Forced to Care

*Coercion and Caregiving
in America*

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Who Cares?

As we enter the second decade of the twenty-first century, the United States faces an acute "care crisis." A spate of recent news articles and studies has sounded alarms about the large and growing gap between demand and supply in caregiving. The number of people needing care has risen much more steeply than the number of those available to provide that care. Nutritional and medical advances have lengthened average life spans so that the fastest-growing segments of the population are the oldest age groups—those in their seventies, eighties, and nineties—while medical advances, including drugs, medical devices, and treatment regimens, have extended life for people with chronic health problems and serious disabilities who might not have survived in earlier times.[1] Simultaneously, trends such as smaller families, geographic mobility, and high rates of employment among women have contributed to shrinking the pool of those who have traditionally provided informal care—wives, mothers, and other female relatives. As Mona Harrington describes the situation in *Care and Equality,* "We have patchwork systems, but we have come nowhere near replacing the hours or quality of care that the at home women of previous generations provided for the country."[2]

This trend has been clear since the 1970s as increasing numbers of women, regardless of marital and parental status, have entered the labor market. By 2000, 73 percent of women with children under age 18 were employed, a percentage that has remained fairly steady in the subsequent decade.[3] And, like other American workers, employed women put in long hours; they are among the overworked Americans, who, on average, work

more hours and enjoy fewer vacation days and less paid leave time than workers in any other industrialized nation.[4] Extended work hours are making it difficult for Americans to meet their obligations to provide both economic support and care for dependent family members.

One reason the crisis has garnered public attention is that caregiving is no longer limited to poor families in which mothers have long had to work to support their families. Today, even relatively affluent middle-class families are experiencing a "time bind" and "stretch out" in their efforts to meet competing demands for income and caring.[5] Although a great deal of the concern about "work–family conflict" has been centered on child care, the fastest-growing aspect of the conflict is engendered by elder care responsibilities. Consider the following facts:

The average American couple now has more parents living (more than two) than children (fewer than two).[6]

Women now spend more years providing care for elderly parents (18) than for dependent children (17).[7]

In 2009, an estimated 43.5 million Americans were involved in caring for an aging relative or friend; about three-quarters of these caregivers had worked outside the home at some point since assuming care.[8]

The burden of elder care, as in other types of caregiving, falls most heavily on women, who constitute around 70 percent of informal caregivers. Women are not only more likely to be primary family caregivers for elderly kin, but they are more likely to care for those with more severe disabilities and to put in more hours of caregiving.[9]

Employed women are only slightly less likely to be primary care-givers compared to their age peers who are not in the labor force. Overall, about half of all employed women also care for a relative.[10]

Family caregivers who were employed full-time outside the home put in an average of 16 hours of unpaid care work, and those employed part-time put in an average of 21 hours; a sizable fraction of employed caregivers, whose elders are more severely disabled, put in over 30 hours a week.[11]

Women of color, especially African American women, are more likely to have to combine elder and disabled care with employ-ment outside the home.[12]

Thus, although balancing employment and parental responsibilities remains a critical issue, the "new frontier" of work–family conflict involves care for elderly and disabled kin. This type of care poses unique challenges. Women who provide elder care are on average older than those who care for children; depending on the study, typical primary caregivers range from their mid-forties to their mid-sixties.[13] Older caregivers are more likely to have their own health problems. Additionally, with the current trend toward later age of childbearing, an increasing number of women—the so-called sandwich generation—are caring for both children and parents at the same time.[14] And, unlike care for non-disabled children, the intensity of both disabled and elder cares increases over time, rather than decreasing. A common pattern is for an employed woman to start off by providing small amounts of care and assistance but then to take on more and more responsibility as her parent becomes more frail and more disabled. Over time, the caregiving demands can become overwhelming.[15]

Many studies have documented high stress levels among family members who provide intensive care or who combine work and care for parents and disabled spouses and children. The demands of intensive care leave caregivers with little time or energy to look after their own well-being, so that their own health suffers. Numerous studies have shown that caregivers experience higher rates of heart disease, high blood pressure, diabetes, and depression.[16] Other studies have documented the detrimental economic effects of caring for elderly or disabled family members. One survey found that more than 50 percent of employed female caregivers accommodated by going to work late or leaving early, working fewer hours, giving up opportunities for upgrading skills or taking on special projects, turning down promotions, taking leaves of absence, choosing early retirement, or giving up work entirely.[17] A MetLife study estimated that employed caregivers who had to make a work adjustment because of caregiving responsibilities suffered a mean loss of $566,443 in wages, $25,494 in Social Security benefits, and $67,202 in pension wealth, for a total loss of $659,139 over the lifetime.[18] Another study found that women who engaged in care early in life were 2.5 times more likely to wind up in poverty than those who did not.[19]

Relatives, friends, and volunteers provide the lion's share (80 percent) of all home care despite the rigors and sacrifice required.[20] Still, they cannot meet the full caring needs of dependents, so there has been

increasing demand for paid caregivers to substitute for or supplement family care. Paid home care is also allocated to women, who make up 90 percent of the care workforce.[21] Here again we find a gap between demand and supply. The U.S. Department of Labor reports that in 2006, 889,000 persons were employed in home health or personal care (undoubtedly an underestimation because many work in the informal job market) and estimates that these numbers will increase by more than 50 percent by 2016.[22]

Despite the purported shortage of available workers, wages remain low, with $9.22 an hour as the median nationwide in 2008, a level that is below the federal poverty level for a two-person household.[23] Medicaid home care benefits and state home care programs mandate low wages, often minimum wage, and also limit the hours of care that recipients can receive. Home care workers have to piece together a living by visiting and caring for several clients a day, often spending a lot of time traveling.[24] Additionally, home care workers usually get no paid vacation or sick leave, and many have no health insurance despite the high rates of on-the-job injury.[25] They are also specifically excluded from coverage by protective labor legislation such as minimum wage, maximum hour, overtime pay, and occupational health and safety laws.[26]

To be sure, paid care work offers its providers some intrinsic rewards, including the gratification of feeling useful and needed by their clients. Indeed, dedication to clients induces many care workers to remain on the job despite the financial sacrifices they may incur. Care workers may even do extra tasks or errands for their clients on their own time.[27] Still, the disadvantages of the work mean that home care work is too often a job of last resort, one that women who lack good options enter as a stopgap. Thus the ranks of paid caregivers are disproportionately made up of women (9 out of 10), racial minority women, and immigrant women.[28] The disadvantages of care work also account for the high rates of turnover, estimated at between 30 percent and 70 percent annually depending on location.[29] Many caregivers report that they enjoy their work and are devoted to their clients but are forced to find other jobs that pay better and offer benefits.[30]

This book is about the ideological and material foundations of the care crisis. It is grounded in the premise that the often untenable strains to which family caregivers are subject and the parlous situation of paid

caregivers are closely intertwined and need to be examined together. The main thesis of the book is that the social organization of care has been rooted in diverse forms of coercion that have induced women to assume responsibility for caring for family members and that have tracked poor, racial minority, and immigrant women into positions entailing caring for others. The forms of coercion have varied in degree, directness, and explicitness but nonetheless have served to constrain and direct women's choices; the net consequence of restricted choice has been to keep caring labor "cheap," that is, free (in the case of family care labor) or low waged (in the case of paid care labor).

I put the social organization of care at the center of a number of important ethical, political, and economic dilemmas in American society and argue that the social organization of care has become preeminently a public issue, one that is integral to questions of economic and social justice, gender inequality, race inequality, class inequality, and citizenship rights. Let us start with some working definitions.

Caring can be defined most simply as the relationships and activities involved in maintaining people on a daily basis and intergenerationally. Caring labor involves three types of intertwined activities. First, there is direct caring for the person, which includes physical care (e.g., feeding, bathing, grooming), emotional care (e.g., listening, talking, offering reassurance), and services to help people meet their physical and emotional needs (e.g., shopping for food, driving to appointments, going on outings). The second type of caring labor is that of maintaining the immediate physical surroundings/milieu in which people live (e.g., changing bed linen, washing clothing, and vacuuming floors). The third is the work of fostering people's relationships and social connections, a form of caring labor that has been referred to as "kin work" or as "community mothering."[31] An apt metaphor for this type of care labor is "weaving and reweaving the social fabric." All three types of caring labor are included to varying degrees in the job definitions of such occupations as nurses' aides, home care aides, and housekeepers or nannies. Each of these positions involves varying mixtures of the three elements of care, and, when done well, the work entails considerable (if unrecognized) physical, social, and emotional skills.

By "social organization of caring" I refer to the systematic ways in which care for those who need it is allocated and how the responsibility for

caring labor is assigned. Caring can be organized in a myriad of ways—in or out of the household, as unpaid family labor or as paid labor in the market. For example, caring can be provided within the home by a family member, friend, or community volunteer without pay or by a servant or home care worker for pay. It can be done in more collective settings such as community day care centers by a combination of volunteers and paid staff or in an assisted-living facility or a nursing home by paid employees. Furthermore, the care may be arranged and overseen by the care receiver, the care receiver's family, a non-profit entity, a government agency, or a profit-making company. Caregivers can be remunerated by care receivers or their relatives, by private insurance, or by government agencies. These arrangements are not mutually exclusive. All these forms exist simultaneously in contemporary societies.

