NEW SOLUTIONS, Vol. 20(4) 441-464, 2010

THE POLITICAL AND ECONOMIC CONTEXT OF HOME CARE WORK IN CALIFORNIA

EL CONTEXTO POLÍTICO Y ECONÓMICO DEL TRABAJO DE CUIDADO EN CASA EN CALIFORNIA

LINDA DELP
CARLES MUNTANER

ABSTRACT

California's primarily female, ethnically diverse home care workforce is at the intersection of the public and private spheres of work and at the front line of recurring policy and budget debates targeting government-funded long-term care services. The convening of a Home Care Research Working Group in 2001 has led to collaborative action research initiatives and advocacy for policies to improve working conditions and home care services. The study reported here demonstrates that: 1) current long-term care policy is inadequate to ameliorate home care stressors such as physical and emotional demands, schedule conflicts, financial strain, and job insecurity; 2) workers' experience of home care differs by gender and by race or ethnic group; and 3) a union that actively engages workers is a viable avenue to provide individual support and empowerment as well as collective advocacy for home care services, critical in an era of attacks against health and social service programs.

RESUMEN

La fuerza laboral de los trabajadores de cuidado en casa (*home care)* consiste en su mayoría en mujeres de diversos orígenes étnicos. Se encuentra en la intersección de los sectores laborales públicos y privados y en el centro de

doi: 10.2190/NS.20.4.d
http://baywood.com

debates políticos sobre los servicios de cuidado a largo plazo financiados por el gobierno. Un Grupo de Investigación sobre el Cuidado en Casa formado en el año 2001 ha resultado en colaboraciones para llevar a cabo iniciativas de investigación-acción y abogacía para políticas que mejoren las condiciones de trabajo y los servicios de cuidado en casa. Uno de estos estudios demuestra que: 1) las políticas actuales de cuidado en casa a largo plazo son inadecuadas para reducir las fuentes de estrés tal como las exigencias físicas y emocionales, los conflictos con los horarios, la presión económica y la inseguridad laboral, 2) la experiencia de los trabajadores de cuidado en casa es diferente según su género, raza o grupo étnico y 3) un sindicato que involucra a los trabajadores activamente es un camino viable para dar apoyo y desarrollar el poder de los trabajadores a nivel individual y collectivo y también para abogar por los servicios de cuidado en casa, lo cual es crítico en una época de ataques contra los programas de salud y servicios sociales.

Demographic changes have fueled the growth of the U.S. home care workforce in recent years, with an estimated 600,000–800,000 workers now employed to care for the disabled of all ages [1, 2]. Despite key advances for workers, a gendered devaluing of care work continues to shape long-term care policy. Home care is characterized by low wages, limited benefits, and stressful working conditions, while the workers themselves remain largely invisible to society at large. Laboring in the isolated confines of individual homes, the predominantly female, ethnically diverse workforce performs tasks construed as unskilled with minimal supervision and support.

This article focuses on workers in California's In-Home Supportive Services (IHSS) Program,[1] the largest publicly funded consumer-directed home care program in the country, employing more than 300,000 workers to care for nearly 450,000 poor elderly and disabled consumers [3]. The IHSS consumer-directed model of home care crosses the boundary between the private sphere of unpaid caregiving and the public sphere of paid employment, by funding care provided in the home and by allowing consumers to choose their own providers, who may be family members. The context of this work—framed by the convergence of economic and political factors, gendered ideologies of care, and labor and social movements—shapes the characteristics of the workforce and of working conditions, as diagrammed in Figure 1. These factors underlie women's sense of responsibility to provide care [4] as well as their access to alternative jobs [5], thus influencing who is in the workforce. They also underlie workers' exposure to job-related stressors, their access to support to cope with those stressors, and the degree of control they have over their jobs and careers.

[1] IHSS is available to anyone who meets income and asset eligibility requirements.

