

SEIU Confronts the Home Care Crisis in California

January 21, 2010

Defining the Crisis

THE HOME CARE CRISIS in California is one example of a larger crisis in the practice of care in the United States.[1] That crisis involves people's way of thinking about care as well as the actual care. After all, care is a relationship in which one person provides another with fundamental support (physical, emotional, etc.), without which he/she would not be able to function at the same level. Yet care is also a service or activity, oftentimes accompanied by emotional commitment, that may or may not take place within the context of close personal relationships and may be paid or unpaid. Care is actually organized in a multitude of (sometimes fragmented) ways, whether within the family, market, state, civil society or across some mix of these four spheres that order life.[2] All types of care are in crisis, but that crisis is particularly salient where both the givers and receivers of care are living on low-incomes because they are more likely than others to patch together resources from all four spheres. Low-income families, who can neither afford to purchase care in the market nor are able to depend solely on family provision, often need to look to the state for public assistance, either of service or funding.

The care receivers of interest in this article are either seniors or people with disabilities who are living on limited incomes.[3] These individuals need some sort of help with activities of daily living, which include eating, dressing, bathing, using the toilet or moving about the home, preparing meals, grocery shopping, managing the household budget, managing medications, doing light housework and other basic activities needed for independent living.[4] They are often related or well-known to their care providers.[5] For example, Candace Howes estimates that 70 percent of the home care workers in California's In- Home Supportive Services (IHSS) network are related to the care receiver.[6]

The actual crisis in care, which has implications for both care workers and care receivers, has resulted from a combination of demographic and economic shifts that have increased the need for care while diminishing the capacity of families to provide it. One of these shifts is the aging U.S. population, which drives the increasing demand for care services. This high demand is further fueled by a general sentiment that people should be able to live in their own homes instead of medical or congregate facilities and by a trend in public administration that accepts community-based services as providing cost savings to the public.

Another important shift that contributes to the crisis is the growing participation of women in the wage labor market, a reality that makes the traditional role of full-time (never part-time) female family caregiver less and less plausible.[7] Not surprisingly, in-home care work is a highly feminized occupation, often filled by women of color struggling to provide both care and income for their own families. This type of care work is considered low-skill, and is done by personal and home care aides. (Home care aides differ from health aides in that they do not provide nursing assistance.) National-level data show that women make up 90 percent of the direct care workers, including nursing assistants, home health aides and personal and home care aides (compared to 47 percent in the labor force as a whole). As compared to other women in the labor force, home care workers are not highly educated — only 41 percent hold a high school diploma or GED, while 27 percent went to college (compared to 92 percent and 63 percent, respectively, economy-wide). On average, direct care workers are 41 years old and one-quarter are single parents. Their ethnic and racial diversity

mirrors the population of care receivers: approximately 50 percent are white, one-third are black, and the remaining 17 percent are Hispanic or other.[8] This already disadvantaged group of home care workers is further marginalized by social constructions that fail to see them as deserving of just remuneration. When coupled with the difficulty of translating this sort of care giving into a market value, it results in the persistent devaluation of home care work in the market.[9]

The devaluation of care work has two important implications in this analysis. First, it keeps caregivers in their historically dependent economic positions despite the *increased demand* for care. They are employed either by private providers that contract with the state and/or directly by the individual receiving in-home assistance. They generally do not receive benefits (e.g., health insurance, pensions, paid time off) and, in 2004, earned a median wage of \$6.99 an hour.[10] Second, it creates a labor shortage. For example, according to the U.S Bureau of Labor Statistics, the need for direct-care workers will increase by 39 percent between 2000 and 2010, but the core workforce for the field will grow by only 1.25 percent.[11] Despite these statistics, where government agencies have determined compensation packages for home care workers, as in California, compensation has been low and absent of any benefits, which perpetuates the home care labor shortage.[12] Furthermore, the labor shortage creates a feedback effect that spurs the persistence of a related policy problem — the inability of family members to find care or to get relief from their care-giving duties. As a result, neither the needs of care receivers nor those of care givers are adequately met.[13] For now, family members look to the state for assistance with respite and other services for care receivers, and, if they are fortunate enough, labor union representation to improve wages and benefits for care givers.

