore focus on those places with robust or illustrative programs—New York, Illinois, Oregon, and California—where organized groups of workers and recipients additionally played a determining role. Moreover, multiple arenas—the public hospital, the social welfare agency, and the market for domestic service—created this political economy of home care.

Home care as a distinct occupation emerged in the crisis of the Great Depression to meet both welfare and health imperatives. Through the New Deal's Works Progress Administration (WPA), state funding began to formulate a new occupation that helped poor families and individuals facing medical emergencies, chronic illness, and old age, while curtailing the costs of institutionalization. One strand—the subject of chapter one—took shape as work relief for unemployed black women who had previously labored in domestic service. State and local governments would provide aid to one group of needy Americans—women with children—through employing another needy group—poor, unemployed women, a majority of whom were African American—as "substitute mothers." Such origins distinguished home care, no matter who actually did the work; haunting this history was the legacy of slavery and segregation that racialized the labor and defined it as low paid and unskilled—as fitting work for black women.

Relieving public hospitals of long-term chronically ill and elderly patients became the other origin of state-supported home-based care. The WPA initiated programs to move such people out of the hospital and give them the necessary assistance to become "independent" at home. These programs often called the workers "housekeepers," reflecting the non-medical designation of manual labor in hospital settings. In either case, social workers within welfare agencies oversaw the provision of care as a service for indigents.

(p.12) Following World War II, we show in chapter two, private family agencies led by women social workers and aided by the U.S. Children's Bureau attempted to turn homemaker services into a good job for older women. Over the next decade, a mixture of public welfare departments and private agencies established visiting homemaker and boarding programs to maintain aged and disabled people in the community rather than in more expensive hospitals and nursing facilities. Rather than a universal benefit, homemaker service was meant for those living on very low incomes.

At the same time, hospitals began their own physician-supervised home care programs in order to discharge chronically ill and impoverished patients more quickly. Home care would be one element in a far-reaching medical-institutional complex. Chapter two therefore charts the emergence of a postwar medical model for home care that contested the professional authority of social welfare caseworkers. Whether provided through the medical model of hospital-based programs or the social assistance model of private or public agencies, the clash

of professional expertise left the home attendant in occupational limbo, expected to perform the auxiliary labor of social or physical rehabilitation and to provide home comforts—still cast as neither nurse nor maid.

The history of home care further allows for a more expansive understanding of the significance of the Social Security Act in the development of the U.S. welfare state, as traced in the first three chapters. Most scholars, like policy makers, have focused on old age insurance, unemployment insurance, and Aid to Families with Dependent Children (AFDC).[26] Yet, by considering the less visible titles of Social Security—those set up for child welfare, adult categorical aid (for age, blindness, and disability), and social services—another portrait emerges. A network of social welfare advocates used these subsidiary health and public assistance provisions as channels for publicly subsidized, non-medical care at home. Through the U.S. Children's Bureau and voluntary, private family agencies, this network of dedicated women (and a few good men) relied upon incremental means, including legislative amendments and administrative rulings. They could never elevate home care to the status of an entitlement; they usually had to attach it to some other benefit or program as a subsidiary service. Thus, even when support for social services for the needy (especially those that would allegedly end welfare dependency) gained ideological and political credence, home care programs remained small, without institutional capacity, prestige, or political clout. Although home-based care would eventually become crucial to the medical system, these programs stayed within the stigmatized realm of welfare policy.

When we look at the provision of such services and the accompanying ideologies of rehabilitation, it appears that the "deserving" clients of social assistance—elderly, chronically ill, and disabled persons—depended on the "undeserving" recipients of AFDC. From the 1930s on, each generation of **(p.13)** government officials and public welfare professionals clung to the premise that poor single mothers could end their own dependency on welfare by maintaining the independence of those incapacitated through no fault of their own—that is, by performing care work. They could become rehabilitated in the process of rehabilitating others. The deserving and undeserving, like the public and private sectors, stood interconnected rather than apart.

Policies that would expand the rights of seniors had a coercive edge when applied to poor single mothers, who found themselves channeled into a low-wage, part-time occupation. The War on Poverty in the 1960s provided new vehicles for the state to expand the home care labor market. Once again, this time under the umbrella of anti-poverty policy, the state set terms that maintained a racialized, gendered occupation. The 1962 Public Welfare Amendments to the Social Security Act asked public welfare departments to identify services that would "restore families and individuals to self-support" and "help the aged, blind, or seriously disabled to take care of themselves."[27] This

emphasis on services and self-support required a labor force that could undertake such tasks. “Manpower development” policy, first under John F. Kennedy and then Lyndon B. Johnson, would direct poor recipients of public assistance along this track. The new Office of Economic Opportunity in 1964 created programs for AFDC recipients to meet the labor shortage in service occupations, especially health and child aides, home attendants, and homemaker aides, programs classified by the U.S. Department of Labor as similar to domestic service.[28] Chapter three revisits the War on Poverty with a new emphasis on how its administrators clearly saw service sector jobs as the wave of the future and used various anti-poverty programs to train poor women to enter that sector at the bottom rungs, as if they hadn’t been there before.