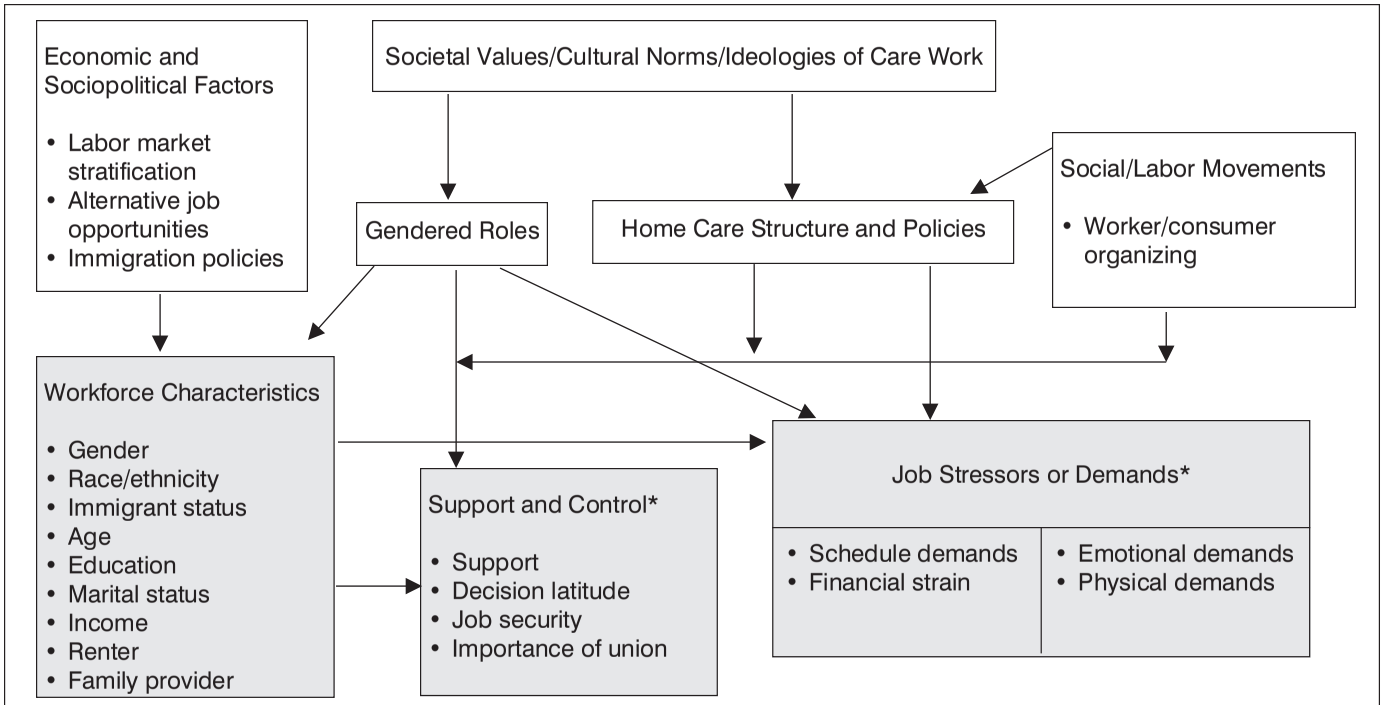

Figure 1. Conceptual model of social, cultural, economic, and political factors that shape home care work.

The location of the work and the gendered nature of the workforce make home care workers vulnerable to policies that exploit women [6, 7]. Prior to unionization, IHSS workers received no health benefits, and their wages were limited to the state minimum. A consumer and worker campaign led first to legislation establishing County Public Authorities—entities with which workers could bargain collectively—and subsequently to unionization and improved wages and benefits [1, 8, 9]. However, resources for home care are subject to recurring budget battles that pit the program's political allies against those who maintain a stranglehold on the budget process, cutting resources for government health and social service programs and threatening the very existence of the program [3, 10]. Home care workers and the consumers in their care bear the brunt of the ensuing budget cuts. Workers are rarely compensated for travel costs, training time, or overtime work [11]. They are paid less than aides in hospitals and nursing homes [12], perhaps because the home is associated with unpaid work. Lacking the clear job descriptions and the built-in structures imposed by institutions, home care workers are likely to work unpaid hours to care for consumers who are authorized an insufficient number of hours to meet their needs [13-15].

BACKGROUND

This study is part of a larger mixed-methods investigation of IHSS workers in Los Angeles County, who comprise half of the statewide total. Methodology, measures, and focus group results, as well as multivariate analyses of factors associated with depression, job satisfaction, and musculoskeletal disorders, have been reported elsewhere [16-19]. In this article we provide a profile of the workforce and explore workers' experience of job stressors, as well as the degree of support and control they have, by gender, race, and ethnicity. We also discuss the role of home care policies, in particular the importance of unionization, in this dispersed workforce.

METHODS

An estimated three-quarters of the Los Angeles IHSS workforce speak English or Spanish as their primary language. A probability sample of 4,530 English- and Spanish-speaking workers was drawn from a total workforce of 72,000 workers on the County payroll at the time of the survey; limited resources prohibited sampling from the smaller groups of workers who speak many other languages. Half (52%) of the sample could not be reached, primarily due to incorrect phone numbers. Ultimately, 74 percent of those contacted (1,614) completed computer-assisted telephone interviews conducted by trained peer home care workers. Six focus groups—three in English, two in Spanish, and one in Mandarin Chinese—were conducted with a total of 71 workers; quotes that

illustrate key themes from the data analysis are presented here to help interpret survey findings.[2]

Survey questions were developed or adapted for the home care workforce from existing measures based on results of focus group discussions. Measures chosen for this analysis reflect the conceptual model of job demands, control, and support [20, 21] as adapted to include emotional demands [22] and as shaped by the framework depicted in Figure 1. This framework derives from a review of the literature and from ongoing discussion among members of the California Home Care Research Working Group. The Working Group, comprised of researchers from a variety of disciplines, labor and consumer advocates, and representatives of public authorities, was initiated in 2001 to identify research needs related to the home care workforce and their working conditions, to conduct research and disseminate findings, and to advocate for policies to improve the IHSS program.[3]

RESULTS: A PROFILE OF HOME CARE WORKERS

> Sheila,[4] an African American home care worker for seven years, cares for her 20-year-old daughter and for another unrelated consumer. In the focus group, she recounted the challenges of caring for someone with multiple sclerosis and shared ideas with other workers about how to care for severely disabled consumers. She is involved in union activities, which she "just loves."
>
> Leonor, a Latina home care worker for 14 years, cares for her son and two other unrelated consumers. Her children, husband, and other relatives depend on her wages. She is in the early stages of diabetes, and began to care for unrelated consumers to accumulate enough hours to be eligible for health benefits. Her husband suffers from depression and depends on her job for health benefits. She longingly articulates her desire for a day off.

