

Growing care gaps, shrinking state? Home care workers and the Fair Labor Standards Act

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Home care work will be among the fastest growing jobs in the USA in the next 10 years, linked to the increase in people aged over 65. Located at the intersection of health care, social policy and the state, home care work is notable for its low pay, job insecurity and irregular hours. The legal and economic precarity of home care workers has roots in the 1938 Fair Labor Standards Act (FLSA). We analyse the FLSA and subsequent amendments regarding home care workers, as a vehicle for exploring American state intervention into and apparent retreat from the social safety net and promoting collective well-being.

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Introduction

Among society's most pressing questions with the aging of the population is who will help growing numbers of frail elderly with routine tasks at home, such as bathing and dressing and cooking. Families often take on these caregiving responsibilities, but the job isn't practical for many working boomers and Gen Xers, families with far-flung children, widows and widowers and the childless elderly. That's why the need is so great for professional home care workers (Farrell, 2018).

The care gap regarding elder care in the USA has reached such a point that *Forbes* now publishes pieces such as Chris Farrell's to explore its dimensions. As more Americans are getting

older, the need for care is on the increase. A range of studies by policymakers, advocates and scholars suggest that there is a strong preference among older people to remain in their homes as they age. Given some support, this is possible for many. Yet, as Farrell remarks, while this is often taken on by immediate family members, an adequate level of support is not always possible for a variety of reasons. Who will care for older people, especially the so-called 'frail elderly', is a pressing policy concern in the USA. It lies at the intersection of macro- and micro-level demographic pressures and structural changes associated with ageing populations and family and household structures, as well as the availability of unpaid and paid care. The expanded need for care is occurring

alongside neoliberal fiscal austerity measures that contract the supply of publicly funded or subsidised care, shifting it towards market-oriented, for-profit delivery mechanisms.

The trend in the USA is towards more community-based home care (rather than institutional long-term care), which is creating increasing demand for home care workers. Occupations in home care work, long associated with ‘women’s work’, are among the jobs expected to grow the fastest in the next 10 years. Yet home care jobs continue to be notable for their low pay, job insecurity and long and irregular hours. This conundrum is our entry point into addressing claims about the ‘shrinking state’. We bring together threads from existing literature on theorising social reproduction and the ongoing gendered and racialised inequalities in home care work, and weave them together with ideas about social policy regimes, state restructuring and the marginalisation of care work in capitalist economies. We focus on this increasingly common group of workers as a vehicle for exploring American state intervention into and apparent retreat from the social safety net and values that promote collective well-being. In particular, we locate the roots of the legal and economic precarity of home care workers in the New Deal and the passing of the Fair Labor Standards Act (FLSA) in 1938 and then trace forward to recent amendments that cover most (but not all) home care workers.

Emerging care crisis: the home care industry and the state

In 2011, while surrounded by home care workers, President Obama announced plans to extend the FLSA to cover home care workers, more than six decades after the original 1938 act excluded them (Office of the Press Secretary, 2011). Also in 2011, the first US baby boomers (born in 1946) reached the age of 65 years. The latest data released by the US Administration on Community Living (2018) indicates that in 2016, there were 49 million people aged 65 and

older, representing 15% (or one in seven) of the population. In 1940 (soon after the FLSA was first passed), there were only nine million people aged 65 and older, 7% of the population. As more of the baby boomers age and enter retirement, the numbers are projected to reach 56 million in 2020 and 82 million by 2040. Who will care for these older people and where and how to pay for that care is a pressing policy concern.

Unsurprisingly then, there is increasing talk in a variety of fora about ‘care crises’, ‘care gaps’ and ‘care deficits’ emerging at different scales and from both the ‘public’ and ‘private’ spheres. On the private side of the equation is the increasing numbers of frailer, older people expanding the need for daily care (both as direct care and as assistance with household tasks). They are joined by the increase in working parents managing the demands of their work–life balance and limited family leave, along with the tensions of being part of the ‘sandwich generation’, caring for their own children and their ageing parents. As more women are in waged work, their availability to provide this unpaid yet vital care work for their own families and in their communities has declined, effectively leading to a care gap in their homes. Despite evidence of a normative and numerical change in men’s engagement in unpaid care work, the proportion of stay-at-home fathers and men as primary caregivers remains small in Western contexts (Boyer et al., 2017). These trends are coupled with a care deficit in the public sphere associated with the high cost and limited availability of private commercial and in-home care, and the withdrawal of publicly funded cash support for families and the diminishing supply of publicly subsidised care. This is exacerbated by a shortage of people going into and staying in home care work.

Boris and Klein (2012), in their historical analysis of home care workers in the USA, argue that to understand the situation of home care workers means “we must reflect on the nature of care and its place within the welfare state” (Boris and Klein, 2012, 8). In many

Global North countries, over the course of the 20th century, welfarist measures were established to address social and economic inequalities, with the goal of creating a more equitable society. In these instances, some care became monetised and commodified as the provision of some aspects of care became waged work paid for either through government programmes or the labour market (Boris and Klein, 2012; Federici, 2013; Jenson, 2015). The extent to which this happened has varied as different nations determined their versions of appropriate levels of state support and then revisited those commitments over time (Jenson, 2015). In Gough's (2013, 208) useful comparative typology of state support and social protections, he describes a social policy regime as "provisions that ameliorate harmful life process and invest in human capacities" and empirically explores how the parameters of those provisions and investments vary over time and across space.¹

Feminist scholars theorise social policy regimes and state power as co-constituted with a range of social relations of difference, including gender, race and ethnicity, as well as class and the ways these get materialised in and through socio-spatial practices and processes in various scales, sites and spaces. Two further sets of concepts come into play here. The first is social reproduction, which can be defined as "a range of activities, behaviours, responsibilities and relationships that ensure the daily and generational, social, emotional, moral and physical reproduction of people" (Bezanson, 2006, 175). Social reproduction has been a key theme for feminist scholars for some time. Highlighting the significance of unpaid domestic labour occurring in the homes of workers, social reproductive labour became theorised as a socially necessary component of capitalism, vital for the daily and intergenerational reproduction and maintenance of 'productive' labourers and their families.