The absence of a comprehensive national policy to address these problems has been propelling grassroots demands to improve policies, at least at local and state levels. In order to make these demands, consumer and worker advocates have had to work within the constraints of the existing institutional framework, which does not easily accommodate the complexities of the family home care workforce. In order to examine this situation more closely, we turn to a discussion of the California system.

Analysis of SEIU Strategy in CA

THE CATALYST for the California home care system is the In-Home Supportive Services (IHSS) program, funded by Medicaid dollars and administered at the county level through departments of social services. IHSS was started in 1973 as a way to reimburse low-income families for providing care to their relatives in their homes, an attempt to address the needs of care receivers and care givers in the early years of the shifting economy. This system was based on two important ideas. First, it created a state funding structure that kept costs down by avoiding expensive long-term institutional settings. Second it was based on an "Independent Provider Model" that designated the care receivers as both the consumer and the employer, an idea deeply rooted in a progressive disability rights movement that rejects a traditional medical model (where care receivers are patients) in pursuit of consumer choice and control.[14] Over the next 30 years, this partnership of ideas between fiscal programming and consumer advocacy would develop social service provisions in most states that disregarded the role played by the worker and created unreasonable job requirements that were poorly compensated, unsafe, and disempowering.[15] In short, this partnership was effective in providing low-cost community-based care, but at the expense of care workers' well-being.

Individuals eligible for IHSS are generally care consumers who meet eligibility requirements under the federal Supplemental Security Income (SSI) program criteria. The system serves more than 360,000 people each month across all 58 counties and costs the state upwards of \$3 billion a year. County social workers interview and assess consumers' service needs and designate the

number of eligible hours of support services that consumers can receive through IHSS. Individuals receiving IHSS are considered private employers having the responsibility and right to hire, train, supervise and fire home care aides, but they do not have the ability to negotiate wages and benefits.[16]

Despite the state of California's attempt to implement a progressive policy that addressed the needs of low-income care receivers and care givers, the relationships it fostered were uneven. Though care receivers had market-based rights as consumers and workers, care givers did not. As a result, prior to the Service Employees International Union (SEIU) home care worker organizing drive in California that began in 1987, the circumstances surrounding home care work (e.g. low wages and workforce fragmentation) had created a particularly oppressed group of workers that lacked any opportunity to exercise or advance their rights outside of private negotiation with the person that they cared for.[17] SEIU's organizing strategy, which is focused on enhancing quality, choice and stability in home care service, successfully brought about concrete and needed gains in wages and benefits, improving living standards for hundreds of thousands of low-income caregivers and care receivers.[18]

In fact, prior to collective bargaining, prevailing wages for IHSS workers were approximately \$6.15 an hour (working 40 hours/week for 52 weeks that comes to \$12,792/year, before taxes) with variations across counties due to the devolved system of administration. Those workers did not receive benefit packages. Collective bargaining has resulted in substantial, if disparate, improvements for home care workers. Currently, 46,000 workers are organized under SEIU UHW (United Healthcare Workers) in 11 northern California counties and 105,000 are organized under SEIU Local 434b in Los Angeles. In addition, SEIU and the American Federation of State, County and Municipal Employees (AFSCME) have entered into an agreement and formed the California United Homecare Workers (CUHW) provisional union that represents more than 170,000 additional home care workers in the state of California.[19]

For example as of 2003, in Sacramento County home care workers earned \$9.50 an hour, plus health and vision coverage, while in Santa Clara County they earned \$10.50 an hour with health, dental, vision, transportation and life insurance.[20] In Los Angeles and San Bernardino counties, the current wage rates are set at \$8.45 and \$9.25 an hour, respectively, with benefits that include health insurance, transportation, and training.[21] The increased wages and benefits have resulted in lower rates of turnover among home care workers, whether or not they are related to the care receivers. In addition, these accomplishments have helped address the labor shortage by increasing the number of people willing and able to take home care jobs. For instance, during the five year period between 1997 and 2002, wages for home care workers in San Francisco County doubled, from \$5.00/hour to \$10.00/hour. During that same period of time, the percentage of workers who stayed in their job for more than one year increased from 39 percent to 74 percent.[22] Moreover, consumers' demand to employ IHSS workers in their homes has increased, due largely to the fact that consumers can now hire a worker they know and trust to provide that care (because the person can now afford to give it) whereas before consumers may have gone without adequate levels of care at all times. Employing care workers from one's personal network (family, community, etc.) increases the likelihood of ethnic and racial matching, which helps to explain why this particular segment of the California workforce is not as highly racialized as others.[23]

These accomplishments have not come easily. From the beginning SEIU was faced with enormous challenges brought about by the fragmented nature of work within the state and county systems of in-home support services, which impeded the process of traditional union organizing in two ways. First, there was no single employer of record against whom to make claims. Second, the workforce was geographically dispersed, with no clear place around which to organize.