[2]Funds for data collection and analysis were provided by the National Institute for Occupational Safety and Health (NIOSH) grant R01OH007440 (Muntaner, PI), supplemented by funding from the Robert Wood Johnson and Atlantic Philanthropies Better Jobs, Better Care Initiative (Howes, PI) and the Institute for Labor and Employment (Abel, Leavitt, Boris, Delp, PIs).

[3]Delp was a co-founder of the California Home Care Research Working Group, which convened regular meetings, policy briefings, and a statewide conference on home care. Funding was provided by the University of California Institute for Research on Labor and Employment and its predecessor. Working Group collaboration was presented as a model of action research by Delp and North at the 5th International Congress of Women, Work and Health in Zacatecas, Mexico, in 2008. Research articles, reports, and policy briefs by Working Group members and collaborators are on the Working Group website: http://laborcenter.berkeley.edu/homecare/. Many thanks to Working Group members for their ongoing collaboration and to Eileen Boris and Loretta Stevens for useful comments on an earlier version of this article.

[4]All names are pseudonyms.

Survey results described below quantify the stressors experienced by home care workers like Sheila and Leonor and highlight similarities and differences by gender and by race or ethnic group.

Sociodemographic Data

Home care workers in this study are about one-third African American (32%), almost one-quarter White (23%),[5] and nearly half Hispanic (45%). The majority are middle-aged women who rely on IHSS wages to enable them to care for family members. They are poor and about half are immigrants. Sample averages conceal significant sub-group differences as depicted in Table 1.[6]

Gender

Workers are predominantly women (86%). With an average age of 52, female home care workers are slightly older than their male counterparts, more likely to be married or living with a partner, and less educated. They report a lower income and are more likely than men to be Hispanic and to be immigrants. Men are more likely to be African American and to be renters.

Race and Ethnicity

The great majority of African Americans are U.S.-born (98%); they are more educated than the Hispanic workers and are the most likely to rent. They are the least likely to be married (28%). Hispanic workers are most likely to be female (93%) and married (65%); they are the least educated (half have less than a high school education) and the most likely to be immigrants (94%) and noncitizens (51%). They report the lowest income, but the least difficulty paying bills, which may reflect a tendency not to complain about hardship [23]. Whites are most heterogeneous in terms of racial and ethnic composition. Somewhat less than half are immigrants (44%), originating from countries as diverse as Armenia, Croatia, Russia, and Saudi Arabia. White workers are the most educated, report the highest household income, and are least likely to be renters.

Job Stressors

Job stressors include the physical and emotional demands of providing direct care, and the schedule-, money-, and health-related stressors that originate in home care policies and can exacerbate care work demands. Focus group participants vividly described the stressors they face on a daily basis, sometimes with sadness, often with humor. Quotes below represent themes that emerged across focus groups and reveal the nuances underlying survey findings.

[5]"White" is a misnomer, as the group is very heterogeneous.
[6]All subgroup comparisons discussed in the text are significant at $p = 0.05$.

Physical and Emotional Demands

Physical demands are measured by workers' overall assessment and by the frequency of performing common tasks (see Table 2). Consumers require assistance with a variety of tasks such as lifting, walking, bathing, and household chores. Hispanic workers report lower physical demands compared to African Americans and Whites, perhaps due to a difference in appraising demands or because Hispanic consumers have different needs.[7] Men report their jobs as more physically demanding than women, possibly because consumers expect men to perform more demanding tasks. Workers rarely experience abusive behavior; those who do are at increased risk of depression [18]. The need to conceal feelings is somewhat more common, especially among Hispanic workers.

Focus group participants discussed the physical and emotional demands of caring for people who are sick, in pain, or dying, as well as those who are unreasonable or abusive. They described health problems ranging from mental exhaustion to back injuries and dog bites; emotional demands include the strain of confronting the death of a loved one or of being subject to verbal abuse.

> When I was taking care of my mom it went well until she got within 4 months of her death. . . . And honest to goodness it takes everything out of you. . . . I was so drained mentally and I haven't been well since.

> Having two or three patients, that takes a lot out of you and then you try to be polite and courteous . . . and they're hollering at you.

A worker of six years who was caring for seven people described the impact of multiple physical stressors:

> One time I overworked so that my two hands had tendon inflammation at the same time. Usually, people just have the inflammation on one hand. The condition is so serious that I can't even hold chopsticks. . . . Now, my nose has serious allergy problems because we contact disinfectant every day. I have to carry eye drops with me too.

Workers described a lack of control over their work environment, someone else's home:

> My client . . . smokes a lot. I get some very sore throats. It makes me kind of sick, all that smoke coming in my lungs. . . . You can't tell them, would you not smoke?

> Another thing, the elders like to have pets; what if the pets bite you? I have been bitten twice.

[7]Overall, 77% of workers care for consumers of the same race or ethnic group: 74% of Hispanics, 63% of Whites, and 93% of African Americans.