Initially, social reproduction was understood as unremunerated activities occurring in the family home that are crucial to the

reproduction of the paid labour force. Making visible the various divisions between care and the economy also has a long history in feminist scholarship, dating back to at least the Marxist-feminist domestic labour debates of the 1970s (Federici, 2013; Folbre, 2012; Strauss and Meehan, 2015). Given the tremendous expansion and commodification of care work, it is now conceptualised as spanning unpaid and paid work. Yet, as Strauss and Meehan explain:

(M)any approaches to conceptualizing the interrelationship of "the economy," "society" and "capitalism" still fail to take into account the relationship between paid labor and unpaid work, or to understand value in ways that don't rely on monetization and traditional definitions of productive activity (Strauss and Meehan, 2015, 3).

In the context of social policy, social reproduction can be achieved through a variety and balance of sources, one of which is the state. This links to the second concept variously known as the 'welfare mix', the 'responsibility mix' and the 'welfare diamond' or 'care diamond'. This captures the ways in which the responsibility for the care of older adults (and the young, disabled and sick) is distributed among families, the state, the voluntary sector and the market (Jenson, 2015; Razavi, 2007). Some states might seek to minimise the extent to which the market determines access to care (this includes the provision of health care and education), and while families might be assumed to hold primary responsibility for their own family members' well-being, some states provide subsidised services or cash benefits for access to early childhood education and elder care, while others expect families to purchase what they need through the market. Social welfare provision, then, depends on a mix of states, markets, communities and families, and feminist scholars remind us that these four institutions themselves are socially constructed by social relations of difference (Abramovitz, 2018;

Kofman and Raghuram, 2015). Bringing social reproduction and the welfare/care diamond into an analysis of the state results in a “political economy approach that embeds welfare institutions in the ‘deep structures’ of social reproduction”, and this then “forces researchers to analyse social policy not merely in technical but in power terms” (Gough, 2013, 209; also see Kofman and Raghuram, 2015).

Nancy Folbre (2012, xi) writes that “everyone is affected by the organization of care work” and that whether “paid or unpaid, care work is often shaped by moral obligations, social norms and personal preferences that greatly complicate its remuneration”. As an occupation and industry, home care is dominated by women and associated with low pay, long and irregular hours, job insecurity, informality and limited coverage under labour laws and regulations (see, for example, Folbre, 2012; Glenn, 2010). Home care work is deeply affected by its social and legal misrecognition as not “real work”. This misrecognition of home care work stems from its historical association with women’s unpaid familial responsibilities and its affective and reproductive (rather than “productive”) character. Indeed, early exclusion of domestic workers from the FLSA and the continued partial exclusion of some home care workers is underpinned by discourses emphasising that care work was and still is different from other forms of labour.

Home care and the state: the FLSA and the exclusion of home care workers

Normitivated notions of domesticity continue to seep into constructions of female-dominated jobs in care work, especially when it occurs in the home (Boris and Klein, 2012; Strauss and Meehan, 2015). Boris and Klein remark that care work is devalued not only because it is feminised and racialised, but also because of the way it has been structured by the state. The devaluation of paid care work is “not only

structural and ideological, but a product of conflict and accommodation between experts, state authorities, workers, care receivers and institutions since the New Deal” (Boris and Klein, 2012, 8).

In the decades leading up to the New Deal, activists had pushed the State—most often at the state and local levels—to take on more of the costs and provisions of social reproduction, such as expanding public health, introducing public parks and some limited proto-social welfare programmes like Mothers Aid and Workman’s Compensation (Abramovitz, 2018). The modern welfare state in the USA can be dated back to various legislation associated with F. D. Roosevelt’s New Deal, notably the 1935 Social Security Act. This introduced, at the federal level, Keynesian-flavoured regulations to revive the economy and undergird Americans’ economic security. From then until the mid-1970s, expanding the welfare state was represented as a means of addressing the economy as well as social and political issues. As Abramovitz (2018, x) explains “(w)elfare state programmes supplied business and industry with consumers armed with increased purchasing power as well as a healthy, educated and properly socialized workforce”.

The 1938 FLSA established some of the most fundamental labour protections for American workers, including a federal minimum wage rate, the 40-hour work week and overtime provisions. It was also the last major piece of legislation passed as part of F. D. Roosevelt’s ‘New Deal’ and was intended to “eliminate conditions detrimental to the maintenance of the minimum standard of living necessary for health, efficiency and general well-being of workers”. The FLSA, along with other major US labour laws, was developed in response to pressure from organised industrial workers in the early 20th century (Nadasen, 2015; also see Mettler, 1998).

In general, the federal government had been shifting towards embracing a role for organised labour and introducing regulations to

undergird economic security and offer some protection from what Roosevelt called “the hazards and vicissitudes of life”. Indeed, and as [Kessler-Harris \(2001, 64\)](#) remarks, “Americans moved from staunch opposition to federal government intervention in the lives of most men (but not women) to eager experiments with government mediations of every kind”. Much of this raised vigorous debate about the government’s relationship to different groups of citizens, and ultimately, these debates circulated around inclusions and exclusions. Which groups should be covered by this social programme or that economic policy, who was a “worker”, what counted as “work”, who deserved which entitlements and benefits? Ultimately, domestic workers, including home care workers, were placed on the exclusion side of the equation.

After much debate and compromise, several occupations were excluded from the FLSA, notably domestic workers and agricultural workers, both occupations dominated by African Americans. This is often described as a concession to Southern Democrats concerned about their ‘southern way of life’ and the centrality of the cheap (African-American) labour component of their region’s racialised political economy and competitive advantage ([Katznelson, 2013](#)). Yet it also reflected what [Kessler-Harris \(2001, 5–6\)](#) calls “gendered habits of mind” that meant that “racialized gender constitutes a central piece of the social imaginary around which social organization and ideas of fairness are constructed and on which social policies are built”.