Yet there remained an irony. Whether under the rubric of rehabilitation, manpower development, or welfare reform, such social services risked reinforcing racial and gender inequalities. Poor women’s path to independence depended on the very household labor that reduced them to the social status of servants.[29] Impoverishment and marginalization were only further reinforced in the mid-1970s, when new amendments to the Fair Labor Standards Act (FLSA) extended labor law protection to domestic workers but specifically excluded elder care aides. Law, social policies, and professionals’ use of rehabilitation ideology developed home care as a stigmatized and low-paying hands-on job in an expanding health care industry.

Throughout this period, as chapters two through four demonstrate, the state did not and could not act alone; it facilitated private long-term assistance. Scholars now commonly refer to the American state as mixed, hybrid, hidden, divided, residual, and public-private. The particular strategy of governance that emerged from the use of private or quasi-governmental entities to fulfill public purposes expanded **(p.14)** state power in hidden, disguised, and often unaccountable ways.[30] Home care reveals the manner in which the distribution of public welfare depends on both public and private entities, which developed in tandem. Most federal welfare policies require implementation at the state, county, and local level. While we tend to think of these as “public programs,” each level of government has relied on private charities, nonprofit agencies, proprietary vendors, and workers to carry out its dictates. The private sector was not initially intended to displace the state. From the 1930s through the 1960s, welfare advocates, case workers, and various federal government officials believed that privately sponsored demonstration projects and public subsidy of family service agencies would further stimulate welfare support and services in the public sector. Starting in the 1970s, through Medicare and Medicaid rules, state subsidies, federal social service grants, job training funds, and vendor contracts, governments boosted a for-profit industry in home care services, opening new conflicts over public funding and the responsibility of the state.

Consequently, this study of intimate labor exposes the inner workings of American federalism. Federalism often is presented as a fixed set of structural constraints. Different levels of government, however, often have competed with each other, sought to outmaneuver the others, or secure more or less power, responsibility, and money. Whether responding to injections of federal funding in the 1950s and 1960s or contractions in social welfare spending in the 1970s and 1980s, states and localities perpetually attempted cost shifting to other levels of government and used various tactics of privatization, including contracting out to nongovernmental entities, through a complicated set of strategic moves. Given public ambivalence over paying for social services for the poor and people of color, especially for labor that many believed should be freely given by wives, mothers, and daughters, home care illuminates the continual renegotiation of the terms, funding, and institutional structures of federal governance.

While the expanding welfare state helped to create this particular low-wage labor market, national budget politics and retrenchment further casualized the job. Under the banner of market reform and deficit reduction, the federal government reined in social welfare spending in the 1970s and 1980s; states and localities desperately coped through privatization of services and “flexible” labor policies. Highlighting New York and California, the states that received the bulk of federal funds, chapters four and five show how states used the politics of budgetary crisis to restructure the labor market for care and the nature of the job. Through their own routes and under different pressures, these states turned more to outsourcing and the reclassification of attendants as independent providers. Over the years the work became harder, but fiscal pressures squeezed the workforce. The subcontracting system, abetted by Medicare and Medicaid, turned home care into a sweated industry, compounding the consequences of worker exclusion **(p.15)** from the nation’s wage and hour law.[31] The ever expanding use of independent contractor designations and a casualized employment relation had broader implications; within a generation, these practices spread throughout the American economy, affecting workers in fields as wide-ranging as retail, financial services, university teaching, journalism, television entertainment, and transport. Home care’s past prefigured the future.

The second half of the book is a story of social movements. Even as the welfare state location of the labor devalued the workforce, it opened up a new site of social and political struggle. With the structure of home care, it was never enough just to win collective bargaining rights with individual vendor agencies. To make economic gains, unions had to go to government. Political brokering with the state thus became an important part of home care unionism.

The state may have organized home care, but it did not do so without contestation and confrontation. Chapters four through seven turn to social movements that erupted within the welfare state. Senior citizens, disabled people, domestic workers, welfare recipients, and aides each shaped the home

care system. In the political cauldron of the 1960s and 1970s, they formed militant civil rights movements of their own. Organizing in the streets, welfare offices, campuses, and state capitols, they pushed forward their own definitions of independence, dignity, access to public services and housing, and rights to support. We bring a range of actors into the welfare wars that ignited in the 1960s and spilled into the 1970s: the Rolling Quads on the Berkeley campus, radical social workers, independent living centers, the National Committee for Household Employment, the California Welfare Rights Organization, the Grey Panthers, the Older Women's League, and the United Labor Unions (ULU). The ULU activists, especially in Chicago, were true innovators, former SEIU President Andy Stern has admitted; they "created a belief that there was actually something that could be done with an incredibly invisible workforce."[32]

How did each of these movements reshape the state and its programs? Their goals and claims overlapped but could be contradictory. Under what conditions were they allies? How did confrontational politicians, like California's Governor Ronald Reagan, unite or divide them? Who would speak for those who labored? Did the culture and structure of unionism and collective bargaining clash with the goals of other stakeholders? Social conflicts within the welfare state and among its recipients forged the terrain upon which unionization took off.