Table 1. Sociodemographic Characteristics of Workers by Race/Ethnicity and Gender (n = 1614)

Sociodemographic characteristic	Total sample	Race/ethnicity				Gender		
		African American	White	Hispanic	p-Value[a]	Female	Male	p-Value[a]
Race/ethnicity and gender (%) (number)	1614	32.16 (519)	22.99 (371)	44.86 (724)	—	85.69 (1,383)	14.31 (231)	—
Mean age (years) (Std Dev)	51.97 (13.50)	53.14 (15.28)	51.09† (14.02)	51.58† (11.70)	0.048	52.35 (13.07)	49.69 (15.66)	0.006
Female (%)	85.69	81.31†	77.63†	92.96	0.000	—	—	—
Married or living with partner (%)	50.50	28.17	53.12	65.11	0.000	51.49	44.55	0.052
High school graduate (%)	66.99	80.17†	82.88†	49.39	0.000	65.44	76.23	0.001
Race/ethnicity (%)[b]								
• African American	32.16					30.52	41.99	0.001
• White	22.99	—	—	—	—	20.82	35.93	0.000
• Hispanic	44.86					48.66	22.08	0.000

Immigrant (%)	52.68	2.02	43.64	93.63	0.000	55.66	34.85	0.000
Non-citizen (green card or work permit (%)	24.28	0.50	6.23	50.58	0.000	26.02	13.90	0.000
Renters (%)	58.85	63.85†	50.7	59.63†	0.001	57.64	66.80	0.009
Household income (mean)	10,720	14,489	18,528	6,525	0.000	10,419	12,710	0.003
Relative and co-resident status (%)[c]								
• Rel, Same H	52.21	38.15	50.84	62.98	0.000	52.25	52.24	ns
• Rel, Diff H	18.97	24.66†	20.54†	14.09	0.000	18.16	23.81	0.043
• Not Rel, SH	3.29	4.05†	4.88†	1.93	0.019	3.04	4.76	ns
• Not Rel, DH	25.53	33.14	23.75†	20.99†	0.000	26.54	19.48	0.023

[a]Tests of significance by race/ethnicity and gender were conducted using two-tailed *t*-tests for dichotomous variables (gender) and *F*-ratio tests for race/ethnicity. Values in the race/ethnicity column marked with † do not differ significantly from others in the same row marked with † at $p = 0.05$ using the Bonferroni multiple comparison tests.

[b]IHSS consumers were 35 percent Hispanic, 33 percent African America, 27 percent White, and 4 percent Other (Asian-Pacific Islander and Native American).

[c]Rel, Same H: Relatives who live in the same home as the consumer; Rel, Diff H: Relatives who live in a different home; Not Rel, SH: Not related, live in the same home as the consumer; Not Rel, DH: Not related, live in a different home.

Table 2. Physical and Emotional Demands, and Schedule-, Financial-, and Health Related Stressors, by Race/Ethnicity and Gender[a] (n = 1614)

		Race/ethnicity				Gender		
	Total sample	African American	White	Hispanic	p-Value[b]	Female	Male	p-Value[b]
Physical and emotional demands								
Physically demanding (1 = Never, 4 = Always)	2.81 (1.12)	3.23† (1.01)	3.34† (0.88)	2.24 (1.04)	0.000	2.78 (1.13)	3.0 (1.04)	0.007
Physical tasks frequency (1 = Infrequent, 5 = Daily)	2.03 (0.64)	2.18 (0.72)	2.27 (0.77)	1.8 (0.36)	0.000	2.02 (0.63)	2.06 (0.69)	ns
Concealed feelings (1 = Never, 4 = Always)	1.81 (1.15)	1.54† (0.95)	1.65† (1.04)	2.10 (1.28)	0.000	1.83 (1.17)	1.71 (1.08)	ns
Abuse (1 = Never, 5 = Always)	1.23 (0.58)	1.28 (0.59)	1.48 (0.80)	1.06 (0.30)	0.000	1.22 (0.56)	1.29 (0.65)	0.062

Schedule-, financial-, and health-related stressors								
More than one consumer	22.63	25.43†	24.66†,§	19.59§	0.030	23.05	20.13	ns
Reported hours/week	33.58 (27.81)	33.53† (25.63)	37.70 (33.07)	31.51† (26.09)	0.002	34.12 (28.48)	30.40 (23.17)	0.059
Days/week	6.28 (1.08)	6.08 (1.13)	6.23 (1.10)	6.45 (1.00)	0.000	6.27 (1.09)	6.37 (0.98)	ns
Unpaid overtime	10.80 (15.21)	11.78 (15.37)	15.51 (17.68)	7.56 (12.08)	0.000	10.62 (15.83)	11.50 (11.81)	ns
Days worked while sick (last month)	2.19 (5.0)	2.93† (6.20)	2.45† (5.44)	1.53† (3.60)	0.000	2.29 (5.15)	1.58 (4.01)	0.040
Difficult to pay bills? (1 = Not at all, 4 = Very	2.39 (1.08)	2.5† (1.09)	2.45† (1.08)	2.29 (1.05)	0.001	2.39 (1.07)	2.43 (1.10)	ns
Have health insurance[c]	77.35	78.11†	76.36†	77.31†	ns	77.88	74.16	ns
Financially difficult to see MD	40.00	22.83†	28.87†	57.97	0.000	41.90	28.48	0.000

[a] *SD* in parentheses.

[b] Tests of significance by race/ethnicity and gender were conducted using two-tailed *t*-tests for dichotomous variables (gender) and *F*-ratio tests for race/ethnicity. Values in the race/ethnicity column marked with the same symbol († or §) do not differ significantly from others in the same row marked with that symbol at $p=0.05$ using the Bonferroni multiple comparison test.

[c] Many Hispanics reported only that they have health insurance, without specifying the kind of insurance. Among those who did specify the kind of insurance, the majority reported having Medi-Cal. By contrast, English-speaking respondents often reported having Kaiser or another HMO, Blue Cross/Blue Shield, IHSS or union insurance or, less frequently, Medi-Cal or Medicare.