The earliest and most immediate challenge for SEIU was finding a way to make claims. At times, an in-home care worker might be considered to have three employers: the consumer purchasing care through available IHSS dollars, a private for-profit or non-profit agency that employs and/or brokers service providers, and the county government agency for IHSS programming that resides within the department of social services. Part of the early organizing strategy led by SEIU, in concert with several consumer advocacy groups and IHSS participants, focused on creating one employer of record, so that there would be one cohesive entity with which to bargain.

In 1992, with the passing of the Public Authority Act, this coalition won an important victory that created an employer of record for every county in California.[24] The Public Authority is an administrative agency within the county department of social services and reports to the county board of supervisors. The IHSS Public Authority submits budgets, writes the paychecks, and is a point of contact for lobbying by consumers and workers. Additionally, it engages in bargaining with the union and assists consumers through background checks, training, referral, and setting qualifications. It also created a mediating entity that, to some extent, could deal with the complex arrangements for consumers and their family members.[25] Consumers maintained employer responsibilities in the selection, hiring and supervision of IHSS workers.[26]

Once the employer of record was established, SEIU could focus on the internal organizing of home care workers. Family home care workers do not work the same "shift" on the same "factory floor" with their "co-workers" — they work in individual homes around the county. Workers have busy schedules that significantly depend on other people's needs, where these people may be their loved ones and/or may be one of several people for whom they work. For example, in California, there are more than 300,000 providers of homecare services where approximately 40 percent are immediate family members or related in some way. Almost half these homecare providers are now organized and represented by SEIU.[27] Still, the workforce is highly fragmented and, as is sometimes the case with other workers, home care workers face a dual set of constraints in choosing how to sell their labor, with market imperatives and family ties often reinforcing one another.

SEIU's worksite organizers focus largely on encouraging workers to participate in the union meetings and lobbying activities because family members and other employees find it difficult to get away from work to participate in organizing activity. Nonetheless, anecdotally, SEIU has found that many family members will often participate in union meetings and lobbying activities to the extent that family members and other employees are able to get away from work or other responsibilities.[28] The union experiences real benefits when it is able to bring the home care workers together in one place to share their experiences, challenges and needs. Workers quickly feel empowered and realize that they can make real gains through collective action. Through this mechanism, union staff is then able to develop leadership and promote activism among its members.[29]

Both interviews with SEIU staff and research presenting union organizing strategies reveal significant challenges for internal organizing. SEIU expends a tremendous amount of resources (mostly in the form of staff time) for outreach to union members, identifying and developing natural leaders among the members and motivating activist approaches to solving workforce problems.[30] The establishment of the IHSS Public Authority in California as the employer of record along with consistent involvement from more dedicated union members has helped address workforce fragmentation to some extent. However, like any labor union, the SEIU organizes workers in order to protect and advance their rights and interests in the labor market, rendering SEIU's scope limited with respect to the broader view of care in society.[31] Moreover, while, unions may help alleviate the consequences of workforce fragmentation, they do not have the capacity to overcome the fragmentation in service delivery created by popular policies, social services programming, and fiscal systems.