In the end, according to [Kessler-Harris \(2001\)](#), the 1938 FLSA only covered perhaps as little as 20% of the labour force, primarily industrial jobs such as mining and manufacturing. Women were disproportionately excluded from the FLSA. Those in garment and textile factories were covered, but not those in low-paid clerical, retail or restaurant jobs. Also excluded was the agriculture sector, as were canneries and food processing plants, as were those employed in transportation or by

the government and non-profit organisations ([Glenn, 2010](#); [Kessler-Harris, 2001](#); [Milkman, 2014](#)). Occupational segmentation meant that the majority of African-American women lacked protection under the FLSA; one-third of them worked as domestic workers. As [Nadasen \(2012, 77\)](#) comments, “the law drew upon the conflation of domestic work with women’s labor of social reproduction and the racialized composition of the workforce, predominantly immigrant and African American, (and thus) reinforced paid household work as a degraded occupation”. In all, various occupational exclusions denied coverage to 90% of African-American women and most Latinas and three-fifths of African-American men (who accounted for 80% of agriculture workers). Subsequent amendments increased coverage to most employees, agricultural workers were included in 1966 and many service sector workers gained coverage with the 1974 amendments, but most home care workers remained on the exclusion side of the equation ([Kessler-Harris, 2001](#); [Mettler, 1998](#)).

Like much of the 1930s New Deal legislation, the FLSA represented a social contract between the state, capital and the working class around the conditions of paid work and economic security. This social contract was dependent on and deeply implicated in the invisible gender contract struck at the scale of the home, based on heteronormative assumptions about the gender division of labour with a male breadwinner and female homemaker ([Kessler-Harris, 2001](#); [Mettler, 1998](#)). That paid care work was not ‘real work’, and the home is not a real workplace percolates throughout the 1938 FLSA ([Kessler-Harris, 2001](#); [Nadasen, 2012, 2015](#)). Although for different reasons, unions and maternalist-inspired advocates for women both pressed to strengthen ‘protective’ labour legislation for (middle class, white) women and to maintain the family and household as a protected private space, supposedly out of reach of state regulation. A strict distinction between home and work, both ideologically and spatially was to

be maintained. Moreover and as [Kessler-Harris \(2001, 105\)](#) laments, “(i)f the final, hard won Fair Labor Standards Act only dimly reflecting the hopes of its originators, it starkly captured the gendered and racialized sensibilities that underlay the political battles”

In 1974, during the Nixon administration and after years of organising by domestic workers, Congress amended the FLSA to extend limited coverage to some domestic workers, including those employed by private households ([Glenn, 2010](#); [Nadasen, 2012](#); [US Department of Labor \[DOL\], 2013a](#)). Though yet again, some legislators argued that domestic work was a private matter to be sorted out between housewives and their ‘maids’, and intimate care should remain within the family and outside of federal labour legislation ([Nadasen, 2015](#)). Some categories of domestic workers (house cleaners and full-time nannies—as opposed to ‘casual babysitters’) finally enjoyed minimum wage and overtime protections under the FLSA, a significant achievement and recognition of their work. However, those engaged in jobs deemed to be ‘companions’ were exempt. Legislators intended that companions provided occasional or limited social support for disabled and older people. However, the US Department of Labor interpreted the exemption more broadly and applied it to workers providing not only social support but also housekeeping and personal care—essentially home care workers (personal care aides and home care aides), including by those workers who lived in and those employed by private home care agencies ([Nadasen, 2012](#); [US DOL, 2013b](#)). Thus, thousands of home care workers were exempted from the most basic labour protections guaranteed by the FLSA.

The contemporary home care system

The care policy landscape in the USA today is complex, taking a variety of forms through a range of programmes that operate across different government agencies and levels

of government. Medicaid and Medicare are the primary ways that home care is funded, both introduced as amendments to the Social Security Act in 1965. Medicaid is a means-tested medical assistance programme for low-income people, with cost sharing between the federal and state governments. It is significant source of funding for long-term care of the frail elderly (and adults with disabilities). Medicare is the federal health insurance programme for people over 65 (and some younger adults with disabilities), paid for primarily through payroll taxes and general revenue ([Duffy et al., 2015](#)). Provision can be via government-operated home care agencies, private non-profit agencies or for-profit agencies associated with one owner all the way to large corporate chains ([Howes, 2015](#)). Regardless of ownership, agencies are funded largely by Medicaid and Medicare, along with 15% from state and local governments, 8% from private health insurance and about 10% from individual care recipients and their families ([US DOL, 2013b](#)). The contemporary home care industry is, as [Rhee and Zabin \(2009, 970\)](#) comment, “located in the growing interstices between the welfare state and low-wage, private service sector”

As an industry, home care is difficult to define using official industrial categories (by the US Census and the US Bureau of Labor Statistics [BLS], for example). It includes parts of two different industries. One is Home Health Care Services, which provide personal care services in the home as well as skilled nursing services and other services, such as physical therapy; medical social services; occupation and vocational therapy; and medical equipment and supplies. The other is Services for the Elderly and Persons with Disabilities, which provides for the social welfare of the elderly and people with disabilities, both in the daycare settings and in the home. Together these two industries employed 2.5 million people in 2016, although not all these people are employed in home care ([BLS, 2018](#)). The range of organisations included in these industries involve non-profit

providers, large for-profit franchise chains and smaller private home care companies offering limited services, such as overnight care (Howes, 2015; Seavey and Marquand, 2011).