Similarly, other researchers have noted that back injuries result from personal care tasks, such as lifting consumers, or from household chores:

> I lifted an electrical wheelchair and with my other hand I vacuumed and I felt a 'click' and then the following day I had pain and on the third day they took *me* in a wheelchair" [16].

The physical and emotional demands of care work can be exacerbated or alleviated by home care policies that determine wages, authorized hours of paid care, benefits, and access to health care.

Scheduling-, Financial-, and Health-Related Stressors

Schedule demands include the number of consumers, hours worked per week, days worked per week, and unpaid overtime hours. Over three-quarters of all workers care for one consumer (77%). Focus group participants express a preference for one or at most two consumers, but may care for more to meet financial needs. Home care is not provided during a traditional 40-hour, five-day work week. Rather, workers report an average of 34 hours per week, spread over 6.3 days, with large variation in the number of reported hours. Hispanics work fewer hours per week and less unpaid overtime, but more days per week, limiting their ability to recover, as expressed above by Leonor. Workers of other races and ethnic groups in the focus groups recounted similar sentiments. A Chinese American worker[8] asserted, "I never have a day off, and always stand by, like a call girl," and an African American woman caring for two consumers exclaimed, "When do you get any days off? I just want two days off. I have my husband for 20 hours a month and another consumer for 88 hours a month."

Focus group participants also highlighted the schedule conflicts of trying to complete tasks within an insufficient number of authorized hours of paid service, of working overtime when unable to complete tasks within the paid hours, and of juggling multiple consumers to ensure sufficient paid hours to meet financial needs and to be eligible for health care benefits. One worker asserted, "When you have two, three, or four clients, you're tired; you can't do everything well." Others stated their reasons for caring for more clients: "But sometimes it's better to have two or three or four or whatever you can get because . . . people die on you and then you're just out in the cold." Leonor asserted her reason for caring for more than just her son: "For that very reason, I got two clients, to have enough hours [to be eligible] for health insurance."

Home care workers are poor; they report a mean household income of $10,720. Almost half of respondents (47%) find it very or somewhat difficult to pay

[8]Workers who did not speak English or Spanish were not included in the survey. Focus groups indicate that Chinese American workers may care for more consumers than workers in other racial/ethnic groups.

the bills. Focus group participants of all racial/ethnic groups live paycheck to paycheck and describe their precarious financial situation:

> This is really a low-paying job. You have a tight budget from the job's income alone. For example, insurance, gas, and rent are all very expensive nowadays. You can't afford them, so you quit driving. Then life becomes more difficult.

Although 77 percent of workers have health insurance,[9] 40 percent were unable to see a doctor in the last year for financial reasons. Hispanic workers report the least difficulty paying bills but the greatest difficulty seeing a physician. The higher percentage among Hispanics and among women may be a result of needing to see a doctor more often; on a scale of 1 (poor) to 5 (excellent), Hispanics' self-reported health status is 2.5 compared to 3.4 for African Americans and Whites, and women's is 2.9 compared to 3.4 for men (data not shown). The disparities may also be a result of economics: Hispanics and women report lower household incomes, so they may be less able to afford co-payments or to lose work hours and wages to see a doctor. One key result is the need to work while sick—an average of 2.19 days in the previous month—potentially affecting the health of both workers and consumers.

Focus group participants spoke frankly about their own aging and their health needs. They noted the irony of providing health care services while having limited access themselves. They conveyed the importance of health benefits within the socioeconomic constraints of being low-wage workers as they passionately described the devastating financial and health impacts of losing health care benefits, albeit limited, if budget cuts proposed by the Schwarzenegger administration were adopted. One worker described the impact: "I would be left with nothing, without health insurance. With my salary, I would have to rely on insurance that costs a lot for my income." Another exclaimed: "Oh, no, no. I have to take medicine regularly because of diabetes. . . . Without insurance, the cost of doctor visits and medicine will be really high. What should I do?"

Control and Support

Measures of control and support in this survey are decision latitude (control over job tasks), job security (control over one's career), support from friends and family, and importance of belonging to the union, here a measure of both control and support. All results vary by racial/ethnic group; all but support also vary by gender as shown in Table 3.

[9]While 77% might be higher than expected among low-wage workers, health insurance coverage is partly explained by union-negotiated health benefits and, especially among Hispanics, by a predominance of Medi-Cal coverage, the California equivalent of publicly funded health care for the poor.

Table 3. Control and Support of Workers by Race/Ethnicity and Gender[a] (n = 1614)

		Race/ethnicity				Gender		
	Total sample	African American	White	Hispanic	p-Value[b]	Female	Male	p-Value[b]
Low decision latitude	69.16 (8.01)	73.21 (8.82)	71.32 (9.52)	65.13 (3.23)	0.000	68.87 (7.86)	70.85 (8.66)	0.001
Job insecurity (% worried about unemployment)	54.06	27.21†	28.98†	86.16	0.000	57.13	35.67	0.000
Support (1 = Very little, 4 - A lot)	2.80 (0.92)	3.02 (1.02)	3.14 (1.03)	2.48 (0.64)	0.000	2.79 (0.89)	2.87 (1.09)	ns
Importance of belonging to union (% very important)	57.29	82.49	75.53	29.89	0.000	56.12	64.29	0.048

[a] *SD* in parentheses.

[b] Tests of significance by race/ethnicity and gender were conducted using two-tailed *t*-tests for dichotomous variables (gender) and *F*-ratio tests for race/ethnicity. Values in the race/ethnicity column marked with † do not differ significantly from others in the same row marked with † at $p = 0.05$ using the Bonferroni multiple comparison test.