State policies created the possibility of a new political unionism that in the last decades of the twentieth century brought together workers, consumers, and voters to demand better wages and better care. Victories in the 1990s and the early years of the twenty-first century did not just happen; they were the culmination of a 35-year struggle that began with the surge in public sector unionism in the mid-1960s. Home care unionism benefited from an **(p.16)** effervescence of organizing among poor, black, Latina, and immigrant women. It originated in movements of domestic workers in New York and San Diego; farm worker unionism in California; public sector militancy bound up with political struggle around state budgets in many cities; and the community organizing of groups like ACORN (Association of Community Organizations for Reform Now), most successfully in Chicago. Mirroring home care's hybrid origins, home care unionism had roots in the welfare rights movement and the dynamic growth in hospital and health care unionism in the latter decades of the twentieth century. Chapters five through seven reveal the dramatic struggles in these different paths toward unionization, as well as their implications for the American labor movement as a whole.

These movements not only reached out to workers in casual or service sectors; they experimented with new structures of representation and distinct forms of unionism. They had to devise legal and political strategies for a neoliberal era in which governments denied that they were the employer responsible for poverty wage rates or 12-hour shifts, the National Labor Relations Board (NLRB) election too often was a dead-end, and even courts refused coverage under the

FLSA. Before caregivers were even able to bargain for better conditions, they had to see themselves as workers and fight for such recognition by the public, the state, and the very users of their services. They had to seek the right to organize in the first place—and as they did so, they came to understand themselves as wage earners, as workers in a class relation to the state, agencies, or, in some cases, the consumers for whom they cared. They had to gain visibility and dignity, two key phrases in both self and media representation of home care providers. With consumer allies, they had to challenge representations of self-sacrificing workers and helpless recipients, as well as the stigmatization of dependency, whether on other human beings or the state.

The organizing of home care calls into question the standard categories of unionization. We are accustomed to thinking of unionism in the United States as taking distinct forms relating to the character of the industry: craft, industrial, public employee, health, or service sector. Despite often-conflicting assumptions about the nature of work, the definition of the worker, and the relationship to the employer, these types of unions have drawn upon similar tactics and aspirations, depending on the historical moment. Though we associate particular unions with workplace-specific strategies, in fact they have deployed electoral politics and lobbying, community mobilization, consumer alliances, and social services provision as tools to win improvements for workers and sometimes broader social change. Because the arrangements for home care have varied by time and place, no single term captures the full range of organizing strategies for this workforce. These unions engaged in political unionism, because they had to influence the state; social movement unionism, **(p.17)** because they depended on mobilizing clients and communities; and service sector unionism, because they helped create this new epicenter of organized labor. As a whole, it is perhaps most constructive to see these new trends as “care worker unionism”: a solidaristic attempt to move the labor of care away from its marginalized status to recognize its centrality to the contemporary political economy.

The final chapters trace the story of how disparate movements finally came together at the end of the century and saw conditions of labor linked with conditions of care. Seniors, disabled people, and families had to accept aides as workers with needs independent of their own. In turn, home care unionism had to plead for larger social goods, advocating better care in order to obtain better jobs for union members.

Whether the process of struggle has provided greater recognition of the value of care labor has remained an open question. Would, for example, the emotional content of the labor achieve legitimacy through unionization? Could real gains in wages, public resources, and quality of care be sustained amid the deep economic and fiscal crisis that erupted in the final days of the Bush era? As the epilogue suggests, this history helps to explain the devastating impact of neoliberal restructuring of the welfare state on the livelihood of home care

workers, the quality of available long-term care, and the fate of democratic unionism. With the new round of fiscal crisis for states since 2008, governors and legislatures turned to pitting “taxpayers” against public workers. And yet plenty of the former will soon be elders in need of care. Longer life expectancy means that more of us live with chronic illness. A majority of Americans, across the spectrum of class and ethnicity, will at some point depend on a caretaker, often one who has long labored in poverty and struggled mightily to balance her own and others’ social needs. The macroeconomic structuring of the occupation, as well as its interpersonal challenges, heighten the stresses of an already emotionally and psychologically intense and economically precarious job. Workers, family members, state administrators, and policy makers all wring their hands in frustration over the undependability of home care services; for the former, there aren’t enough steady hours; for the latter, there never seem to be enough trustworthy workers. Although the assumption has long held that only through low-waged labor could we provide long-term care, perhaps it is time to reframe the question. Can we really afford to maintain a system that impoverishes workers and stigmatizes both the recipients and providers of care?

Home care has existed in a clouded nether world between public and private, employment and family care. It was possible because of the devaluation of not only women’s work but the stigmatization attached to the labor of poor women of color. The epilogue further considers the degree to which we have **(p.18)** met the challenge of balancing respect, dignity, and social rights for recipients *and* providers. The continuing struggle for good care and worthy work makes this an ongoing story, propelled by political confrontations and upheaval within the trade union movement, state capitols, and the halls of Congress, and the inevitable dependency that is the human condition.

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