However, the particular mixture and balance of paid and unpaid, commodified and non-commodified, and private and public forms have varied across time and place, reflecting a society's economic structure, prevailing beliefs, political systems, and cultural practices. In the United States the social organization of care has been characterized by reliance on the private household, feminization and racialization of care, devaluation of care work and care workers, and abnegation of community and state responsibility for caring. The persistence of these characteristics, despite (or perhaps because of) the frequent lip service given to the spiritual and moral qualities of caregiving, is rooted in fundamental philosophical principles, social structures, and cultural practices that have survived (in somewhat altered forms) since the early republic. For this reason, an examination of historical continuity and change in these structures, beliefs, and practices is essential for understanding the material and ideological underpinnings of the contemporary social organization of care. Such an analysis is also crucial to identifying contradictions and fault lines that might be exploited to transform the way care is organized in our society.

The final concept is that of coercion, which I define as physical, economic, social, or moral pressure used to induce someone to do something. In the case of caring, two specific forms of coercion are particularly relevant. The first form is status obligation. As described by Alvin Gouldner, status obligations are duties assigned to all those in a given

status, for example, wife, mother, daughter. Gouldner notes that status obligations "may require an almost unconditional compliance in the sense that they are incumbent on all those in a given status simply by virtue of its occupancy."[32] A status obligation can be contrasted with the norm of reciprocity, in which an obligation is incurred as a *debt* for gifts and services that one has received. Status obligation can also be contrasted with contractual obligations that are incurred as a result of voluntarily entering into an agreement to provide services in exchange for pay or other considerations. Scholars since the time of the nineteenth-century anthropologist Henry Maine have argued that as Western societies modernized, they shifted from reliance on status relations to contractual relations. In this view, market relations have been more or less completely contractualized, but family and kin relations have remained "premodern" in that status obligations remain in force.[33] I will argue that status categories such as race and gender continue to shape both market and kin relations. Consequently, women are charged with a triple status duty to care, on the basis of (1) kinship (wife, daughter, mother), (2) gender (as women), and (3) sometimes race/class (as members of a subordinate group).

The second form of coercion is racialized gendered servitude, by which I mean a labor system in which one party has the power to command the services of another. In some instances, the power is de jure, in that one party is recognized by law as having a property right in the person and/or labor of the other. Slavery, indentured labor, and debt bondage are prominent examples of racialized gendered servitude that have at one time or another been legally recognized in the United States. In other instances the power is de facto, in that it grows out of marked inequality between parties, whether economic, physical, or social. Contemporary examples of inequalities that have fostered servitude include undocumented immigrant workers in sweatshops in U.S. territories, impoverished child servants in many parts of the world, and women trafficked into sex work or domestic services. I use the qualifier "racialized gendered" because the lines that distinguish those who command services from those who provide them are often those of race and gender (e.g., white/black, male/female), and ideologies that support the rights of those who command others are framed in terms of natural differences between races and genders.

As we will see in Chapter 2, these two traditional forms of coercion were "modernized" and reestablished during the country's transition from a predominantly agricultural society to an industrial economy. This shift took place over the course of the nineteenth century and occurred unevenly across regions and sectors of the economy. In two distinct but intersecting threads in the history of caregiving, the first trajectory is that of a "free-labor" system that developed in the industrial and advanced sectors of the economy. The households of workers in free-labor sectors came to be characterized by a gender division of labor in which men were primarily responsible for breadwinning through outside employment in the labor market and women were made responsible for housework and caring in the "private sphere" of the family. The second trajectory is that of unfree-labor regimes that survived into the early twentieth century in peripheral regions of the country, especially in primary sectors of the economy such as agriculture and extractive industries. In these sectors, households relied on outside employment from both men and women. The labor markets in these sectors were structured so that men of color were tracked into and confined to low-wage, non-mechanized labor, and women of color were tracked into domestic service and caring labor for more privileged households. The imprint of these historical formations can still be seen in contemporary patterns and practices in both unpaid and paid caring labor.

In Chapter 3, we will examine how these trajectories intersected in class, race, and ethnic relations among women. During the late nineteenth and early twentieth centuries, as part of its nationalist aspirations, the United States sought to reform groups and individuals who were seen as deviating from "American ideals" and thereby as threatening national unity. These reform efforts opened up opportunities for elite and middle-class women to extend their caring activities into the public realm as agents of "female reform." Their role became that of educating subaltern women in the ideals and practices of female domesticity and caring. Three female domestication efforts will be examined: the training of Native American women in the Indian boarding school system, the rehabilitation of women inmates in female reformatories, and the "improvement" of non–Western European immigrant women through so-called Americanization programs. These efforts shored up prevailing ideological constructions of women as carers and

moral touchstones of the family and ultimately of the nation. Importantly, these case studies demonstrate that reshaping subaltern women to fit middle-class norms of female caring was integral to efforts to control racial, ethnic, and lower-class "others."

Chapter 4 delves into the roots of the inequitable burden that women bear for unpaid care labor. We will develop the concept of caring as a status duty for women and examine the role of the state in defining and enforcing this obligation. I focus on two areas in which the state historically articulated and enforced women's obligation to care: marriage and family law, which codified wives' duty to provide domestic services, including nursing care, and social welfare provisions for dependent disabled individuals, which presumed that family members, particularly wives and mothers, had primary responsibility for providing unpaid care. Despite nineteenth- and twentieth-century modernizing reforms, law and social policy have continued to affirm the principle that the family, and not the community or the state, bears primary responsibility for meeting dependency needs, and that family members (parents, spouses) are obligated to provide care for other family members.

Paid care work has long been treated as though it was an extension of women's unpaid domestic labor rather than as a legitimate form of wage labor with its own standards, training requirements, and pay scales. In Chapter 5, we will focus on the exclusion of home care workers from legal protections provided by the federal Fair Labor Standards Act and the Occupational Safety and Health Act. Justifications for excluding home care workers from standard protections have historically been framed in two ways: first, the need to protect the privacy of the household so that it can function as a haven in an otherwise heartless world, and second, the household employer's entitlement to the services of domestics servants and caregivers so as to ensure that members enjoy the comforts that a home is intended to provide. In contrast to explanations for the exclusion of home-care workers that focus on the first set of justifications, namely the location of home-care work in the private household, I will argue for the equal significance of the second set of justifications, namely the quasi-property rights that employers enjoy with respect to servants. An examination of U.S. immigration laws that allow entrants holding certain kinds of visas to be accompanied by household servants further reinforces the conclusion that the exclusion of home-care workers from protections provided to other categories of

workers has rested on its dual construction as an aspect of private household family relations (therefore governed by principles of altruism and status obligations) and as an extension of earlier relations of indenture and slavery (therefore governed by principles of property ownership).

Chapter 6 sheds light on how contemporary neoliberal economic and political trends have contributed to the caring crisis. We have witnessed the confluence of three trends that have intensified the demands and difficulties of caregiving and have exacerbated the coercive factors that impinge on both informal and low-paid care work: first, the devolution of care (especially acute health care and nursing) back into the private household; second, the dismantling of welfare programs for poor mothers so as to compel them to undertake low-wage jobs in the labor force; and third, the neoliberal economic restructuring that has displaced people from traditional means of livelihood in poorer countries that make up the global south, thus sharply accelerating female labor migration to the United States and other rich countries in the global north. We will examine the impact of these developments on the care labor of three groups most affected: white middle-class women, poor single mothers, and immigrant women from the global south.

Taken together, the historical accounts and contemporary developments demonstrate how caring labor has undergone continuous reorganization in concert with changes in political economy. Despite the shift of care from home to the market and back again and from unpaid to paid and back again, race, gender, and class have remained central organizing principles of care labor. As a result, care labor remains an arena where coercion holds sway and where full freedom and citizenship are denied.

Assuming that legal and economic coercion is not a good basis for quality care and that the true needs and interests of care receivers, family caregivers, and paid care workers must be addressed in order to create a caring society, in Chapter 7, we will look at the ways in which care work needs to be rethought and reorganized. Rethinking care involves dismantling the dichotomies that have delimited care: private versus public, love versus money, and altruism versus self-interest. Confining care to one side of these dichotomies (private, love, altruism) has obscured the public function that care labor serves and has masked its central place in the economy. Rethinking care also requires attention to

the needs of care receivers and caregivers and a balancing of the right to receive needed care with the right to provide care without excessive economic penalties or sacrifice of well-being. We will also examine alternative goals and strategies for addressing the care crisis and the extent to which they mitigate the coercive structures that have disadvantaged care workers.

Together with other advanced industrial countries in the world, the United States faces an unprecedented challenge of ensuring that its growing numbers of elderly and disabled citizens receive the care they need and deserve. Addressing this issue demands a fundamental rethinking of care that will require us to uncover and analyze the material and ideological roots of the present care system and to understand how the system has come to rely on the exploitation of women's labor and the denial of equitable benefits and entitlements. Exploitation has been made possible by multifarious forms of coercion, ranging from personal moral persuasion to the force of impersonal legal doctrines, from internalized feelings of obligation to external constraints of the labor market. By tracing the multiple strands of coercion, I aim to expose the social inequality and denial of social citizenship that lie at the heart of our present system of caring.