As with the industry, the definition of a home care worker is not straightforward. Home care workers provide a wide range of tasks, including assistance with the basic activities of daily living such as dressing, bathing, feeding and toileting, as well as the instrumental activities of daily living that enable someone to live independently, such as preparing meals, managing medication and finances. These workers are often included in what are collectively known as ‘paraprofessional direct care workers’ (by the US Department of Health and Human Services, for example). This occupational grouping includes personal and home care aides (sometimes called personal attendants) and home health aides, and sometimes home care-based nursing assistants are also included. The BLS *Occupation Outlook Handbook* (2018) indicates that personal care aides are generally “limited to providing non-medical services, including companionship, cleaning, cooking and driving.” Home health aides, while designated “non-medical,” provide basic health-related services (depending on the state they live in), such as checking a client’s pulse, temperature and

respiration rate. They may also help with simple prescribed exercises and with giving medication. Occasionally, they change bandages or dressings, give massages, care for skin, or help with braces and artificial limbs. With special training, experienced home health aides also may help with medical equipment such as ventilators, which help clients breathe. Personal care aides and home health aides often visit more than one client in the same day, some visiting four or five. The worker–client relationship is frequently long term, sometimes lasting for several years.

The BLS *Occupational Employment Statistics* provides national industry-specific occupational employment and wage estimates, allowing a breakdown of occupations by industries. Figure 1 is based on the numbers employed in home care occupations for the two home care industries (Home Health Care Services and Services for the Elderly and Persons with Disabilities), compared with those same occupations in all industries for 2002–2016. Overall, the number of home care workers across all sectors has grown markedly in the 15-year period from 2.3 million in 2002 to 3.7 million in 2016, a growth of 59.5%. A remarkable increase in and of itself, but additionally, an increasing share of these workers are employed in just the two home care industries; that share rose from 23%

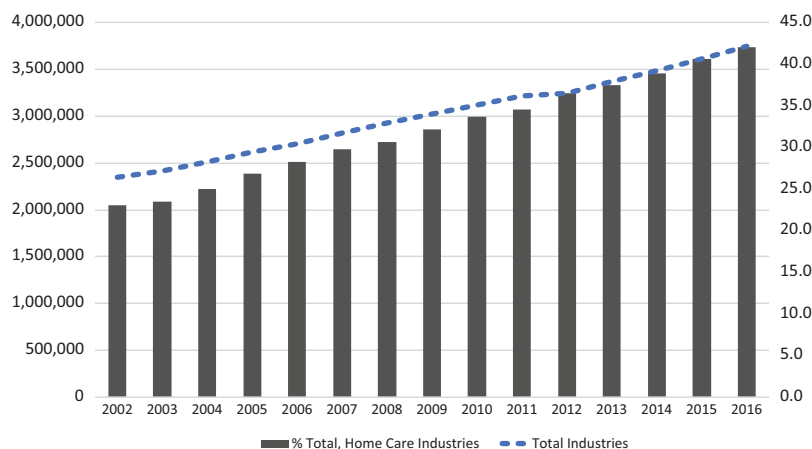


Figure 1. Absolute growth in home care occupations and percentage of those occupations in home care industries. Source: BLS (2018).

in 2002 to 42% in 2016. This shows the increase in these occupations generally, but also the increasing importance of their presence in the home care industry.

According to the [BLS \(2017\)](#), home health aides and personal care aides are projected to grow 41% between 2016 and 2026, creating over 1.2 million new job openings. This is not only much faster than the average for all occupations (7%), but it also makes them the third and fourth fastest growing occupations (solar photovoltaic technicians and wind turbine technicians are first and second). This projected occupation growth obviously echoes the anticipated future expansion of the population aged over 65 years.

Despite being such a significant and growing workforce, as [Table 1](#) shows, home health aides and personal care aides earn a median annual income of about \$13,800 (\$11 per hour), compared with \$31,000 for all occupations ([BLS, 2017](#)). However, due to the unpredictable and inconsistent nature of home care work, most work less than full time, averaging about 34 hours per week, and only 42% work full-time, year-round (also see [Campbell, 2017](#)). Moreover, about half of home care workers rely on some kind of public assistance programme to supplement their income, especially if they are women of colour ([Paraprofessional Healthcare Institute \[PHI\], 2017](#)). Care work in general is deeply saturated with the histories of socio-economic inequalities around race, class and gender in the USA, and these remain the central organising principles in the differential distribution and social organisation of care work ([Glenn, 2010](#)). Glenn argues that 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 minorities and immigrant women into positions entailing caring for others” ([Glenn, 2010](#), 506). As is evident in [Table 1](#), home care work remains a highly feminised and racialised occupation. Over 85% of those

Table 1. *Profile of home care workers, 2015.*

	All industries	Home care industries
Gender (%)		
Women	47	88
Men	53	12
Race/ethnicity (%)		
White	69	42
Black or African American	11	28
Latinx (any race)	15	21
Asian	5	6
Median age (years)	42	45
Education (%)		
High school graduate	26	35
Some college, no degree	18	18
Employment (%) and income		
Part-time or part-year employment status	25	68
Median personal earnings	\$31,000	\$13,800
Median family income	\$66,011	\$44,100
Poverty level (%)		
Less than 138%	n/a	57
Less than 200%	n/a	53
Public assistance (any) (%)	27	52

Note: na, not available.

Source: [BLS \(2018\)](#) and [PHI \(2017\)](#).

employed in home care industries are women, and women of colour account for 55% of the work force, compared with 31% in the economy as a whole.