Furthermore, the union has acknowledged that unresolved issues persist around brokering services for respite care, leveraging resources from other agencies (e.g. educational services, elder affairs, and disability services), and training the workforce. However, while it is the role of the state to formally address respite and service provisions that link consumer needs with worker needs, little has been accomplished in this regard. One program designed to address coordination problems is the National Family Caregiver Support Program (NFCSP), which provided states with federal grants designed to coordinate care giver support services. These small \$125 million awards are dwarfed by recent market rate value estimates of care giving as well as the number of households that perform extra care duties for people with disabilities and seniors.[32] In California, the NFCSP was primarily able to identify service gaps that the union, caregivers, and advocates already knew existed in terms of language and culturally appropriate service, transportation, respite, training, counseling, and financial assistance. The jury is still out as to whether or not the program has made any impact on coordination and access to services.[33]

One glaring limitation of the California model is the absence of any mechanisms for addressing the now well- documented financial and emotional burdens carried by families, which can be placed into the following five categories. First, the fragmented service system results in either uninformed decision making by families, leaving them ill-prepared to deal with the requirements of care, or forces caregivers into a case manager role that takes significant time and puts a constant demand on care duties in the home.[34] Second, emotional stress results from interpersonal relationships that attempt to strike an often impossible balance between the care receiver's needs and desires and the caregiver's capacity to provide.[35] Third, poor training regarding lifting and moving has resulted in injuries and physical stress. Additionally, under tight financial and time constraints caregivers will forgo medical help for themselves.[36] Fourth, one out of every five caregivers will quit his/her regular job to provide in-home care and one-third of care giving households will deplete all or most of their savings in the process.[37] Fifth, due to the cost of accessing information and services, committed caregivers (especially family members) pay out of pocket for many expenses associated with medical and health needs when the consumer is normally eligible for coverage.[38]

The example of SEIU home care worker organizing in California provides one example of how the rights of home care workers and consumers both can be advanced within the existing (largely liberal) institutional framework; it also highlights the limitations of that framework. The SEIU strategy, bound by existing institutional constraints, pursues an alignment with market norms that reconstructs care givers as workers, care receivers as consumers, and traverses multiple definitions of the employer. To some extent, the private or informal practice of care is interpolated into the public sphere and organized through the market. Yet, as this analysis illustrates, the practice of care actually overlaps the spheres of family, civil society, market and the state, especially where low-income families are concerned. Actors in civil society, such as advocates for care receivers and care givers (e.g. labor unions) mediate economic and political processes that dominate the liberal paradigm.

Despite the successes of the California model that were achieved through grassroots organizing, coalition building, state policy changes and a strong presence by organized labor, the long-term capacity of this framework to overcome the problems inherent in workforce and service delivery fragmentation is uncertain. Specifically, the fragmented and still primarily informal nature of in-home care inhibits leadership development and activism, limits access to information and services, and places the economic burden on those least prepared to deal with it — low-income families. In order to transcend these issues, the advancement and protection of rights for home care workers must include additional institutional and policy arrangements that are coordinated by the state. These new arrangements should accomplish a balance between serving and advocating for consumers, advancing worker rights and protecting the various family arrangements that are chosen

by the individuals within them.

For people who support a progressive labor movement but do not want to negate important policy concerns regarding quality of care and cost containment, it is imperative to address these larger system problems within the context of existing, emerging, and new welfare provisions. While we have focused on family home care workers, it is important to emphasize that the lack of any existing comprehensive national policy to address these issues affects *all* homecare workers. In the following section, we offer some conceptual tools that may help in solving the care crisis in a more comprehensive and inclusive way. We argue that care givers and care receivers may benefit from a reconceptualization of care and its role in ordering society, which could help inform complex policy issues that simultaneously impact healthcare, social services, labor markets and families.

Toward a New Conceptual Framework

THE ROOTS OF THE HOME CARE CRISIS rest in a tension that exists between what many see as the way care work ought to be carried out as compared with the way care work manifests itself in post-industrial society. The tension persists, at least in part, because of ideological, institutional and policy legacies that serve as constraints in accommodating the contemporary economic and demographic realities of life in the United States.[39] Most of the institutions and policies that mediate the relationships between individuals, families, the state, and the market, were constructed in the context of an industrial capitalist economy, and thus reflect the dominant liberal ideology that informed their creation. That dominant liberal ideology tends to divide society into two spheres: a public sphere where people engage in markets and politics and a private sphere that consists primarily of the family and home life where people seek solace from the public sphere.