Neoliberalism and Globalization

Demographic and cultural changes, neoliberal economic policies, and economic globalization are among the contemporary developments exacerbating the care crisis by intensifying the conflicts between caring and earning and increasing the stresses on caregivers, both unpaid and paid. Numerous studies have documented the tremendous growth in the population of disabled children and adults and elderly persons in industrialized countries. In the United States, because of federal and state health and disability policies favoring home-based care, a substantial majority of those needing long-term care live at home rather than in institutional settings. The U.S. Department of Health and Human Services, using 2000 Census data, estimated that 13 million Americans with disabilities, including children and working-age adults, were living in private homes; it also projected that this number will more than double by 2050, with much of the increase coming from a rise in the elderly population.[1]

At the same time that the population of those needing home-based care has been expanding, the capacity of informal care givers—families and friends—to provide care has been shrinking. Demographically, the working-age population aged 18–64 is growing much more slowly than the population 65 years and older.[2] Social changes such as smaller family size, geographic mobility, and the increase in full-time employment among women are reducing the number and availability of family members and friends who can provide unpaid caring labor.[3]

Because they have fewer people with whom they can share the load, those who do provide informal care are more burdened. Employed

women who also perform caring tasks are stretched by the competing demands of earning and care. Rates of poverty, drug dependency, and incarceration have also increased such that many parents are unable to care for their children. As a result, more distant relatives may assume responsibility for children to avoid having them sent into foster care. Indeed, one of the most notable trends over the past two decades has been the increasing numbers of grandparents, and even great grandparents— mostly women—who are the primary caretakers of children. Some of these grandmothers may also have their own elderly parents and relatives to care for and have their own health problems that make caring difficult.[4]

Perhaps most fundamental are economic changes brought about by so-called neoliberal economic policies and globalization. The shifting of production outside the United States has reduced the number and percentage of relatively well-paying unionized manufacturing jobs. The growing service and retail sectors offer primarily low-wage, part-time, and contingent employment, usually without benefits. Simultaneously, under neoliberal restructuring, government spending on welfare entitlements has been cut, and public services have been subcontracted to private companies. In the meantime, neoliberal policies have been imposed by international banking and financial institutions on developing countries. These policies have included the selling off of state enterprises to private entities, the appropriation of land formerly used for subsistence agriculture to produce large-scale export crops, and the opening of formerly protected markets to foreign products. These measures have left millions of people in developing countries without their traditional means of livelihood. As a consequence, many people have turned to migration to find work in more prosperous areas. Significant portions of migrants, especially women, find jobs in low-wage service sectors in the global north.

These developments have had multifarious consequences for caring labor. Rather than dealing with the many and complex ramifications of these developments, I will focus on three representative case studies that typify trends in the present period: health care cost containment that has led to the "off-loading" of health care to family caregivers; welfare reform that has diverted poor women's labor from family care to low-wage employment; and the deinstitutionalization and privatization of care for the elderly disabled that has further disadvantaged home-care workers.

Intensifying Home Care

One of most noteworthy trends in recent decades has been the off-loading of medical treatment for both acute and chronic conditions from hospital to homes. This shifting is part of a larger strategy within the service sector to transfer work from paid employees to consumers, thereby reducing labor costs and maximizing profits. Examples of work transfer include replacing counter clerks and sales people with customer self-service in retail trade, replacing tellers with automated teller machines in banking, and replacing reservation clerks with on-line booking in the airline industry.[5]

In the medical arena, work transfer has been driven by cost-containment structures imposed by health-care delivery and health-care financing systems. Pressure to slash health-care costs by insurance companies and some government agencies has resulted in the shortening of costly hospital stays. Patients are released to go home "quicker and sicker" while they still require medical monitoring and nursing care. Additionally, the de-institutionalization and independent living movements have supported the shift toward home-based care. Politically organized disabled persons have lobbied to get laws passed requiring states to provide services and accommodations that will to allow them to live independently in their communities.

The ideological rationale for deinstitutionalization is that the home offers a superior environment for the patient. It draws on stereotypes of home and hospital as starkly different. As William Ruddick notes, "Home is commonly conceived and experienced as a place of security, comfort, privacy, and liberty to be oneself. By contrast the hospital is often thought of and experienced as a place of insecurity, discomfort, intrusion, and demands for compliance and conformity.[6] The economic rationale for deinstitutionalized care is that extended hospital and nursing-home care is too costly and should be reserved for short-term treatment until the patient is "stabilized." The lower cost of home and community care is premised on the assumption that all or most of the care will be provided for free by family members and volunteers.

Thus, since the 1970s there has been a general trend away from institutional care for chronically ill or disabled children and adults and frail elderly. The consequence is that more people are being cared for at home, and more people are providing more unpaid caring for relatives,

neighbors, and friends. A *New York Times* article in 1999 reported that an estimated 26 million Americans were providing nursing services such as administering medication and checking vital signs for sick or dependent relatives, putting in an average of 18 hours per week. A survey by the National Caregiver Alliance and AARP (the organization formerly known as the American Association of Retired Persons) published in 2004 found that 21 percent of adults were caring for relatives or friends 18 years of age or older.[7]

The contemporary transfer of care from the hospital to the home represents a reversal of the post–World War II expansion of institutionalized health care. In that period, the medical establishment succeeded in portraying the hospital as a superior environment for patient care because the home could not be kept sufficiently sterile and lacked the facilities and equipment to provide modern medical diagnosis and treatment. Physicians for the most part stopped making home visits. Instead, patients were expected to travel to or be transported to hospitals or clinics for diagnosis and treatment. In one sense, it would seem we have come full circle to an earlier period when the sick, disabled, and elderly were nursed at home by a female relative, neighbor, or friend. However, the rise of managed care, the bureaucratization of health financing, and the development of high-tech medical devices for home use have dramatically altered the demands of home care.

First, patients being released home today are on average sicker than in previous years and are often dependent on ventilators or other devices. They need more attention and for longer periods than those nursed at home in the past. Many would have died sooner from their underlying conditions in the past but are now kept alive much longer by modern drugs and high-tech medical devices. Starting in the 1980s, medical manufacturers entered the growing home health care field by developing and marketing portable, so-called user-friendly versions of high-tech medical devices for use in the home. High-tech devices designed for use by patients themselves and untrained family members include equipment for infusion therapy (administering anti-pain, antibiotic, antiviral, and chemotherapy medications through a vein); feeding tubes (parenteral and enteral infusion of nutrient solutions for those unable to process or absorb food); ventilators (delivering oxygen and suctioning mucus for those with cardiopulmonary disease); dialysis machines (removing waste and excess fluid for those

with kidney disease); and monitoring systems (for apnea and cardiac functioning).[8]

Nancy Guberman and colleagues find it significant that "medical professionals have delegated highly complex medical and nursing activities, activities which they refuse to delegate to other semi-professional groups (nurse aides, home-care workers, etc.), to untrained family members." The willingness of medical professionals to delegate responsibility to family members signals that they are trivializing the demands of high-tech care.[9] The assumption seems to be that high-tech equipment makes specialized knowledge and skill unnecessary much in the way that the assembly line reduced reliance on workers' skill.

What is especially striking about high-tech home treatment is that the usual medical hierarchy in which physicians (at least theoretically) oversee the work of nurses and other hospital personnel does not operate. Indeed, physicians are notably absent. They don't follow up with patients, never observe treatment being given, and exercise no oversight. Once patients are released from the hospital or nursing home, they are on their own after a brief prerelease orientation and perhaps a few home visits by a nurse or technologist.

High-technology home medical devices have been touted (by manufacturers and health administrators) for giving patients greater autonomy and mobility, so that they can "sustain normal activities far from the hospital." In practice, the devices impose considerable restrictions. In a study that compared instruction manuals for equipment with the actual experience of patients and their family caregivers, Lehoux, Saint-Arnaud, and Richard found that "the devices always both enabled and constrained the patients' daily activities and broader lives." They reported, "Some patients compared their situation to patients worse off than themselves (lateral comparisons) and tended to define their technology as capacity enhancing. Others compared their current situation to their life before technology (historical comparisons) and were much more critical of restrictions imposed by technology." Indeed, some users of high-technology devices felt a kind of "slavery to technology." They might be able to go out to a social event, for example, but "the constant presence of supplies, such as syringes, masks and bandages, nonetheless reminds everyone around of the medical nature of the technology. Tubes and noises are obvious markers that something is wrong with the user. For instance, in the case of oxygen therapy . . . [the] device makes a

regular schlock . . . schlick sound that is loud enough to be heard by people within a 2-metre range."[10]

There is a certain irony in the notion that users of high-tech home devices can live in the comfort of their own homes rather than in a sterile hospital environment. In practice, high-tech treatment transforms the home into a hospital-like setting. Space in the home has to be reconfigured to accommodate equipment, cords, tubes, and bulky supplies. In the case of oxygen therapy, the sound of the respirator is a constant background noise. Alice, a caregiver interviewed by Cameron Macdonald, described sleeping next to her ventilator-dependent husband as "sleeping with the living lung." Caregivers have to strive constantly to maintain an aseptic environment.[11]

Family dynamics and interpersonal relations are also affected by the imposition of new and often unwelcome roles and responsibilities. Patients may feel guilty for being burdens, and family caregivers may feel they have little choice but to accept the burden in order to save a loved one's life. Family schedules are dominated by the necessary routines of high-tech care—changing IVs, sterilizing equipment, and keeping track of supplies. Safety features that warn about possible malfunctions create a pervasive sense of anxiety for both care receivers and caregivers. Emergencies and technological "incidents" require immediate response. Macdonald notes that sometimes school-age children must learn to deal with machinery and provide care, as in the case of Suzanne's children, aged 16, 14, and 7. Suzanne's husband, Bill, was dependent on a ventilator, and Suzanne had to work full-time to support the entire family. Her children knew "how to recognize the meanings of different warning beeps from the ventilator, how to assist with kinked tubes, and how to help their father clear fluid from the tracheotomy site." Still, Suzanne worried: "Yeah my biggest fear is that some day one of the kids is going to walk in and find him on the floor. That just scares the living daylights out of me."[12] In these scenarios, the home as hospital is far from being the place of refuge and relaxation depicted in idealized conceptions of home.

The issue of coercion is highly germane to the circumstances of family members involved in high-tech home care. Possibilities for coercion arise in at least four ways: the degree to which individuals in particular status positions feel compelled to take on a disproportionate amount of high-tech care, the lack of alternatives (or only negative ones) for individuals

making decisions about technology-dependent relatives, the extent to which individuals providing intensive high-tech home care lose aspects of their identities and personhood, and the difficulty of "opting out" either temporarily or permanently once an individual or family has assumed responsibility for home care.