Ironically, although they work in a health care industry, 40% of home care workers live in households receiving Medicaid and 18% of home care workers lack health insurance, a drop from 35% in 2010, primarily due to the Affordable Care Act, which expanded a variety of options for health insurance coverage ([Campbell, 2016](#); [PHI, 2017](#)). This is particularly troubling considering, first, the vast majority of home care workers are also paid directly or indirectly through Medicare and Medicaid-funded home care programmes ([Howes, 2015](#)), and second, home care workers have one of the highest rates of injuries and illnesses of all occupations, well above the national average ([BLS, 2018](#)). The on-the-job injuries come

from tasks such as lifting clients in and out of beds and bathtubs; even with equipment such as Hoyer lifts this can be hazardous work. Similarly, assisting clients in standing or walking can cause injury (England and Dyck, 2012). Additionally, clients with mental health issues might engage in difficult and even violent behaviour, and of course, risk of infection is part of the job (Duffy et al., 2015). Currently, several stories are emerging about sexual harassment on the job (Spector et al., 2014), in addition to the widely documented instances of racism and discrimination and even veiled accusations of theft (England and Dyck, 2012).²

The Fair Labor Standards Act and home care in the 21st century

Since the FLSA was first introduced in the 1930s, the economy and labour force have changed markedly, with the rise of the service sector and the growth of women's employment, including mothers (Milkman, 2014). Initially excluded, some jobs associated with domestic work eventually were covered under the FLSA, with home care work continuing to remain an exception despite its growing significance. In the 45 years since the passage of the companionship exemption in 1974, the number of private-sector home care agencies and the number of home care workers have increased markedly (see Figure 1 for some sense of this in the early 21st century). Through amendments to Medicaid in 1981 and subsequent waivers, states gained the option to provide long-term care in home- and community-based care services provided via agencies, in addition to institutional settings (Howes, 2015). By 2011, when the Obama Administration first proposed revising the companionship exemption, nearly two million home care workers were employed by private, usually for-profit agencies, and not covered by the FLSA (Office of the Press Secretary, 2011). After two years of review by the Office of Management and Budget, in October 2013, the Final Rule was

announced that the FLSA would extend basic labour protections to these workers, with a date effective in January 2015. Soon after the announcement of the Final Rule, three major associations representing networks of home care agencies challenged it in Washington DC District Court (Home Care Association of America, the International Franchise Association, the National Association for Home Care and Hospices v. Weil et al.). They won a partial summary judgement against the US Department of Labor in District Court on the basis of "arbitrary and capricious exercise of authority" and "irreparable harm" to home care providers, Medicaid payment models and home care clients' health. It was appealed by the Department of Labor and reversed, and the new ruling went into effect in October 2015 and full implementation began in January 2016.

The new ruling creates two major changes to the existing companionship exemption. First, the definition of "companionship services" is now restricted to the provision of "fellowship and protection". Second, third-party employers such as private home care agencies can no longer claim exemption from the FLSA, regardless of the kind of tasks their workers perform and where (US DOL, 2013a). Now the two million home care workers (home health aides and personal care aides) employed by private home care agencies are covered by minimum wage, overtime and other labour protections. The significance of this change cannot be understated. However, the delivery of home care has changed in recent years with the growth of consumer-directed home care. If clients hire their home care worker directly from a home care agency, those workers are covered by the FLSA. However, not all home care workers are covered. It is increasingly common for workers to find their way into already low-paid home care work through other routes that are not always covered by the FLSA.

The increasingly familiar class of workers in nonstandard forms of labour, the so-called 'independent contractor', is making its way into

home care work (Howes, 2015). These workers are often in jobs that were previously categorised as ‘employees’ and had better labour protection. It is part of a growing set of business strategies that essentially shift market risk to individual workers. In the 1990s, states started to move away from provision via agency-directed home care programmes towards models that emphasise consumer-directed home care (all 50 states now offer some form of consumer-directed care services) (Sciegaj et al., 2016). In the agency-directed programmes the state reimburses home care agencies that assign workers to particular clients. The consumer-directed programmes are funded differently. They were originally developed to give clients greater flexibility to address their specific care needs, and to allow the client more control and independence over managing their care needs. Under this model, the state positions the client as an employer with responsibility for finding, hiring, directing and firing home care workers. While important for clients’ self-determination, this may well conflict with the workplace rights of home care workers (Howes, 2015; Smith, 2007). In addition, the client can hire someone who is classified as an ‘independent provider’. This growing category of workers are not agency employees and are often in informal employment arrangements, paid through publicly funded consumer-directed programmes or directly by the client. The *Paraprofessional Healthcare Institute* (2017) estimates that there are at least 800,000 independent providers employed through publicly funded consumer-directed programmes and also notes that state governments generally not do not track how many are employed in this fashion. This means the state is further invisibilising already well-hidden and undervalued employment.

Shrinking state? Changing social policy and the changing state

The expansion of the contemporary home care industry is occurring in a different phase

of state formation, one marked by redrawing the boundaries between civil society, the market and the state, in the name of neoliberal flavoured fiscal austerity. Most often this has involved efforts by the state to balance the tensions between domestic commitments to their territorialised political system with being economically competitive in a globalising economy. As a state form, neoliberalism involves an agenda aimed at reducing government spending while increasing economic efficiency and competitiveness through the rhetoric of free markets, privatisation and marketisation (Cowen and Smith, 2009). In short, the state has transformed into a model of governance underpinned by economic liberalism that calls for privileging the market and limiting government spending, especially on social welfare programmes (Hendrikse and Sidaway, 2010; MacLeavy, 2012).

David Harvey’s description of neoliberalism and the role of the state is useful here. He defines neoliberalism as a theory and practice drawing from a strand of political economy that posits that “human well-being is best advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices” (Harvey, 2005, 2). Clearly, this is a shift away from the more Keynesian welfarist vision of statecraft underpinning mid-20th-century ideologies that promoted social programmes that advance “human well-being” through “institutional frameworks” based on collective responsibility. This neoliberal turn is evident in many different sorts of states across the globe adjusting at least some of their policies and practices, “sometimes voluntarily and in other instances in responses to coercive pressures” (Harvey, 2005, 3), to embrace deregulation, marketisation and privatisation.