Control over Job Tasks

At a mean of 69.16 on a scale ranging from 24 to 96, home care workers have a relatively high level of decision latitude, a measure of skill discretion and decision authority. African Americans report the highest decision latitude and Hispanics the lowest. Women report lower scores than men which may indicate that consumers afford male workers more discretion and authority than they do women or it may reflect the constraints facing women who must juggle paid and unpaid gendered care roles.

Job Security

More than half of home care workers (54%) worry about becoming unemployed. Job insecurity is a particular concern for women and for Hispanics, perhaps reflecting the greater percentage who have not graduated from high school, are immigrants and, for women compared to men, are older—all obstacles to finding alternative employment. It may also reflect a concern about loss of work-related health benefits. One worker described the domino effect on her wages and health benefits when the person she cared for passed away:

> When I had 112 hours [authorized work hours a month], I had insurance, but they took it away just like that. My patient died, and I was left with only 80 hours, so then they told me that I didn't qualify and they cut my insurance [and health benefits] like that.[10]

Support

Spouses, friends, and relatives are a source of emotional support willing to listen to personal problems and can be relied on "to some extent" when "things get tough at work." Whites report the greatest access to support, followed by African Americans, and then Hispanics. Focus group participants mentioned receiving support and advice from friends, relatives, other home care workers, adult children, and consumers.

Role of the Union

Ninety-seven percent of workers responded that belonging to the union is somewhat or very important. Overall, more than half (57%) report that belonging to the union is very important to them, with a high of 82 percent among African Americans and a low of 30 percent among Hispanics. These results may reflect the higher family caregiver rate among Hispanics or the historical origins of the union in the African American community [24]. Focus group participants

[10] At the time of the focus groups (April 2004), eligibility for health care benefits had just become more liberal. Previously, workers were eligible if they worked at least 112 hours/month; effective April 1, 2004, they became eligible if they worked at least 80 hours.

described the role of the union in providing emotional and instrumental support through classes, a food bank, and a registry; in advocating for their rights when paychecks were late due to delays in finalizing the state budget; in constructing an identity and dignity for them as a previously invisible workforce; and in creating a mechanism for workers to have a collective voice to shape home care policies.

Workers of all racial/ethnic groups spoke of the emotional and instrumental support they found:

> Here I've found another family . . . the union means a lot to me because here we don't find just other people but companionship.

> The union instructs us in first aid, in English classes, in computers . . . they motivate us.

> They support me. If I have a problem I can call; like if my grandma [who I care for] don't have food I can come to the union.

Others spoke of the role of the union in advocating for policies to support the IHSS program and creating an avenue for their individual and collective voices:

> I like my union because they're strong. . . . They're our voice to be heard. And they come to us, the members, and ask us to come out and get the message out.

> I've been to Sacramento [state capitol] twice, attended demonstrations, and had the newspaper interview. At first, I am afraid of speaking up, but now I've learned a lot and even talked to the legislative member in the event at the park.

Descriptive and focus group results above are also validated by multivariate analyses which demonstrate that, controlling for other factors, workers who believe that it is very important to belong to the union are 2.6 times more likely to be very satisfied with their jobs as home care workers [25].

DISCUSSION

These results provide a profile of the Los Angeles County IHSS workforce: predominantly middle-aged, poor women of color, many of whom are immigrants. In that regard, they are situated squarely in the context of the low-wage workforce and in the socioeconomic and political context diagrammed in Figure 1. Here class and gendered societal norms about care intersect to create home care policies that are not adequate to alleviate the stress of the work or to meet the health and financial needs of the workers. Those forces, however, are influenced by social movements and labor organizing, by worker and consumer coalitions. In the context of budget crises, it is increasingly critical that there be a collective voice to maintain home care services and improve policies that benefit the health of workers and enable them to provide quality care.

Data from this study indicates a need for policies that improve conditions of home care work. It also provides evidence of gender and racial/ethnic differences in workers' home care experience. Finally, it highlights the importance of a structure that allows workers a collective voice—to define, shape, and advocate for policies to improve working conditions, a daunting task in the current climate of budget cuts to social and health care programs.

Home Care Policies

Inadequate home care policies contribute to the stress of demanding and unstable care work, increasing the risk of work-related injuries and the need to juggle multiple consumers, and requiring workers to forego health care. Lack of protection from work-related injuries emanates in part from the nature and structure of work that bridges the traditionally private unpaid sphere of the home and paid employment in a complex public structure with different roles for consumers and county and state government agencies. The resulting lack of clarity creates confusion about who is responsible for providing education and equipment to prevent work-related injuries and illness [26] and to compensate workers for those injuries [27].

Workers' difficulty accessing the health care system is an indicator of systemic inadequacies in the U.S. health care system, highlighted in recent debates over health care reform; it also emanates from policies that do not adequately address the specific needs of low-wage workers who provide home-based care. Lack of a sick leave policy or a system to provide backup care limits access to health care even for workers with health insurance. Like other low-wage workers without sick leave, home care workers cannot afford to lose wages to see a doctor. In addition, they confront the guilt of abandoning the consumer in their care, forcing many home care workers to assign a low priority to their own health needs and to work while sick or skip medical appointments. Home care policies to provide sick leave and respite care would alleviate the untenable situation described by a worker forced to forego an appointment for cancer treatment because the consumer needed her. Home care workers also face the loss of wages and benefits tied to their employment, which in turn is tied to consumers' health, highlighting the need for policies to provide stable health benefits regardless of potentially dramatic fluctuations in hours of work due to the hospitalization or death of a consumer.