Regarding the pressure of expectations, feminist historians such as Emily Abel have noted that the closest female relative is viewed as the natural choice to provide care.[13] Nel Noddings notes, "Traditionally, the only acceptable excuse a woman has been able to offer is competing duties to care. Thus, a woman with several small children might be able to suggest, without guilt or shame, that her unmarried sister accept the duty to care for their elderly parents. The unmarried sister, however, could not escape the duty to care by pointing to her own projects personal or professional."[14] Similarly, a parent, especially a mother, if offered the option of caring for a ventilator-dependent child at home rather than have the child cared for in an institution surely feels obligated to accept the burdens of home care; to do otherwise would be viewed by others as evidence of an unnatural lack of motherly instincts. To a lesser but still significant degree, spouses feel duty bound to care for a ventilator- or dialysis-dependent partner at home rather than having them stay in a nursing home; refusal would indicate a lack of commitment, with particularly harsh judgments placed on a wife for failing to do her spousal duty.

The latter examples raise a second aspect of coercion, which is the degree to which individuals actually have choice, namely acceptable alternatives from which to choose. Often the alternative to assuming complete responsibility for home care is placing the relative in a nursing home. Cameron Macdonald describes the situation of Veronica, a 50-year-old secretary who was caring for her father, who had end-stage emphysema. Although she was willing to care for him in her time off because she considered the available nursing home "ghastly," she resisted learning to suction his lungs when they filled with fluid. Instead she called 911 several times a week to have her father taken to the emergency room to get his lungs suctioned. Macdonald concludes, "At the time of our interview, she was receiving increased pressure on all sides to either learn the procedure or put him in a Medicaid-funded nursing home that she described as 'filthy and depressing.'"[15]

Sometimes the alternative is even direr, namely that the patient would be allowed to die. Macdonald reports on the case of Tina, a 40-year-old

high school teacher whose brother needed a bone marrow transplant to treat his leukemia and would require 24-hour care after the transplant. Tina explained:

> The hospital social worker kept asking me if I could quit my job. Or if I could pay for a nurse to come in 24–7. She said he would need me to keep the house sanitary and that he couldn't be left alone for more than 20 minutes in case he spiked a fever and died. . . . Well I couldn't quit my job. I'm the only income and the only insurance for my kids. I asked her what would happen if I said no. She said he would be denied the procedure, even though his insurance would pay for it. Basically, he would die if I didn't find some way to get him 24-hour care. I couldn't believe it.

In the end Tina was able to line up 30 friends and relatives to take turns monitoring her brother's condition.[16]

A third issue that pertains to coercion is the degree to which caregivers surrender certain aspects of their personhood, such as violating valued aspects of their identity and giving up their own projects. For example, a mother of a technology-dependent child may have to administer procedures that inflict serious pain and suffering, thus violating a deeply valued self-identity as a protective mother who shields her child from pain and suffering.[17] She will also have to forego employment and activities that are important to her sense of self.

All caregivers who are enmeshed in full-time care find their autonomy restricted as their schedules are dictated by the needs of the care receiver, with little time to dedicate to their own pursuits. High-tech care is notable for exacerbating the loss of self because of the intensity and constancy of demands. By definition, a technology-dependent care receiver cannot survive if oxygen or fluids run out or equipment malfunctions. Thus the caregiver has to remain in close proximity to monitor conditions and to respond to alerts and emergencies. In such situations caregivers themselves are tethered to the demands of medical devices and confined to the home. One carer of an IV-dependent husband curtailed social activities, saying, "I didn't dare go out, absolutely not," and a wife responsible for performing dialysis four times a week said, "It's like being in jail, you can't go anywhere."[18] Another caregiver expressed the weight of accountability that was transferred along with the burden of care: "It's a huge responsibility. You think, what if something were to happen and you don't know what to do. Who's going to

live with that on the conscience for the rest of their life. Not the hospital. Not the nurse. Not the guy with the pencils trying to save money. It's the person who will have had to live through that."[19]

Finally, there is the issue of whether and how high-tech carers can discontinue caring if they decide they no longer want to carry on. One of the main features of "free labor" is the right to leave a job; thus, being bound to work for an indefinite term is the essence of coercion. At present, not only are there no clearly defined limits to the burden that an individual or family group can be expected to take on, there are no clearly accepted means of exit for those who no longer want to continue caring. Families differ in their financial, physical, and emotional resources and therefore also differ in their capacity to provide care. Moreover, individual and family resources change over time and become eroded or even exhausted.

James Arras and Nancy Dubler argue that in a just society it would be understood that there are moral limits to what might reasonably be expected from caregivers. The notion of moral limits means not only that individuals and families not be pressured or made to feel guilty for refusing to take on what they see as an unsupportable burden. It also means that family members and friends who have taken on high-tech care have the right to change their minds if they find the burden unsupportable. Any arrangements thus need to be seen as provisional or for a specified contractual period and as requiring periodic reassessment.[20] Yet treating care arrangements as contingent and contractual would violate deeply held assumptions about family and home. What is supposed to distinguish the family from other institutions is that the love (caring) and dedication among members is unconditional and absolute. As Robert Frost wrote in his poem, "The Death of the Hired Man," "Home is the place where, when you have to go there, / They have to take you in."[21]

An underlying issue is that although managed care policies often focus on the welfare of the care receiver, they fail to take the welfare of unpaid caregivers into account.[22] Even studies on the impacts of high-technology home care, for example, tend to focus on the impacts on the health and well-being of the patient; relatively few studies have focused on the effects of providing high-tech care on family caregivers. This is another instance where focusing on the needs and welfare of care recipients can render caregivers and their labor invisible.

Devaluing Mother Care

Responsibility for caring labor in the home, whether for children, the elderly, or the disabled, has traditionally been defined as women's responsibility. In the case of single mothers who lacked support from a male breadwinner, this responsibility has always been problematic. As will be discussed below, local and federal assistance to poor single mothers has always been stingy, with the majority being disqualified on moral or racial grounds.

Yet, for a brief period from the 1960s to the 1980s struggles waged by civil rights activists created a climate that led the U.S. Congress to expand welfare so as to provide some semblance of a safety net for more single mothers and their children under Aid to Families with Dependent Children (AFDC). For the first time, sizable numbers of poor African American mothers were able to gain access to welfare. Even though whites still constituted the majority of AFDC recipients, the typical welfare recipient came to be viewed by the larger society as a single African American woman. Attacks on welfare intensified in the 1980s, feeding on historic racial prejudices. Influential critics such as Charles Murray and Lawrence Mead framed the issue as one of AFDC fostering "welfare dependency" and discouraging poor women from becoming self-sufficient through employment.[23] Thus, simultaneously with medical cost-containment policies that have forced family members to take on more unpaid care work for sick and disabled relatives living at home, so-called welfare reform has sought to reduce spending on income support by diverting poor single mothers' labor from caring for their own children into paid employment outside the home. Reform efforts culminated in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which abolished AFDC and replaced it with Temporary Aid to Needy Families (TANF). TANF was designed to end welfare as an entitlement, limiting welfare benefits to five years over one's lifetime and making benefits contingent on efforts to get paid work. It also devolved responsibility for policy making and administrative oversight from the federal government to state and local entities and to the private sector. For this reason, work requirements and provision of childcare, job training, and other programs to support mothers' transition to employment have come to vary greatly from state to state.[24]

The demand that single mothers take on more paid labor outside the home may seem paradoxical given the prevalent "family values" rhetoric that calls for mothers to forgo or cut back on employment in order to spend more time with their children. However, it is consistent with the gender, class, and race construction of caring labor. The TANF program made explicit what have long been unstated assumptions: that care labor is only properly carried out when it occurs within a self-sufficient male-headed household and that poor women's and women of color's unpaid caring for their families has little social value and does not deserve public support. The fact is that single mothers on welfare have always worked to supplement stingy welfare payments. Thus the expectation and even requirement that single mothers should earn outside income is not a new development.

The earliest public assistance programs for single mothers were Mothers' Pensions, which were established by state legislatures during the Progressive Era. Advocates of Mothers' Pensions such as Edith Abbott, Sophonisba Breckinridge, and Julia Lathrop came from the settlement house movement and were concerned about child welfare and single mothers' economic vulnerability and low wages. They viewed Mothers' Pensions as a means to allow poor women to raise their children at home rather than neglecting them or placing them in orphanages. The Illinois legislature passed the first Mother's Pension law in 1911. Other states soon followed suit, and by 1920, 40 states had such laws.[25]

Contrary to the intents of maternalist advocates, lawmakers and administrators did not intend for Mothers' Pension Programs to allow poor women to stay home with their children. Uniformly stingy in their grants, administrators of Mothers Pensions expected not only mothers but also their children to engage in some form of paid work. For example, in 1913, only two years after its passage, the Mothers' Pension law in Illinois was amended to make work a requirement. The law specified that a mother "may be absent [from home] for work a definite number of days each week to be specified in the court's order." Grants were in fact contingent on recipients working. To determine eligibility, women and their children were examined to determine the extent to which they could work. Linda Gordon notes, "Most mothers' aid recipients, including widows, continued to work for wages, 84 percent in Philadelphia, 66 percent in Chicago and San Francisco, and 57 percent in Los

Angeles." She notes that these figures were underestimated because of the underreporting of women's labor.[26]