The financialisation of life has become more commonplace as the market dominates

the everyday—privatisation, reregulation and public sector cuts. As [Hochschild \(2012, 9–10\)](#) remarks, “many aspects of post-1970s American life slipped from the realms of community commons and government into the market. Prisons, parks, libraries, sectors of the armed forces, security services, schools, universities—these have moved, in full or in part, into for-profit hands. The market, it is said, can do things better—even in the home”. The growth of home care and the emergence of both for-profit agencies and independent contractors should be understood in the context of neoliberal policies and politics that underscore a discourse about the continued retreat of the state from direct welfare provision ([Pratesi, 2018](#)). In addition to being one of the fastest growing sectors within the American economy, the home care industry is a \$74 billion industry ([PHI, 2017](#)). For-profit agencies were able to become Medicare certified in 1981, and their share has grown markedly since then, accounting for 62% of agencies in 2010, and for-profits have garnered much higher revenues and profits than other types of providers ([Cabin et al., 2014](#); [Howes, 2015](#)). Some of the growth can be linked to increased demand, but there is also an element of budget balancing by governments, given that home care is cheaper than institutional care ([Duffy et al., 2015](#); [Rhee and Zabin, 2009](#)).

In terms of impacts on social policy, as Nancy [Fraser \(2013: 4\)](#) puts it “(r)escued from the historical dustbin, ‘neoliberalism’ authorized a sustained assault on the very idea of egalitarian redistribution”. She goes on to point out that a feminist movement built on pressing to modify the welfare state by extending “its egalitarian ethos from class to gender, now found the ground cut from under their feet” ([Fraser, 2013: 4](#)). As with other social policy regimes, those inspired by neoliberalism are also spatially contextual, culturally produced and constituted with systems of social difference ([Abramovitz, 2018](#); [Gough, 2013](#); [Kofman and Raghuram, 2015](#)). The social, economic and governance changes wrought by neoliberalism

have animated feminist scholars to revisit political economy approaches through the lens of social reproduction ([Bakker, 2007](#); [Federici, 2013](#); [Strauss and Meehan, 2015](#)). Even the Keynesian welfarist state had only assumed public responsibility for some parts of social reproduction, most of it remained the responsibility of women, leaving it invisible and yet also undervalued as skilled work ([Armstrong and Armstrong, 2004](#)). As neoliberalised social policy is about narrowing the scope of the state’s responsibility for care, [Bakker \(2007\)](#) refers to the *reprivatisation* of social reproduction to capture how social reproduction is being repatriated to the private sector (the market) and the private sphere (the home). Moreover, the gender contract “assumes particularly harsh tones and shades under neoliberal times” ([Pratesi, 2018, 67](#)), evidenced by economic inequalities and the (re)privatisation of social reproduction and lived out as curtailed workers’ rights, lower wages and limited access to need-based social provision.

In the context of the USA, neoliberalisation has involved the reorganisation or ‘rolling back’ of the scalar, spatial and temporal configurations of state formations. Accompanied by the mantra of ‘less government’ aimed at stemming the growth of the social provision, limiting taxes and “the destruction and discrediting of Keynesian welfarist and social-collectivist institutions (broadly defined)” ([MacLeavy, 2012, 251](#)). However, this unfolds alongside a qualitative shift to active state building, most often of a penal and even carceral sort, involving rolling out new institutions and new regulatory reforms around, for instance, social assistance, immigration and health care. This reconfiguration of responsibilities involves not only the neoliberal restructuring of the welfare state, but also a shift away from collective responsibility and towards neoliberal values of consumerism and individual responsibility that draws on forms of individualism and freedom in which people are expected to be more self-reliant and are responsibilised as moral agents.

Nevertheless, even in its seemingly diminished form, the welfare state provides and regulates collective services intended to meet basic social needs. Thus, neoliberalisation often means more, not less, state intervention, and as MacLeavy (2012, 252) remarks, “rather than simply encouraging the withering away of the state, neoliberal programmes of government have instead entailed reconstitution of state capacities and political subjectivities across different spatial contexts.” The welfare state is not shrinking, but instead different sorts of ‘welfare’ are emerging associated with new modes of state apparatus. Hendrikse and Sidaway (2010, 2039) problematise the claim that “neoliberalism is a simple case of less state, more market,” insisting instead that it is a “the reconfiguring of both, so they become more thoroughly intermeshed”.

As Boris and Klein (2012, 7) point out, home care is “straddled between welfare and a state-subsidized medical sector” and is created around a workforce whose employment is heavily dependent on public funding (both as the source of their pay, and, for many through their eligibility for Medicaid, for their own health care). It is also an industry that is built around intimate personal worker–client relationships, which often binds people together beyond the pay check. In fact, perhaps in contrast to Strauss and Meehan’s (2015, 3) critique of the interrelationship of capitalism, the economy and society being conceptualised without grasping the relationship between paid labour and unpaid work, and failing “to understand value in ways that don’t rely on monetization and traditional definitions of productive activity”—the home care industry is an exception. The industry fundamentally relies on ‘paid’ labour that is often unpaid or underpaid (for instance, in terms of overtime) and pivots on the nonmonetary value of caring about, as well as for, clients. While the revenues of the for-profit segment of the home care industry have grown, the inflation-adjusted median hourly

wages for home care workers have stagnated, growing from \$10.33 in 2006 to a mere \$10.49 in 2016, suggesting not only a relative decline in real wages, but also that rates for services have increased while wages remain low, pointing to the importance of precarious labour for the profit margin in this sector (PHI, 2017; Seavey and Marquand, 2011).

The erstwhile ‘privacy’ of a client’s home being the workplace of a care worker contributes to the intimate employee–employer relationships that blur the lines of employment. In short, as Glenn (2010, 136) argues, “by reason of its location in the home, paid caring labour has been treated by the legal system similarly to unpaid domestic labour, as a labour of love,” governed by private familial relations of affection and nurture and thus represented as not appropriate for state or market intervention. The National Association for Home Care and Hospice, one of the three major associations in the Home Care Association of America v. Weil case, is currently actively lobbying Congress for a reversal of the Final Rule extending minimum wage and overtime coverage to home care workers. As the home is increasingly presented as the ideal site for elder care, this means “a workforce is required that will accept the poor pay, long and uncertain hours and the limited employment rights and regulatory oversight that often accompany paid care work in the home” (Schwiter et al., 2018, 463).