For example, care is often thought to be a relationship that is relegated to the private sphere — something that takes place among family, friends or close-knit community members. In that discourse, care is largely seen as a voluntary activity, so that caregivers provide care to care receivers and, is thus decommodified (or at least taking place outside of mainstream market relations).[40] The construction of care as voluntary and private misses at least two important elements of care, even between family members, that are relevant in a post-industrial society: (1) a duty-based compulsion to provide care and (2) the costs to the caregiver.[41] In other words, this private negotiation is increasingly not possible (a reality that is difficult to deny) in the post-industrial economy where women are likely to work for wages outside the home, often to ensure that their families' basic needs are met. In order to combat this discourse, a competing discourse has evolved to reflect the market implications of care work.

In one strand of that discourse caregivers become care workers and care receivers are seen as consumers of care. As illustrated by the success of SEIU organizing in California, this discourse is empowering for both parties and implies that market norms of remuneration and choice (rather than family norms of love and duty) should enter the picture. However, in pushing the discourse of care primarily into the market, this construction risks veiling the important familial and relational components inherent in care work because market norms do not allow for the concept of long-term reciprocity that comes with family relations.[42] In addition, market discourse risks glossing over the fact that there are a whole set of actors and institutions cutting across spheres which mediate the relationship between the providers and receivers of care. The mediating agents include the state/county government, family, the union and advocates for care workers as well as care receivers, where individuals may be actors in more than one of these institutions. Thus, neither the dominant discourse of care as an activity existing in the private or family sphere, nor the competing discourse of care as existing in the public sphere of market fully captures the complexity of these relationships, especially for people with limited incomes. Instead, by viewing care as a set of activities that take place primarily within one sphere or another, dominant and radical discourses

implicitly recognize the various principles that dominate within those spheres and generally argue for the prominence of one over another (market over family, family over market, state over market, etc.).[43]

Even though the dominant liberal division of spheres into public and private are not sufficient for conceptualizing the way care is delivered in post-industrial society, we assert that the concept of sphere differentiation can still prove useful to help resolve the actual care crisis. Different spheres have different norms that govern the distribution of goods and services within them. These norms compete for political attention in the broader realm of the state — differentiation is a way to accord priority for some norms over others, depending on the stakes.[44] Still it is important to emphasize that these conceptual spheres, as well as the real individuals operating within them, ". . . are positioned in multiple, overlapping webs of discourse, which both constrain and enable individual agency." [45] We assert that viewing care as its own conceptual sphere, which overlaps with the spheres of state, market, family and civil society, may allow us to overcome some of the institutional and policy constraints that impede the simultaneous realization of good care provision and workers' rights protections.

What, then, ought to be the principles that govern the sphere of care? Scholars as diverse as Michael Walzer, Elizabeth Anderson, Deborah Stone, and Eva Feder Kittay offer some useful tools for understanding the limitations of existing ideology and institutions. We use their work here, and build on it, to suggest a new approach for looking at care. Combining the suggestions of Deborah Stone[46] and Eva Feder Kittay[47], we articulate four guiding principles that ought to govern a sphere of care. We do this to illustrate that care is more than an activity and more than a personal relationship, but is actually a critical sphere with broader societal impacts that are important enough to merit the development of its own norms, rather than defer to norms that govern other spheres and thereby reinforce the racialized, gendered and classed nature of care in the U.S. today. Differentiation by sphere, rather than by race, class, gender, ability/disability, can enable us to develop agreement on universal principles and the rights that protect those principles in order to guide public and private policy decisions, helping to overcome the continued marginalization of care workers along the lines of race and gender.[48]

Bowles and Gintis differentiate among sites and practices. They are: appropriative, distributive, political and cultural. Following these principles, our first principle is that individuals should be able to make reasonably unconstrained choices regarding the provision of care for themselves and their loved ones (a distributive action). The second principle states that people who provide care should be appropriately trained and justly compensated for that work (with wages and benefits), regardless of their kinship relationship to the person being cared for (a political action). The third principle asserts that people who need care should be able to get the level of care they require in the most dignified manner possible (a political action). Finally, the fourth principle claims that there ought to be a balance in accommodating the concerns and rights of persons who provide care as well as those who receive it (a cultural action). In the section that follows, we assess the California home care model in light of each of these principles.

Conclusion and Recommendations

IT IS CLEAR from the preceding analysis that SEIU organizing in California has been at least somewhat successful in battling the devaluation of home care work and addressing the labor shortage. However, it is not yet clear how well this strategy accommodates the four principles we have outlined in the previous section. In this section, we assess the strengths and weaknesses of the California home care model in light of the four principles we have outlined. This assessment provides us with the basis for a set of final recommendations for other states to consider.