Mothers' Pension administrators also applied moral criteria, limiting eligibility only to widows and deserted mothers, so that unmarried (presumably unworthy) mothers were excluded.[27] In making determinations about eligibility, local officials routinely refused pensions to African American and Mexican widows and single mothers. They reasoned that African American mothers were "employable" irrespective of their specific circumstances. They took it for granted that jobs as domestic workers or field hands were always available and that black women should fill these positions as they always had. As for Mexican widows, county officials in Los Angeles argued that the "feudal" background of Mexican immigrants would lead them to "abuse" grants from the state.[28]

A similar pattern characterized the implementation of the Aid to Dependent Children (ADC) program in the 1930s. Depression-era stringencies had all but wiped out state relief programs, including Mother's Pensions. In response to the mounting economic crisis and widespread unemployment, the U.S. Congress passed the Social Security Act (SSA) of 1935 to provide a basic safety net. Social insurance provisions of the SSA included Survivors Insurance for Widows of Workingmen in certain industries. This insurance provided funds sufficient to meet a family's basic needs and did not have any means testing, home inspections, or rules governing the conduct of widows or their children. However, women whose husbands worked in excluded fields such as agriculture and service jobs, as well as women whose husbands had divorced or deserted them, or who were never married, had to rely on public assistance provisions of SSA, in this case Title IV, which created ADC. The program provided one-third of funds allocated by states and counties to implement the program. Title IV attempted to reduce discrimination and broaden coverage by requiring participating states to implement the program in every county and to expand eligibility to include deserted, separated, and unmarried mothers, which only a few state Mothers' Pension programs had allowed.[29]

As in the case of proponents of Mothers' Pensions, early supporters of ADC intended to create a program that would keep single mothers at home to care for their children. Frances Perkins, President Roosevelt's Secretary of Labor, testified to a Senate Committee, "You take the mother

of a large family, she may be able-bodied and all that, but we classify her as unemployable because if she works the children have got to go to an orphan asylum."[30] Edith Abbot, Dean of the School of Social Service Administration at the University of Chicago, testified, "These laws are predicated on the theory that long-time care is necessary for these children, that the mother's services are worth more in the home than they are in the outside labor market."[31]

The ADC program was administered by local boards, many of which did not share Perkins's and Abbott's views. A study of ADC in Minneapolis found that the welfare board "made an organized effort to force single girls who are on relief to accept jobs as domestics at home at starvation wages." In several states, including Virginia, South Dakota, and New Jersey, and in Washington, D.C., local welfare offices closed cases when agricultural or domestic jobs were available. In rural areas, able-bodied women were expected to work at harvesting tobacco and cotton, while in urban areas they were directed toward service occupations—as servants, hotel and restaurant workers, cleaners, and laundresses. Yet, administrators of government work programs, such as the Federal Emergency Relief Administration and the Work Projects Administration, deemed single mothers "unemployable," thus closing off these routes to relatively well-paid employment.[32]

African American, Mexican American, and other mothers of color were more likely to be denied eligibility than white women. In 1943, Louisiana implemented an "employable mother" rule that any capable woman with a child over 7 years of age should be denied assistance if there was fieldwork available. Georgia adopted a similar rule in 1951 that required able-bodied women with children over the age of 3 to work when "suitable work" was available. In both cases, the rules were intended to disqualify black women. By 1962, 33 states had inserted work requirements in their ADC regulations; many of these states cut off aid to any recipient who refused a job offer.[33]

After World War II, the rise of black civil rights activism, mass migration of African Americans to northern cities, and the increase in African Americans on urban welfare rolls (even though the majority of welfare recipients were white) gave rise to increasing attacks on welfare. In 1960 the Louisiana legislature passed a "suitable home" law that instantly disqualified 23,000 predominately black children born out of wedlock from receiving ADC. The law was part of a biannual packet of "segrega-

tion" bills designed to keep blacks "in their place." The Louisiana actions garnered national attention only when, alerted by U.S. activists, an English city council in Newcastle-on-Tyne organized an airlift of baby food to feed the children of New Orleans. A year later, the city manager of Newburgh, New York, Joseph Mitchell, enacted harsh cutbacks on welfare, limiting assistance to 3 months and setting stringent work requirements. Newburgh's actions attracted national attention and widespread support.[34]

According to Lisa Levenstein, these events turned welfare into a smoldering public issue, placing it at the center of racial politics and making "public assistance into a scapegoat for the nation's ills for the first time, but not the last."[35] Even among supporters of ADC, public assistance came to be seen less as a means to ensure that poor single mothers could care for their own children and more as a means by which black women could avoid employment. President John F. Kennedy proposed and Congress passed a series of amendments to SSA that mandated that the program, renamed Aid to Families of Dependent Children (AFDC), expend more for job training and counseling for welfare clients and provide "work incentives" for women on assistance.[36]

These work incentives became required for states with the passage of the 1967 amendments to the Social Security Act, which created the Work Incentive Program (WIN) that encouraged employment by providing education, job training, and structured job searches that recipients carried out and reported back on efforts to find work. Importantly, it allowed recipients of AFDC to keep part of their earnings. Even at peak funding in 1980 ($350 million), WIN provided only $250 to serve each potential recipient. Susan Blank and Barbara Blum note that "Operating the WIN employment and training programs cost welfare agencies more than issuing monthly benefit checks, so WIN became little more than a registration requirement for many recipients."[37]

With the rise of the civil rights movement in the 1960s, welfare recipients and their advocates became active players, organizing under the banner of "welfare rights." Their efforts, as revealed in their self-designation, were aimed at asserting economic support for poor women and children as an entitlement and ending racial discrimination in welfare policy and enforcement. Civil rights and anti-poverty lawyers filed suit in courts challenging state regulations that disqualified many poor

women and had discriminatory work requirements. These suits resulted in a few victories, notably overturning regulations that denied assistance to full-time workers. However, the courts upheld the right of individual states to set work requirements, including requirements that were more stringent than those mandated by the federal government. Strict work requirements functioned to deny coverage to many poor women, thus impeding their opportunity to care for their own children full-time.[38]

Another effort to reshape welfare policy occurred in 1988, with the passage of the Family Support Act (FSA) of 1988. The FSA created a new state-operated program known as Job Opportunities and Basic Skills (JOBS), which was designed to move more AFDC recipients from welfare to work by matching state contributions for child care, by increasing child care subsidies, and by continuing child care and Medicaid subsidies for a year after the transition to paid employment. However, funding for the JOBS program depended on individual states' willingness to put up their own funds in order to receive a federal match. Most states failed to claim all of the federal dollars to which they were entitled. In 1993, nearly one-third of the $1 billion of available federal funds went unclaimed. The success of JOBS programs varied hugely, depending on local leadership and initiative. The General Accounting Office reported that in 1992 only one-fourth of eligible recipients were engaged in JOBS activities in any given month.[39]

How does the history of governmental efforts to get women off welfare and into work outside the home relate to poor women's unpaid caring under the 1996 Temporary Aid to Needy Families (TANF) program? Many critics of TANF have charged that it represented a radical shift from an earlier time when mothers caring for minor children were held in high regard and deemed worthy of public support. As the foregoing history shows, respect for mothers caring at home was never unalloyed. Public assistance programs consistently treated African American mothers' caring as less worthy than that of white mothers. Moreover, the ideal of full-time motherhood has coexisted with the doctrine of family self-sufficiency. The two are congruent within the context of a male-headed household in which economic support and caring are divided along gender lines. They conflict when mothers and children lack a male breadwinner, and mothers are then expected to take on earning as well as caring in order to make the family self-supporting. Advocates

of Mothers' Pensions and ADC understood that low-wage employment posed a serious obstacle to mothers being able to support their children and that therefore the economic value of mothers' care work in the home was greater than the earnings their labor could command in the market. But, as we have seen, once enacted, the programs focused not on making it possible for single mothers to care for their children but instead on compelling them to fulfill their parental obligation to earn.

The stated goals of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which created the TANF program, were to reduce dependence of low-income families on government aid, promote employment and self-sufficiency, promote marriage, and reduce births outside of marriage. The TANF program differed from previous AFDC welfare-to-work programs by placing time limits on assistance—five years over a lifetime—and requiring recipients to make efforts toward paid employment within two years. PRWORA established benchmark "work participation rates" for states, starting at 25 percent and rising to 50 percent by 2002, and provided incentives to states to reduce welfare rolls in the form of "caseload reduction credits." These credits could be used to offset work participation rates, thus creating an incentive for states to remove recipients from the rolls and deny new applicants.[40]

The most visible short-term "success" of the TANF program was to reduce welfare rolls. Surveys and studies of case loads in the four-year period after the TANF program was created found that the number of recipients fell by 6.5 million, more than a 53 percent drop, with a further 300,000 fewer recipients in the fifth year. This five-year period was one of economic expansion, so there is some question about how much of the decline was caused by welfare reform. Indeed, caseloads had fallen by 18 percent in the three-year period leading up to the passage of PRWORA, partly because of state-level reforms but mostly because of favorable economic conditions.[41]

Of course, measuring the success of welfare reform solely by reduction in welfare rolls is similar to measuring success of deinstitutionalization solely by the fact that there are fewer people in institutions without taking into account the increase in homelessness. In neither case does it mean that those who are no longer included are doing better; it only means they're not being counted. Using data from the 2002

National Survey of American Families, Gregory Acs and Pamela Loprest estimated that 19 percent of recipients who left the welfare rolls could be described as "disconnected." That is, they were not on TANF, not employed, not living with a working spouse or partner, and not on disability. Who are these "dropouts"? Acs and Loprest confirmed that most are women who confront multiple barriers to employment. More than 30 percent have poor physical or mental health, 38 percent have less than a high school education, 47 percent have last worked more than three years previously; 8 percent have a child under 1; and 20 percent have a child with a disability who receives Supplemental Security Income.[42]

In the absence of public assistance and steady earnings, poor women have historically turned to informal sources of assistance such as occasional gifts from a child's father, loans of cash from a sister, or emergency housing from an uncle. These "informal" sources of assistance are as irregular and impermanent as welfare or the kinds of jobs that are most readily available; they can disappear suddenly if a partner gets arrested, a sister loses her job, or an uncle loses his apartment. Receiving assistance from family also entails reciprocal obligations, so it usually involves adding to the amount of unpaid labor that single mothers must perform.