Conclusion

Home care is located at the intersection of health care, social policy and the welfare state. As most of the funding comes from federal, state and local governments (although it is Medicaid and Medicare that are especially important), home care is a version of public sector employment. In broad terms, the contemporary state has retreated from funding and directly providing public services associated with social reproduction, but it has also introduced apparatus

that increases market-oriented, for-profit delivery mechanisms. An apparent shrinking of the state in quantitative terms is linked to a qualitative shift in state building, both underwritten by neoliberal ideology and practices that alter the parameters of the role of the state, citizenship and popular understandings about the public-private and collective-individual relationships. This double move is apparent in the social policies, including the FLSA, governing home care, and is likely to continue to be a significant sector on which to focus research, as home care is predicted to be one of the key sources for jobs going forward: even in recent periods of jobs lost (the Great Recession, for instance), jobs were added to the home care industry.

The structure of the current economic accounting system cannot easily assign or measure the market value of care work (Folbre, 2012). Yet the state has been and continues to be an important site of women's struggles for the valuation of care, whether paid or unpaid. Even in neoliberal times this remains the case. In the past, the state took on some aspects of social reproduction, and the legislative and public debates associated with amending the FLSA about whether home care is 'real work' worthy of labour protections appear not to have led to its higher valuation (in monetary and even in cultural terms). Kessler-Harris' notion of "gendered habits of mind" (2001, 6) are still in play. They continue to shape the discussions and the boundaries of political possibilities and thus the parameters of social and economic policy that directly affect the working conditions of home care workers, which, even with the 2015 extension of FLSA to cover minimum wage and overtime protections, remains a precarious occupation. The site of home care work obviously cannot be changed, and as ageing-in-place at home becomes the model for elder care, the continued demand for home care workers can only be expected to grow, and without further shifts in political will, perhaps with it the care crisis too.

Endnotes

¹ While our focus here is on the changing US social policy regime at the federal level, there is variation within the USA. States differ in how, for example, they structure Medicaid and the extent to which they require extensive training and whether they enable unionisation or extend state-level labour protections to include home care workers. For instance, some states and municipalities have passed "Domestic Workers Bill of Rights", which includes home care workers (England, 2017).

² Domestic workers have long been active in fighting for better workplace rights, including at various points in the history of the FLSA (for historical and contemporary overviews, see Boris and Klein, 2012; England, 2017; Nadasen, 2012, 2015).

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References

- Abramovitz, M. (2018) *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present*. New York: Routledge.
- Armstrong, P. and Armstrong, H. (2004) Thinking it through: women, work and caring in the new millennium. In K. R. Grant, C. Amartunga, P. Armstrong, M. Boscoe, A. Pederson and K. Willson (eds) *Caring For/Caring About: Women, Home Care and Unpaid Caregiving*, pp. 5–44. Toronto: University of Toronto Press.
- Bakker, I. (2007) Social reproduction and the constitution of a gendered political economy, *New Political Economy*, 12: 541–556.
- Bezanson, K. (2006) The neoliberal state and social reproduction: gender and household insecurity in the late 1990s. In K. Bezanson and M. Luxton (eds) *Social Reproduction: Feminist Political Economy Challenges Neoliberalism*, pp. 173–214. Montreal and Kingston: McGill-Queen's University Press.
- Boris, E. and Klein, J. (2012) *Caring for America: Home Health Workers in the Shadow of the Welfare State*. Oxford: Oxford University Press.
- Boyer, K., Dermott, E., James, A. and MacLeavy, J. (2017) Men at work? Debating shifting gender