Principle 1: Individuals should be able to make reasonably unconstrained choices regarding the provision of care for themselves and their loved ones (a distributive action).

Union organizing brought about higher wages and benefits, which in turn provided for a larger supply of home care workers, thus providing greater choice for IHSS eligible consumers. However, not all consumers who need home care assistance are IHSS eligible, therefore this strategy results in a fundamental inequality in the distributive action of care in that not everyone's needs are addressed equally. Instead choices remain limited, especially for those who barely miss meeting the IHSS eligibility requirements and are not wealthy (or well-insured) enough to finance home care privately. This affects the appropriative action of getting someone to perform the labor of care. In addition, one question that remains unanswered is whether the organizing of home care workers will diminish consumer control over their own care, even within the IHSS network. There is a need for additional research around the extent to which consumers exercise choice and control in the provision of care, which is both an important measurement of the quality of care as well as a skill in which workers need to be trained.

Principle 2: People who provide care should be appropriately trained and justly compensated for that work (with wages and benefits), regardless of their kinship relationship to the person being cared for (a political action).

Not all home care workers serve IHSS eligible consumers and not all home care workers are paid. As a result, some home care workers experience different levels of training, support and compensation than do others. Working conditions that are fragmented and variable feed a range of problems that affect everything from dignity to basic pay and benefits. The implications of this fragmented system exist within the state of California, but also beyond, to organized and non-organized home care workers across the country. Stabilizing the workforce requires a commonly understood and executable set of definitions around what constitutes care work and the resources, at the very least, to figure out who is doing it (a political action). It also requires inclusion of all home care workers within any newly established parameters, not only those who qualify for union jobs.

Principle 3: People who need care should be able to get the level of care they require in the most dignified manner possible (a political action).

Despite increasing the number of care workers, the California model still encompasses a coordination problem that impedes the ability of people to get the range of services they need. The state ought to provide the coordinating role, including access to information, in order to ensure that it is equally accessible to all California residents. All states and the federal government should be expending significant resources to develop and evaluate coordinating models within the vein of the National Family Caregiver Support Program.

Principle 4: There ought to be a balance in accommodating the concerns and rights of persons who provide care as well as those who receive it (a cultural action).

In order for this principle to be met there needs to be a dynamic, ongoing dialogue about what people need and how people can provide it that involves both the consumer and the provider. Union organizing and coalition building is a step towards a broader dialogue but, as evidenced by the long history of union organizing in the United States, cannot alone bring about a long-lasting and inclusive cultural movement.[49] Additionally, policy evaluation and program development that is designed under costs constraints and accountability requirements cannot take the place of public education and debates about the social and cultural importance of care. What, then, can other states learn from the California model?

Even within the existing institutional and conceptual frameworks, there is much that states can do to address the crisis of care. Most importantly, states can learn the following important lessons from the successes and limitations of the California model. Care is improved, for consumers and workers alike, when care workers are justly compensated. Yet, states that view both the work of care and access to it as policy problems cannot rely on unions alone to advance the cause for just compensation. Unions, by definition, advocate on behalf of their members while collective bargaining agreements are intended to cover those members. At the same time, unions have no capacity to address the problems surrounding the coordination and fragmentation of service delivery. States must take an active role in coordinating these services and providing information to consumers. We recommend that states pursue one of the following two alternative policy strategies in the immediate term while also embarking on a larger scale long-term project.

In the immediate term, we suggest states pursue one of the following two strategies. One option is for states that foster both a progressive consumer rights' movement and labor organizing to bring together these two groups to get benefits while assigning themselves to deal with coordination issue. The other option is for states to establish a living wage and benefits package for all home care workers — so that the benefits of better compensation (which include a bigger, more qualified and stable workforce) are not limited to unionized care workers and the consumers eligible to employ them.

In the long term, we urge states to foster a culture of collaboration between consumer groups, workers, and public agencies that maintains an ongoing dialogue about the nature of care services and delivery as society experiences demographic, economic, technological and other shifts that are bound to arise in the future. This national level discussion can inform the norms that ought to govern the policy choices and practices of families caregiving.