Inequalities

Home care policies are framed by ideologies that devalue care work and dependence, women, people of color, and immigrants [4, 28-30]. All home care workers are thus affected by systemic policy failures, but subgroups of the workforce may be disproportionately affected. Such effects are not unique to home care; they have also been documented among workers in the hotel industry

[31] and among poultry workers [32]. In the home care workforce, gender, racial, ethnic, and class disparities are additionally overlaid by the feminized structure of family caregiving and by societal norms and expectations that women will provide care even at the expense of their own health [33]. Blurred boundaries between paid and unpaid work and devalued care work, as demonstrated by low wages and limited benefits, compound the stressors inherent in the physical and relational nature of providing home care. Women work more hours and more days while sick than men, have greater financial difficulty seeing a physician, and report lower decision latitude and greater job insecurity. These outcomes reflect an economic, political, and cultural reality that limits alternative job opportunities due to labor market stratification, especially for older, less educated women.

Results confirm the persistence of racial and ethnic differences found in other IHSS studies of stress and job satisfaction [25, 34], turnover [9], and the informal caregiving arena [35, 36]. Hispanics—of whom the great majority are women and immigrants, and who report the lowest overall levels of income and formal education—find it most difficult to see a doctor due to financial constraints and are most worried about losing their jobs. Qualitative research with Canadian workers employed by agencies documents the daily discrimination facing workers, often immigrants of a different social class, race, or ethnic group than the consumer [37]. In the consumer-directed model of care described here, in which consumers choose their providers, almost three-quarters are related (71%) and 77 percent are of the same ethnic group. The remaining one-quarter of the population may, however, face discrimination similar to that documented for agency workers.

Research on specific ethnic groups in the paid home care work arena in California deconstructs the processes whereby immigrant workers interpret and perform home care work and highlights the complex intersection among gender, race, ethnicity, religion, and immigrant status overlaid by social class. Solari [14] differentiates between Jewish and Orthodox Christian immigrants from the former Soviet Union, describing how differences in the immigration settlement process and religious/cultural affiliations influence their respective use of discursive practices to create identities of professionalism and sainthood that give value to their IHSS home care work. Ibarra [38] examines the experiences of Mexican immigrant workers and the unrecognized skill and authentic emotional labor they deploy to create meaning in their work, a finding echoed in multivariate analyses of job satisfaction [25]. And previous analyses of focus group data from this workforce identified more commonalities than differences, but highlighted discrimination facing Hispanic workers due to language differences and limited knowledge of workers' rights [16].

Racial and ethnic differences described here between African Americans and Hispanics also parallel differences associated with immigrant status, making it impossible to distinguish the effects of race, ethnicity, and immigrant status. Precise mechanisms that explain those differences were not elucidated and

warrant further investigation in this workforce where complex gender, race, ethnic, family, and class dynamics intersect. Further research will require modeling job stressors separately by gender, ethnic group, and immigrant status; expanded use of qualitative methods to interpret workers' varied experiences; and examination of job demands and access to resources in the context of other life stressors such as unpaid care responsibilities.

The impact of job stressors on different racial and ethnic groups, and the intersection with class and gender, have implications in all of society as poor women of color increasingly fill the care gap left by women entering the paid workforce. Research in the home-based care arena among immigrants and women of color—who clean, who care for children and the elderly—highlights the potential for exploitation of women of color, with immigrant workers particularly at risk in an increasingly global economy [38-42].

Role of the Union and Home Care Workers' Voice

The slogan that brought workers together throughout their decade-long organizing campaign—"Invisible No More"—spoke to an intrinsic need for recognition, dignity, and respect, and transformed how workers saw themselves and were seen by others. These results demonstrate the role of union representation in this dispersed workforce of women with a historically limited voice in shaping the policies that affect their living and working conditions. The IHSS structure, a result of social and labor movement organizing, has the potential to foster a collective voice to advocate for the needs of workers and consumers. Like many other consumer-directed models that give consumers a right to choose their care provider, it allows for the employment of family members, a historic advance that acknowledges the traditionally unpaid, unrecognized work of women and that enhances the ability of poor women to care for family members, an option too often available only to those with the financial resources to forego employment in the formal economy [4]. Unlike many other consumer-directed models, IHSS worker and consumer organizing created a mechanism for union representation. Given the close ties between workers and consumers and the historic coalitions forged between the two groups [1, 8, 24, 43], their collective voice has the potential to improve policies or, within the constraints of the current economic crisis, to fight to maintain critical services. This collective power is a fundamental difference between IHSS and other consumer-directed models that provide cash grants to consumers for use in hiring workers directly [44], a model with varied applications in the United States and Europe [45]. While based on tenets of consumer empowerment [46] and equity for women whose care work has historically been devalued [47], cash grant models frame home care in terms of individual rights and responsibility. Unlike IHSS union and public authority structures, which give workers

an avenue to bargain collectively and consumers a mechanism to build a cohesive advocacy force, many cash grant models place responsibility for negotiating the terms of employment at the dyadic level. This negates the importance of a collective voice for workers through union representation, and undermines the potential to build coalitions of workers and consumers, as well as a social movement to advocate for improved home care policies. In a climate of severe budget cuts and attacks on vital social and health care services, structures that give workers and consumers a collective and unified voice become vital to preserving quality services and jobs in the home care arena.