As to transition from welfare to employment, studies conducted in the first few years after the TANF program was created found a substantial rate of employment (60 percent) for those who left welfare and a rise in employment (28 percent) among those still receiving aid.[43] The vast majority of employment was low-wage, slightly above minimum wage; even though averaging 35 hours a week, overall wages averaged about two-thirds of the federal poverty line for families. Three-quarters of workers received no vacation or sick days, and more than half were without medical benefits.[44] Over a quarter worked mostly night hours, during which it is difficult to find child care coverage.[45] Studies of the jobs held by recipients and former recipients in Maryland, South Carolina, Washington State, and Wisconsin found that a majority of former recipients worked in food preparation, sales, clerical support, or other service sector jobs.[46] As Sharon Hayes summarizes the situation, "The problem for most welfare clients, then, is not getting a job, but finding a job that pays enough to bring the family out of poverty, offers benefits, and is flexible enough to make room for the circumstances of single

parenting. The odds of finding that job—and keeping it—are not good when you are a woman with low skills and children to care for."[47]

Several major large-scale studies collected data on urban and rural poor families over several years following the implementation of the TANF program. These studies yielded rich quantitative information and ethnographic observations that bear on such important questions as whether welfare recipients have been able to remain employed for sustained periods of time; whether families are financially better off when mothers are employed instead of on welfare; and how mothers' employment affects children's well-being. Additionally, these data have been used to assess the effectiveness of specific provisions within the TANF program to encourage marriage and discourage births outside of marriage.[48]

Of central concern for this volume are two questions: How have work requirements and time limits affected the amount, form, and quality of care that single mothers provide for their children? And, to what extent do single mothers feel they are able to provide the kind of care they want for their children? Interviews with poor single mothers reveal that they subscribe to the widely held ideal of self-sufficiency. Moreover, women on welfare agree with advocates of reform that single mothers should work to support themselves and their children and that they ought not to expect others who are employed to support them.[49] It is thus not surprising that mothers who have transitioned to jobs report that they have greater self-esteem than when they were not employed. Mothers' attitudes are echoed by adolescent children, who, perhaps aware of the stigma attached to being on welfare, report feeling better about themselves when mothers are employed.[50]

Single mothers simultaneously subscribe to the dominant ideal of motherhood, which stresses the importance of mothers being attentive and available, especially in the early years of a child's life. Laura Lein and her co-authors observe:

At the core of mothers' experiences with the labor force lies a conflict. Almost universally, mothers make mothering their top priority. While policy makers might argue that self-sufficiency is a primary value, for the mothers we talked to, being a good parent comes first. Mothers weighed the possibilities provided in the labor force against the needs of their children. The greatest needs for which they contended were

for a stable and consistent home and, perhaps even more, a way of life that was secure, providing the necessities of daily living in a regular and predictable fashion.[51]

Poor mothers' prioritizing mothering over employment needs to be understood in the context of their experiences in the labor market. They value "self-sufficiency" but often do not see their low-wage jobs making them self-sufficient.[52] The kinds of jobs they typically can get are low-waged, often part-time and/or temporary, and offer no vacation time or health insurance. More than half of all mothers transitioning to work enter the service sector, which is characterized by irregular hours and lack of benefits. These kinds of jobs do not offer sick days or flexibility to allow for such contingencies as a child getting sick or problems with child care. In such cases, mothers give priority to their child's interests; they may not show up for work and so get fired, or they may decide it is not worth jeopardizing their children's well-being and quit. Andrew London and his colleagues report on the case of Toni, a 20-year-old white mother of two, who explained why she gave up her job at a suburban McDonald's:

At first I started off in the morning time. . . . I had somebody watching my children and they wasn't picking my son up on time from school. . . . He was going to get put out of the program. So I switched to nighttime so that I could pick him up. And then I was making him late to school because I was so tired. I was getting in the house like 1:30–2:00 . . . and I couldn't get up in the morning to get him ready for school. So, I just tried to get back to daytime and they didn't have room and that was it.[53]

Because they place a high priority on their children's needs, having high-quality child care while working is an important and difficult issue. The TANF program supposedly includes subsidies for child care during the first year of employment. However, some experts have found that most mothers eligible for subsidies do not receive them,[54] so single mothers have to patch together child care. Because of the length of their work days and long commutes, nearly two-thirds of full-time low-income working mothers in Chicago "relied heavily on at least two caregivers (in addition to themselves) during the course of their children's typical day." Single mothers who had kin who were willing and able to provide child care assistance (e.g., watching after children before or after school,

giving them snacks and meals, accompanying them from school to an after-school program) were most able not only to get jobs but to keep them. Roy, Tubbs, and Burton note, "Almost every mother arranged for almost all of her children to spend part of the day with a family member." Mothers reported that their own mothers provided the bulk of child care assistance.[55] Although it is undoubtedly true that grandmothers enjoy spending time with their grandchildren, in this case their childcare labor is "obligatory"—a status duty. If they do not provide assistance, their daughters will not be able to work, and their grandchildren will suffer. By performing unpaid child care, they are subsidizing the low-wage system and relieving the state and the employer from having to pay for the cost of social reproduction.

Many single mothers who have taken outside jobs complain that they do not get to spend enough time with their children. These women have the same ideals as other mothers, that parents should see their children off to school, spend mealtimes with them, oversee their homework, and read them bedtime stories. Even those who say that they have gained financially or psychologically from employment fear that their relationships with their children suffer because they have less time to spend with them. Celeste, a single mother interviewed for a 2004 study by Andrew London and colleagues, recognized the benefits of working, saying "The income is much better, and they [my four children] can get more and they're more proud of me and I'm proud of myself." However, she also spoke of loss—the loss of time with her children: "You know sometimes when they come home, cause I have to be at work by 5, so I leave at 4. When they come home from school I'm right out the door. I just give them a kiss, and I don't have that time with them no more." Danielle, a mother of two stated that the costs of work for her children outweighed the benefits: "I feel better when I go to work. . . . I like being around people. I just wish I didn't have to work so long. . . . I think I should be home when my kids get out of school, I should be here with them. But I'm not, who knows where my kids will grow up and go . . . what way they're gonna turn."[56]

That these mothers' experiences are common is confirmed by the 2003 study by Chase-Landale et al. of 2,402 low-income children and mothers in Boston, Chicago, and San Antonio. According to time-use diaries kept by mothers, preschoolers "experienced a significant decline in time spent with their mothers. When mothers moved into employment, they

decreased total time with their preschoolers by an average of 2.1 hours a day." As for adolescent children, Chase-Landale et al. noted: "There is some evidence in the literature showing that mothers are able to compensate for time away from [adolescent] children due to employment by cutting down on sleep, leisure or volunteer activities, and our time-use data suggest that when mothers went to work, they cut back on personal, social and educational activities that did not involve their children."[57] This giving up of "personal projects" and time for oneself is similar to the sacrifices made by family caregivers of medical technology–dependent children and spouses and helps explain the high levels of stress, tiredness, and anxiety that poor working women report.

Tubbs, Burton, and Roy's 2005 investigation of time use in low-income African American, Latina, and white families in Chicago further fills out the picture by showing the ways mothers juggle multiple demands and carve out "family time" with their children. The mothers made special efforts to engage their children in talk, spend mealtimes with them, provide treats, and play with them in the course of daily activities. The authors noted, for example, "Working single mothers in particular intentionally sat down to family meals with their children but did not eat with them. Their work schedules were not synchronized to their children's mealtimes, so although they were home during their children's dinner, their typical dinner meal occurred prior to or after the children's dinner time." Barbara, a 35-year-old single parent with two young children reported that she mostly snacked during the day rather than sitting down to meals. She added, "even in the evening when I do eat, I probably wait (until) after the kids have eaten. I want to make sure they've eaten." Another single mother, Cherry, said "I don't eat, I am telling you; I can't because I need to make sure this one does his homework . . . and this one doesn't go outside and cut out on me, and I need to makes sure (this one) is okay. I might get a bit here or there, but I don't really eat."[58]

Another analysis by the same researchers showed that working single mothers sacrificed employment opportunities and their own health to maintain their children's well-being. Yolanda, the mother of a kindergartner and a sixth grader, worked in a paper factory while her children were in school. Her children went to different after-school programs, an arrangement that was difficult in terms of transportation and problematic for the children, who wanted to be together in day care. To

pay for better after-school day care that both could attend, Yolanda took a third shift job delivering papers from 1:00 a.m. to 5:00 a.m. while her children slept. Low-income mothers often had long commutes on public transportation, prolonging time away from children. Barbara stayed at home and cared for her children during the day. "After preparing and serving dinner, she caught public transportation to the suburbs where she worked in a large package-loading company. Unfortunately, the suburban bus system and Chicago's bus and train system are not synchronized, with suburban buses unavailable when she finished her shift. She waited 2–3 hours for the first morning bus 3 days each week." Barbara confessed, "I always fall asleep on the (Chicago city) bus—I gotta stop that. Miss my stop."[59]