Footnotes

1. There are similar crises in other types of care work, including childcare, but the focus of this article is home care.
2. Eva Feder Kittay (2001). "A Feminist Public Ethic of Care Meets the New Communitarian Family Policy," *Ethics*, 111(3), 523; Evelyn Nakano Glenn (2000). "Creating a Caring Society," *Contemporary Sociology*, 29(1), 84-94; Bowels and Gintis (1987). The conceptual tensions are reflected in the discourse, which sees people receiving care as either care receivers, care consumers, or patients and people providing care as either care givers, care workers or providers. While we acknowledge that discourse matters, we use all of these terms throughout the article, in part to reflect the constraints that existing institutions place on discourse and in part because the essence of our argument is that none of these constructions alone is adequate to resolve the crisis.
3. Susan Rogers and Harriet Komisar (2003). *Who needs long-term care?* : Georgetown University Long-Term Care Financing Project.
4. Ibid.
5. We do not argue that home care workers ought or ought not be related to care receivers; the dynamics of interpersonal and family relationships vary. For some people, it may be desirable to have a family member provide care while others may prefer to purchase care in the market (given the resources to do so). The point we wish to emphasize here is that the existing patterns have emerged due to constrained choice on the part of caregivers and care receivers.

6. Candace Howes (2004). *Upgrading California's Home Care Workforce: The Impact of Political Action and Unionization*: University of California Institute for Labor and Employment. A description of IHSS is provided in the next section. While all IHSS workers are home care workers, not all home care workers are employed through IHSS.
7. These shifts have also worked to reinforce the gendered and racialized nature of care work, which has historically been devalued in capitalist society. As Glenn (2000) argues, it is difficult to separate the social construction of care work from the social constructions of traditional care workers. We recognize that race and gender factor together prominently in any analysis of care work, but do not explicitly apply those lenses in this article.
8. Bureau of Labor Statistics. (2005). *Women in the Labor Force: A Databook*. Retrieved March 20, 2006; National Clearinghouse on the Direct Care Workforce. (2005). *State Activities*. Retrieved November 28, 2005; Matthew Stewart (2005). Former Work Site Organizer, Service Employees International Union Local 715, Personal Interview.
9. Glenn (2000); Nancy Folbre (1995). "Holding Hands at Midnight: The Paradox of Caring Labor," *Feminist Economics*, 1(1), 73-92.
10. Bureau of Labor Statistics. (2006-07). *Occupational Outlook Handbook, Personal and Homecare Aids*. Retrieved February 20, 2006. By 2004, the Bureau of Labor Statistics reported that the average wage for home care workers, not including self-employed direct care workers, in CA was \$9.97 per hour (National Clearinghouse).
11. Bureau of Labor Statistics. (2006-07). *Occupational Outlook Handbook, Personal and Homecare Aids*. Retrieved February 20, 2006; Paraprofessional Healthcare Institute. (2002). *Long-Term Care Financing and the Long-Term Care Workforce Crisis: Causes and Solutions*. Washington, DC: Citizens for Long Term Care.
12. Nonetheless, it is important to note that family members tend to be more committed care workers, meaning that turnover (a common problem brought about by labor shortages) is not as salient an issue as in traditional labor markets.
13. This analysis centers on low-income family care workers, while explicitly recognizing that in order to address their issues, we must also take into consideration issues of concern to care receivers as well.
14. Stewart (2005); Beverly Takahashi (2003/04). "Home Care Organizing in California," *WorkingUSA*, 7(3), 62-87.
15. Paraprofessional Healthcare Institute. (2001). *Direct-Care Health Workers: The Unnecessary Crisis in Long-term Care*: Domestic Strategy Group of the Aspen Institute.
16. California Department of Social Services. *In-Home Supportive Services*. Retrieved February 9, 2006; Stewart (2005); Takahashi (2003/04).
17. Ibid, Ibid.
18. Service Employees International Union. (2005). *Quality Home Care Commission*. Retrieved November 6, 2005.
19. SEIU Local 434b. (2006). *Service Employees International Union Local 434B The Long Term Care Workers Union Chronology*. Retrieved February 11, 2006.