- divisions of care, *Dialogues in Human Geography*, 7: 92–98.
- Cabin, W., Himmelstein, D. U., Siman, M. L. and Woolhandler, S. (2014) For-profit Medicare home health agencies' costs appear higher and quality appears lower compared to nonprofit agencies, *Health Affairs*, 33: 1460–1465.
- Campbell, S. (2016) *The Impact of the Affordable Care Act on Health Coverage for Direct Care Workers*. Bronx, NY: PHI. <https://phinational.org/wp-content/uploads/2017/07/aca-impact-dcws-brief.pdf> [Accessed April 2018].
- Campbell, S. (2017) *Racial and Gender Disparities with the Direct Care Workforce: Five Key Findings*. Bronx, NY: PHI.
- Cowen, D. and Smith, N. (2009) After geopolitics? From the geopolitical social to geoeconomics, *Antipode*, 41: 22–48.
- Duffy, M., Armenia A. and Stacey, C. L. (2015) *Caring on the Clock: The Complexities and Contradictions of Paid Care Work*. New Brunswick, NJ: University of Rutgers Press.
- England, K. (2017) Home, domestic work and the state, *Critical Social Policy*, 37: 367–385.
- England, K. and Dyck, I. (2012) Migrant workers in home care: responsibilities, routes and respect, *Annals of the Association of American Geographers*, 102: 1076–1083.
- Farrell, C. (2018) The shortage of home care workers: worse than you think. *Forbes.com*, <https://www.forbes.com/sites/nextavenue/2018/04/18/the-shortage-of-home-care-workers-worse-than-you-think/#759e4803ddd4> [Accessed April 2018].
- Federici, S. (2013) *Revolution at Point Zero*. Oakland, CA: PM Press.
- Folbre, N. (2012) *For Love and Money: Care Provision in the United States*. New York: Russell Sage.
- Fraser, N. (2013) *Fortunes of Feminism: From State-Managed Capitalism to Neoliberal Crisis*. Brooklyn, NY: Verso.
- Glenn, E. N. (2010) *Forced to Care: Coercion and Caregiving in America*. Boston: Harvard University Press.
- Gough, I. (2013) Social policy regimes in the developing world. In P. Kennett (ed.) *A Handbook of Comparative Social Policy*, pp. 205–224. Cheltenham: Edward Elgar Publishing.
- Harvey, D. (2005) *A Brief History of Neoliberalism*. Oxford: Oxford University Press.
- Hendrikse, R. P. and Sidaway, J. (2010) Neoliberalism 3.0, *Environment and Planning A*, 42: 37–42.
- Hochschild, H. (2012) *The Outsourced Self: Intimate Life in Market Times*. New York: Metropolitan Books.
- Howes, C. (2015) Home Care: The Fastest Growing Low-Wage Industry, *New Labor Forum*, 24(2): 98–105.
- Jenson, J. (2015) Social innovation: redesigning the welfare diamond. In A. Nicholls, J. Simon and M. Gabriel (eds) *New Frontiers in Social Innovation Research*. London: Palgrave Macmillan.
- Katznelson, I. (2013) *Fear Itself: The New Deal and the Origins of Our Time*. New York: Liveright Publishing.
- Kessler-Harris, A. (2001) *In Pursuit of Equity: Women, Men and the Quest for Economic Citizenship in Twentieth Century America*. New York: Oxford University Press.
- Kofman, E. and Raghuram, P. (2015) *Gendered Migrations and Global Social Reproduction*. London: Palgrave Macmillan.
- MacLeavy, J. (2012) The lore of the jungle: neo-liberalism and statecraft in the global-local disorder, *Area*, 44: 250–253.
- Mettler, S. (1998) *Dividing Citizens: Gender and Federalism in New Deal Public Policy*. Ithaca, NY: Cornell University Press.
- Milkman, R. (2014) Women workers and the Fair Labor Standards Act, past and present. In A Paper Series Commemorating the 75th Anniversary of the Fair Labor Standards Act. US Department of Labor. <https://www.dol.gov/asp/evaluation/reports/FLSAPaperSeries.pdf> [accessed March 2018].
- Nadasen, P. (2012) Citizenship rights, domestic work and the Fair Labor Standards Act, *Journal of Policy History*, 24: 74–94.
- Nadasen, P. (2015) *Household Workers Unite: The Untold Story of African American Women Who Built a Movement*. Boston: Beacon Press.
- Office of the Press Secretary (2011) We can't wait: President Obama Will announce administrative action to provide minimum wage and overtime protections for nearly 2 million in-home care workers. *White House Press*, 15 December 2011. <https://obamawhitehouse.archives.gov/the-press-office/2011/12/15/we-can-t-wait-president-obama-will-announce-administrative-action-provid> [Accessed July 2018].
- Paraprofessional Healthcare Institute (2017) US Home Care Workers: Key Facts. https://phinational.org/wp-content/uploads/2017/09/phi_home-care_factsheet_2017_0.pdf [Accessed April 2018].
- PHI. (2018) *Workforce Data Center*. <https://phinational.org/policy-research/workforce-data-center/>. [Accessed March 2018].
- Pratesi, A. (2018) *Doing Care, Doing Citizenship: Towards a Micro-Situated and Emotion-Based Model of Social Inclusion*. London: Palgrave Macmillan.
- Razavi, S. (2007) *The Political and Social Economy of Care in a Development Context: Conceptual*

- Issues, Research Questions and Policy Options*. Programme on Gender and Development (Paper No. 3). Geneva: United Nations Research Institute for Social Development (UNRISD).
- Rhee, N. and Zabin, C. (2009) Aggregating dispersed workers: union organizing in the 'care' industries, *Geoforum*, 40: 969–979.
- Schwiter, K., Strauss, K. and England, K. (2018) At home with the boss: migrant live-in caregivers, social reproduction and constrained agency in the UK, Canada, Austria and Switzerland, *Transactions of the Institute of British Geographers*, 43: 462–476.
- Sciegaj, M., Mahoney, K. J., Schwartz, A. J., Simon-Rusinowitz, L., Selkow, I. and Loughlin, D. M. (2016) An inventory of publicly funded participant-directed long-term services and supports programmes in the United States, *Journal of Disability Policy Studies*, 26: 245–251.
- Seavey, D. and Marquand, M. (2011) *Caring in America: A Comprehensive Analysis of the Nation's Fastest Growing Jobs: Home Health and Personal Care Aides*. Paraprofessional Healthcare Institute. <http://phinational.org/sites/phinational.org/files/clearinghouse/caringinamerica-20111212.pdf> [Accessed July 2018].
- Smith, P. R. (2007) Home sweet home: workplace casualties of consumer-directed home care for the elderly, *Notre Dame Journal of Law, Ethics and Public Policy*, 21: 537–560.
- Spector, P. E., Zhou, Z. E. and Che, X. X. (2014) Nurse exposure to physical and nonphysical violence, bullying and sexual harassment: a quantitative review, *International Journal of Nursing Studies*, 51: 72–84.
- Strauss, K. and Meehan, K. (2015) Introduction: new frontiers in life's work. In K. Meehan and K. Strauss (eds) *Precarious Worlds: Contested Geographies of Social Reproduction*, pp. 1–22. Athens, GA: University of Georgia Press.
- US Administration on Community Living (Department of Health and Human Services) (2018) Profile of Older Americans: 2017. <https://www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2017OlderAmericansProfile.pdf> [Accessed May 2018].
- US Bureau of Labor Statistics (2017) Occupational Outlook Handbook: Home Health Aides and Personal Care Aides. <https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm> [Accessed March 2018].
- US Bureau of Labor Statistics (2018) Occupational Employment Statistics, 2002–2017. <https://www.bls.gov/oes/> [Accessed March 2018].
- US Department of Labor (2013a) *Fact Sheet: Application of the Fair Labor Standards Act to Domestic Service, Final Rule*. Wage and Hour Division. <http://www.dol.gov/whd/regs/compliance/whdfsFinalRule.pdf> [Accessed March 2018].
- US Department of Labor (2013b) Final rule: application of the Fair Labor Standards Act to domestic service, *Federal Register*, 78: 60454–60557. <http://www.federalregister.com/Browse/Document/usa/na/fr/2013/10/1/2013-22799> [Accessed January 2018].