As these examples indicate, sleeping is one of the things single working mothers sacrificed to accommodate employment and caring. Tubbs and her colleagues found that 20 percent of low-income mothers had "non-normative sleep patterns," catching some sleep during the day; many had "split schedules" in which their sleep was briefly interrupted by childcare or household duties. Tubbs et al. note that most mothers sacrificed personal time by giving a high priority to time with their children. " 'My time' typically occurred late at night after the children were asleep or during a nap, often in front of the TV." The authors conclude that employment requirements have forced poor women to integrate multiple time demands into their schedules. "In a sense, as their temporal orientations have shifted, low income mothers have lost control over how to allocate family time, and at times even endanger their own health through inadequate diet, sleep deprivation, and elevated depression and anxiety."[60]

All of these findings speak to the fragility of poor single women's "self sufficiency through employment" and the contingent nature of their ability to care for their children while employed. Low-income mothers are better able to sustain employment if they are physically and mentally healthy and their children do not have chronic conditions or behavioral problems *and* they have considerable informal support from family and kin, because they receive little or nothing in the way of public assistance. Mothers with multiple problems and inadequate informal support experience greater overload and negative spillover between family care and work. Under these conditions, which are all too common, they cannot sustain employment over the long run.[61] For poor women the issue is not

the one that welfare reform has promised—that parents' employment is a precondition for family well-being; rather the issue is that a fundamental level of family well-being—including time and energy for caring—is a precondition for successful parental employment.[62]

Commodifying Care

Even as the amount of time and effort that women have been forced to devote to unpaid home health care for family members has increased, and as poor women's energies are being diverted from caring labor in the home to paid employment, there has also been greater reliance on the services of paid home-care workers.

As we have seen, federal and state policies favor non-institutional care for the elderly and disabled and also assume that family members will provide a great deal of unpaid care. However, policy makers increasingly recognize that paid home care is often needed to supplement informal care in order to keep disabled children and adults and frail elderly out of institutions. Many states have developed programs to provide home care for low-income children, parents, seniors, and people with disabilities either through direct payments to clients or through public or private home-care organizations.

The biggest source of public funds for home health and personal care comes from the joint federal–state Medicaid program, which instituted Home Health Services as a mandatory benefit for individuals who are entitled to care in a nursing home and added Personal Care Services (PCS) as an optional benefit in 1993. As of 2005, 26 states and the District of Columbia offered the PCS benefit.[63] Medicaid legislation also contains a waiver program that allows states to provide services not usually covered by Medicaid "as long as these services are required to keep a person from being institutionalized."[64] Every state offers home-care services, with most operating under these waiver provisions. States may set their own eligibility criteria but must conform to federal guidelines in order to receive grants and matching funds. As a consequence of Home Health Services, the Home Care Benefit waiver, and Personal Care Service benefits, the allocation of Medicaid funding for long-term care shifted substantially from institutional to home care. According to an AARP analysis, by 2005, more than one-third (37 percent) of Medicaid funding for long-term care was spent on home care. Out of total

Medicare spending on long-term care of $94.5 billion in 2005, $59.5 billion was spent on institutional care, and $35.0 billion was spent on home care.[65]

The growing demand for home care and the increased availability of state funds during the period before the recession that began in 2008 fueled growth in the market for paid home care. This growth was reflected in the rising numbers of those employed in providing direct care and in the proliferation of third-party entities that broker home-care services. However, in at least some states (such as California) this growth may be endangered by drastic cuts in state-funded home-care programs for 2010 and future years.

The U.S. Department of Labor (DOL) divides paid home-care workers into two categories, home health aides (who provide personal care with bathing, toileting, and dressing) and personal and home-care aides (who provide assistance with daily living activities such as housekeeping and preparing meals). According to a recent DOL report, 1.55 million workers were employed in these two occupations in 2007.[66] This number was expected to mushroom for reasons discussed above. DOL experts have projected the two occupations to be among the fastest-growing jobs in the United States, with an increase of 48.7 percent in home health aides and 50.6 percent in personal and home-care aides between 2006 and 2016, at which time 2.33 million workers are expected to be employed in these occupations.[67] All of these counts almost certainly underestimate the actual numbers of home-care workers, since, as will be noted below, a goodly portion of the home-care labor market is underground—part of the so-called "gray market."

A second effect of the boom in paid home care has been the proliferation of home-care brokers. Some of this demand is being met by non-profit organizations, such as visiting nurse associations, which have set up special divisions to provide home care to paying clients, and by public agencies such as those that administer California's In Home Support Services program at the county level.[68] Another type of non-profit is the worker cooperative, the model for which is the Cooperative Home Care Associates (CHCA), located in South Bronx, New York. CHCA was founded in 1985 with the dual purpose of providing quality home care and providing quality jobs for women wanting to leave welfare. It has contracts with state agencies to provide home-care services and currently provides jobs for 1,600 individuals.[69]

The most striking development, one that is typical of the neoliberal privatization of welfare, has been the entry of profit-making corporations into the field of home care. Their entry has been made possible by policies whereby state agencies administering programs for disabled and elderly contract services to outside entities, including profit-making companies. These companies recruit, screen, train, and employ workers who are sent out to care in recipient's homes. The availability of private health insurance dollars and federal Medicaid funds with which states and counties can pay for home health care and personal care at home has created a stream of income upon which corporations can draw.

The for-profit sector of home care, in turn, is stratified to serve different socioeconomic segments of the market. At the high end are full-service agencies that offer supervised home health and personal care for affluent seniors who can afford premium service or whose care expenses are covered by corporate employee assistance programs or long-term care insurance. Two examples are the SeniorBridge company that operates in 15 locations in the Northeast, as well as in Chicago, San Antonio, and Florida, and HouseWorks, a Boston firm that has been identified by the *New York Times* as "a boutique agency with fewer than 700 clients and gross revenues of $9 million." These upscale companies offer trained and supervised home care aides as one part of an array of home medical and health services provided by nurses, social workers, nutrition and exercise specialists, and home health and care aides, all overseen by a care manager.[70]

Competing for clients of more modest means are local home-care companies that offer only non-medical services. They cater to recently discharged patients and seniors requiring ongoing assistance, offering such services as light laundry and housekeeping, meal preparation, and escorting to doctor's appointments. Clients pay out of pocket or from Medicaid allowances. Many private firms are part of chain franchises. In exchange for franchise fees, the franchiser provides training in running home-care businesses, for example, how to recruit home-care workers and how to market and attract clients. One of the largest franchisers is Home Instead, which claims to have more than 700 "independently owned and operated franchisers [sic]" and to employ 37,000 part-time care workers tending to 43,000 elderly clients. Visiting Angels, founded in 1998, claims 300 home franchisees in 46 states.[71]

Even with these increased options, according to a *New York Times* article in 2007, more and more families are turning to the underground "gray market" to find affordable care. One might well intuit that the simultaneous entry of corporate investors and entrepreneurs into the home-care market and the development of a substantial underground economy around home care are interrelated consequences of present-day neoliberal economic policy.[72] In global cities such as New York, we find both a booming corporation-dominated formal economy alongside a vibrant underground economy, and growing affluence alongside rising poverty. Poor families and individuals have often had to work in or acquire goods and services from the underground economy to get by. What seems new is that many affluent middle-class families that do not ordinarily participate in the underground economy are doing so when they look for household help and for home care for their parents.

Clients use the gray market to avoid having to pay agency fees. For example, in New York State, a bonded, insured, and certified agency worker cost $24 an hour (of which $8.22 went to the worker), while a gray-market caregiver could be hired for half the agency rate.[73] For clients, the advantage of using the gray market is that they can afford more hours of care; for care workers, the advantage is that they can often earn more per hour and avoid deductions for taxes, although it sometimes means giving up Social Security and health insurance. Clients and care workers link up through informal referrals among friends and neighbors.[74] The main drawback for clients is the lack of formal screening, background checks, or training; however, they may also feel more comfortable when a caregiver has been "vouched for" by someone in their personal network rather than when a "stranger" has been sent by an impersonal company. Moreover, experienced home-care workers are often part of immigrant communities and/or have worked in agencies and nursing homes and know other caregivers. They can thus offer stability and flexible coverage by being able to recruit a relative or a friend to replace them, substitute during vacation time, or provide additional hours if the elder gets sick and needs more hours of care.[75]

I offer my own experience as an example of the workings of the gray market. In 2005 I was seeking home care for my mother, who needed assistance while recuperating from a back injury after falling on a bus. She needed assistance with showering, meal preparation,

light housework, and laundry. During a few initial inquiries to organizations in the local Japanese American community, I was advised that the most common and effective way to find a caregiver was to ask around my friends and acquaintances. An acquaintance who ran a twice-monthly senior program at a local church gave me the name of a Filipina woman, Julita,[76] who had taken care of a senior from her program. Julita was an experienced caregiver, middle aged with a sunny personality and a take-charge attitude. She was listed with a local hospital as a home health aide for recently discharged patients and also did freelance home care. My friend had told me that I would have to pay $16 to $18 an hour, and Julita said she would charge $16 if it was "under the table." I decided I would prefer to employ her legally and pay for social security and unemployment insurance, but once Julita met my mother, she agreed to work "on the books" for $16 anyway. For the first two months, we wanted to have someone with my mother around the clock "just in case." Julita said she could sleep in at night because she had a day job already and offered to find other women to work during the day hours. She introduced us to Malea, a young Filipina, and to Haben, an Eritrean immigrant woman, both of whom she knew through the local hospital. Julita asked us to make out any checks owed to Malea to her, and she would pay Malea. Haben had a sister, Naeema, who had recently arrived from Eritrea and needed a job; she was only beginning to learn English, but after a couple of weeks, Naeema took Haben's place. Later, when my mother needed only a few hours a day of help, Malea and Naeema took alternate days. Eventually Malea got a job as a cashier at a drugstore, and Naeema worked four hours a day, six days a week to help with meals, to accompany my mother on walks, and to take her shopping. Julita in the meantime started working full-time caring for the mother of the woman who had originally recommended her to me.