20. SEIU Local 250. (2003). *Facts About the Campaign for a Livable Wage for Homecare Workers in Fresno County*. Retrieved February 9, 2006, 2006.
21. SEIU Local 434b. (2006), Ibid.
22. Howes (2004).
23. Candace Howes uses the terms ethnic and racial matching to describe an employment relationship in which the caregiver and care receiver come from the same ethnic and/or racial group. See: Candace Howes (2002). "The impact of a large wage increase on the workforce stability of IHSS Home Care Workers in San Francisco County" Working Paper; Howes, C. (2004).
24. Stu Schneider (2003). "Victories for Home Health Care Workers: Home Care Workers Get Organized," *Dollars and Sense*, 25-27.
25. Stewart noted during an interview that family relationships could be incongruous to employment relationships; for example, a mother might work for her daughter, and that a mediating agency served an important purpose; Stewart (2005).
26. National Clearinghouse on the Direct Care Workforce. (2005). *State Activities*. Retrieved November 28, 2005.
27. Mary Ruth Gross (2006). Director of Homecare Division SEIU UHW, Personal Interview; SEIU Local 250. (2003). *Facts About the Campaign for a Livable Wage for Homecare Workers in Fresno County*. Retrieved February 9, 2006, 2006.
28. Gross (2006).
29. Stewart (2005).
30. Ibid; Takahashi (2003/04); Schneider (2003); Gross (2006).
31. Oxford Reference Online. (1999). "*labor union*" n. Retrieved November 28, 2005.
32. Peter S. Arno, Carol Levine and Margaret M. Memmott (1997). "The Economic Value of Informal Caregiving," *Health Affairs*, 18(2). Arno, Levine and Memmott calculated conservative mid-range market values for in-home care provided to seniors and adults with disabilities in the U.S. at \$196 billion a year. A similar model was used by Wilson, *et al.*, (2005) to estimate the market rate for in-home care provided to disabled and chronically ill children which produced a low-end value of \$241.5 billion. See: Leslie Wilson *et. al.* (2005). "The Economic Burden of Home Care for Children with HIV and Other Chronic Illnesses," *American Journal of Public Health*, 95(8), Additionally, it is estimated that 16% of U.S. households are providing in-home care and, as an example, this small grant award of \$125 million under the NFCSP in California, averages \$8 per caregiver household for the year. See: S. Whittier *et al.* (2005). "Availability of Caregiver Support Services: Implications for Implementation of the National Family Caregiver Support Program," *Journal of Aging and Social Policy*, 17(1).
33. Whittier *et. al.* (2005).
34. Arno, Levine & Memmott, (1999), 182.; Michael W. Rabow, Joshua M. Hauser, and Jocelia Adams (2004). "Supporting Family Caregivers at the End of Life: They Don't Know What They Don't Know," *Clinician's Corner*, 291, 483-491; Kelli I. Stajduhar and Betty Davies (2005). "Variations in and factors influencing family members' decisions for palliative home care," *Palliative Medicine*, 19,

21-32.

35. Wilson, et al. 1445-1452.

36. Arno, et al. (1999), Ibid.; Rabow, et al. (2004).

37. Ibid.

38. Arno, et al. (1999), Ibid.

39. Walzer (1983).

40. Glenn (2000).

41. Folbre, (1995).

42. Elizabeth Anderson (1993). *Value in Ethics and Economics*. Cambridge, MA: Harvard University Press.

43. Walzer (1983), Ibid.

44. Anderson (1993); Bowles and Gintis (1987), Walzer (1983).

45. It is not clear into how many spheres society should be delineated; arguably, the development of new conceptual spheres can emerge at any time as the socio- economic context of the United States reconfigures itself; Jennifer Shea (2005). *Citizenship Rights, Contracts and Four Spheres of the American Welfare State*. Paper presented at the Annual Meeting of the Georgia Political Science Association, Savannah, Georgia, November 10- 12.

46. Deborah Stone (2000). "Why We Need A Care Movement," *The Nation*, March 13.

47. Kittay (2001).

48. Anderson (1993); Walzer (1983). It is important here not to confuse universal principles with universal treatment — universal principles may require differential treatment, in order to provide equal protections to the most marginalized groups.

49. Steve Babson (1999). *The Unfinished Struggle: Turning Points in American Labor, 1877-Present*. New York: Rowman & Littlefield Publishers, Inc.