As the case of these caregivers indicates, formal and gray markets for home care are not completely separate. Some care workers, like Julita and Haben combine part-time private sector work and gray market work to get enough hours to support themselves. Other workers, such as Malea, who would not qualify for agency work and are not certified, work only in the gray market. These workers are not included in official statistics on home-care aides and home health aides, so their numbers cannot be ascertained. However, anecdotal evidence suggests that they are very numerous and that they are heavily made up of immigrant

women, with the largest representations from Latin America, the Philippines, Africa, and the Caribbean.

Although clients, public agencies, and for-profit firms lament the shortage of home-care workers, they have not raised wages and benefits to attract more workers. To the contrary, Medicaid and other programs limit hourly wage rates, often to federal or state minimum wage levels. Home health aides and home-care aides remain among the lowest paid of all occupations, with average wages for home health aides of $9.66 an hour and for home care aides of $8.74. These earnings are about half of the average for all workers of $18.84. With full-time, year-round work, home health aides would earn an average of $20,100, while home-care aides would earn $18,180, both with virtually no benefits. However, even these figures are misleading because two-thirds of home care workers do not work full-time the year around.[77] This is in part because Medicaid and insurance programs restrict the number of hours they will cover for each care receiver. Consequently, workers typically care for two or more clients each day to piece together an income. They are not paid for time spent traveling from one home to another, which can be considerable. Not surprisingly, the average home care worker's earnings was about two-thirds of full time, so that the average earnings of many were well below the official poverty line. A U.S. General Accounting Office report found that nearly one in five (18.8 percent) care workers had incomes that were below the poverty line, and more than one in seven (14.8 percent) received food stamps.[78]

Who Are the Paid Home-Care Workers?

The consequence of low wages and challenging work conditions is that few women or men choose home-care work if they have other options. As a result, the ranks of home-care workers are disproportionately made up of those whose choices are limited. One picture can be gleaned from official sources. U.S. Census data indicate that paid personal and home-care aides are overwhelmingly women (91.8 percent). They are disproportionately immigrants (24.9 percent), and whether immigrant or native, half are people of color (49.7 percent). Home-care workers are also likely to be older (median age of 46) and to have lower levels of education (30.9 percent with less than high school) than workers in other occupations.[79]

Because workers in the gray market are not accounted for in U.S. Census data, their composition may differ from those who are in the formal economy. It seems likely that newly arrived immigrants, especially undocumented immigrants, form a much higher percentage of those in the home-care gray market than those who are included in the Census. Domestic service including home care in the gray market is one of the few readily available jobs for undocumented women because they do not have the papers necessary to sign up with an agency or home-care company. As a Filipina undocumented immigrant in New York City working unofficially explained:

> My options were limited, my priorities were very clear: support my children, give them a better future, and then to support myself. My only realistic option was to work, and work meant anything that the system will allow. If you don't have work authorization you can't find things—even if you have education and skill. So that's how Philippines [sic] become domestic workers here. It's not a choice. It's not the best option for us but you do it to survive and support our families.[80]

Employers may prefer immigrant women not only because they are cheaper but also because they view them as superior caregivers. They view women from the global south as coming from traditional cultures in which families honor and take care of the elderly. Employers feel that they are more likely to work without complaining and show proper deference. Further, the immigrant's lack of citizenship makes her more "pliable" and controllable. Thus, employers can more easily take advantage of the worker. Immigrant care workers often face the problem of "job creep," being expected to take on additional tasks beyond those originally agreed upon. One care worker recalled, "You have to deal with the family, who maybe wants you to do their work, like the laundry and going shopping, and that's not what you're there for. If they don't clean up you have to clean up but you're only supposed to be cleaning the area around the patient. You get accused of things you didn't do."[81]

As in early twentieth-century relations between housewives and servants, the employment of immigrant women in home care often involves a division of labor in which the main task of family members is to organize and monitor paid caregivers who perform the physical, hands-on "dirty" work. More affluent women fulfill their obligation to care by delegating the more onerous and time-consuming aspects of their caring

obligation. And, as in the case of domestic service, paid home-care labor actually reinforces the gender division of caring labor; it also helps maintain the myth of the private family as the realm of caring and dependency and justifies the family-centered care model in which wives/daughters/mothers are ultimately responsible for the care of family members. Employing women from "traditional" cultures is particularly effective in "familizing" paid care work. If caring is viewed as a cultural trait or a natural attribute of women from Latin America, Africa, and Asia, then their labor can be seen as effortless and not real work. Thus, even though they are working for pay, immigrant caregivers help to sustain the ideal of informal family care.[82]

We can see that all of the larger trends in the global economy converge in shaping the situation of paid home-care workers: In the global north these forces include the outsourcing of production; the increasing reliance on the service sector for economic growth; the feminization of paid labor; low reproduction rates with consequent aging of the population; neoliberal economic policy such as downsizing the welfare state; and increasing income inequality. In the global south, these forces include economic "reforms" imposed by international financial institutions that have led to reduction of state welfare, selling off of state-run enterprises, and destruction of subsistence agriculture in favor of monoculture of export crops.[83]

Having lost their traditional means of livelihood and even minimal government safety nets, large segments of the rural populations in the global south have turned to transnational migration in search of work so as to support their families. A substantial portion of female migrants to the global north have found work in the service sector, including cleaning, domestic service, and home care. Like other migrant workers, they send remittances to their families in their home countries, thereby helping to keep their families and their countries afloat. For some ailing economies, such as those of the Philippines, Mexico, El Salvador, Guatemala, Algeria, Turkey, and Albania, remittances from migrants working abroad constitute a substantial portion of national incomes. In the countries where they migrate, their labor helps to bridge the contradiction between social policy that places responsibility for the care of citizens on families rather than the state and economic policies that have reduced the capacity of families to provide unpaid care, for example, by forcing members, including mothers, to devote more time to

paid employment. In short, migrant care workers are central to the maintenance of families and economies in both north and south.[84]

The social organization of caring labor has emerged as a vastly complex and variegated structure that spans the boundaries of the "private" and the "public" spheres and brings the market directly and powerfully into the home. This structure also crosses national boundaries, transferring care labor from the global south to homes in the global north. Whereas in the past, caring was largely taken for granted as belonging in the private family sphere and as an activity natural to women, we see that the way in which it is organized and carried out is far from "natural" but rather is shaped by political and economic forces, social policy, and popular discourse. We can nonetheless see significant indications of continuity in the imposition of coercion, even if the outward appearance of the forms may have changed. Today, more women than ever before are being forced to care, in new and problematic ways.

Notes

1. Who Cares?

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were women. An earlier survey study by the National Alliance for Caregiving and AARP, *Caregiving in the U.S.* (2004), 8, found that women caregivers provided an average of four more hours a week of care than their male counterparts and made up 71 percent of those caring for those requiring the highest level of care. The downloadable report is available at http://www.caregiving.org/data/04finalreport.pdf (accessed December 18, 2009).

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2. Caring for One's Own and Caring for a Living

1. The terms "production" and "reproduction," adopted by (Marxist feminist) scholars, originated in Friedrich Engels's remark that the "determining factor in history is, in the final instance, the production and reproduction of immediate life. This . . . is of a twofold character: on the one side, the production of the means of existence, of food, clothing and shelter and the tools necessary for that production; on the other side, the production of human beings themselves, the propagation of the species." Friedrich Engels, *The Origin of the Family, Private Property and the State* (New York: International Publishers, 1972), 71. I use the terms "reproduction" and "social reproduction" more or less interchangeably with "care labor" in that they all refer to the work required to maintain people as social, emotional, and intellectual beings on a daily and intergenerational basis.

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- Over 6,000 home health aides (HHAs), RNs and LPNs on staff
- All of our home health aides receive 30 hours of training over the state requirements
- We are a licensed and insured agency
- We have over 20 years of experience serving New Yorkers
- All of our home care aides must pass comprehensive drug tests, fingerprinting and criminal background checks
- We provide comprehensive in home services including companionship, private duty nursing, personal assistance, housekeeping, home health aides, PRI [Patient Review Instrument] assessments as well as geriatric care management
- We provide in home care, part time or full-time, live in care or congregate care at an assisted living facility or retirement community.

Indicating the transnational nature of the caring labor force in the United States, the six home health aides featured under "Our Outstanding Caregivers" are: Maria (a Russian immigrant), Rosa (originally from Puerto Rico), Veronica (African American), Hawanatu (from West Africa), Eleanor (Haitian), and Frankie (a male, from Puerto Rico). Descriptions are available at http://www.partnersincareny.org/a_index.html (accessed June 17, 2008).

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franchisers states, "Home Instead Senior Care is one of the most affordable options in all of franchising. Total start-up costs range from $39,050–$52,050, including the initial franchise fee of $27,500 (US & Canada)." This URL is http://www.homeinstead.com/frandev/Lists/FAQLib/ShowFAQ.aspx (accessed July 8, 2008). Visiting Angel's Web site notes on its contact site: "Visiting Angels® / Senior Homecare By Angels® has established over 400 senior home care franchises in 47 states across the United States (and Canada). We advertise and market nationally for homecare client leads and distribute hundreds of home care client leads each week to our franchisees!" The contact page can be reached via Visiting Angel's franchise Web site at http://www.livingassistance.com/fran%20op.htm. Like many franchise operations, it maintains separate or interlinked Web sites for clients (http://www.visitingangels.com/default.asp) (both accessed July 8, 2008).

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7. Creating a Caring Society

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