Active involvement by workers in unions that support, empower, and represent them is critical to the process of building workers' collective voice [48, 49]. Considerable upheavals have occurred in the union structure since Los Angeles home care organizing was hailed nationally in 1999 as "the biggest organizing victory for the U.S. labor movement since . . . 1941" [50]. On a positive note, concerted efforts to reach Hispanic and non-English-speaking workers have made headway; however, restructuring, jurisdictional tensions, and the failure of prominent local leaders undermine the efficacy of the labor movement. Decisions made by new leadership at all levels will determine the degree to which the union is able to engage workers as a collective force and build effective coalitions with consumer groups. This study captures workers' vision of a viable union that supports them and advocates for them and for IHSS programs. To the degree that the labor movement embraces and facilitates worker involvement in coalition building and political strategies, it can build a stronger force to confront the political and economic forces that devalue the work of the women and people of color who provide critical long-term care services to meet a growing societal need.

Limitations and Strengths

This study has several limitations. The survey sample excluded workers who do not speak either English or Spanish, and bivariate analyses presented here do not tease out the effects of gender, ethnicity, and immigration status. The cross-sectional nature of the study may underestimate the impact of job-related stressors; that is, the composition of the workforce may reflect the healthy worker effect common in occupational health research and documented in the caregiving arena by Pavalko and Woodbury [51]. This snapshot is framed by a particular political and economic context; it will require ongoing dialogue with workers to capture their voices and engage them in research and key policy decisions. This study's strengths are the use of mixed methods and a focus on workers employed in the increasingly popular consumer-directed model of home care, given past attention to workers employed by agencies. Further research to explore differences by race, ethnicity, gender, and family provider status is important to fully understand this workforce, to identify factors that

contribute to stress and satisfaction, and to inform initiatives to improve conditions for workers and consumers.

Collaborative Action Research

This study is one of many initiated by participants in the California Home Care Research Working Group and facilitated by collaboration among researchers, labor and consumer advocates, and representatives of public authorities. The group's multidisciplinary character fostered inclusion of different perspectives and methods; labor-consumer collaboration identified critical research needs and provided a mechanism to disseminate results and take action. Group members have testified before policymakers to advocate for improved policies and to confront attempts to pit the needs of workers against consumers in the budget appropriation process. Research alone is clearly insufficient; nonetheless, research findings have contributed to recurring policy advocacy efforts to maintain vital long-term care services.

REFERENCES

1. L. Dresser, "Cleaning and Caring in the Home: Shared Problems? Shared Possiblities?" in *The Gloves-Off Economy: Workplace Standards at the Bottom of America's Labor Market*, eds. A. Bernhardt, H. Boushey, L. Dresser, and C. Tilly, 111-136 (Champaign, IL: Labor and Employment Relations Association, 2008).
2. R.J.V. Montgomery, L. Holley, J. Deichert, and K. Kosloski, "A Profile of Home Care Workers from the 2000 Census: How It Changes What We Know," *The Gerontologist* 45, no. 5 (2005): 595-600.
3. S. Wallace, D. Padilla-Frausto, C. Mendez-Luck, A. Benjamin, E. Durazo, and N. Pourat, *Budget Proposals Turn Back Clock 30 Years in Long-Term Care Services for California Seniors* (Los Angeles: UCLA Center for Health Policy Research, 2010).
4. E.K. Abel, "A Historical Perspective on Care," in *Care Work: Gender, Labor and the Welfare State* ,ed. M.H. Meyer, 8-14 (New York, NY: Routledge, 2000).
5. C. Howes, "Love, Money, or Flexibility: What Motivates People to Work in Consumer-Directed Home Care?" *Gerontologist* 48, spec. iss. 1 (2008): 46-59.
6. J. Aronson and S.M. Neysmith, "'You're Not Just in There to Do the Work': Depersonalizing Policies and the Exploitation of Home Care Workers' Labor," *Gender and Society* 10, no. 1 (1996): 59-77.
7. M. Morris, J. Robinson, and J. Simpson, *The Changing Nature of Home Care and its Impact on Women's Vulnerability to Poverty* (report prepared for Status of Women, Canada; 1999).
8. L. Delp and K. Quan, "Homecare Worker Organizing in California: An Analysis of a Successful Strategy," *Labor Studies Journal* 27, no.1 (2002): 1-23.
9. C. Howes, "Upgrading California's Home Care Workforce: The Impact of Political Action and Unionization," in *The State of California Labor*, ed. R. Milkman, 71-106 (Los Angeles: University of California Institute for Labor and Employment, 2004).
10. S. Wallace, A. Benjamin, V. Villa, and N. Pourat, *California Budget Cuts Fray the Long-Term Safety Net* (Los Angeles: UCLA Center for Health Policy Research. 2009).

11. R. Hayashi, J.W. Gibson, and R.A. Weatherly, "Working Conditions in Home Care: A Survey of Washington State's Home Care Workers," *Home Health Care Services Quarterly* 14, no. 4 (1994): 37-48.
12. W.H. Crown, D.A. Ahlburg, and M. MacAda, "The Demographic and Employment Characteristics of Home Care Aides: A Comparison with Nursing Home Aides, Hospital Aides, and Other Workers," *Gerontologist* 35, no. 2 (1995): 162-170.
13. E.K. Abel and M.K. Nelson, "Circles of Care: An Introductory Essay," in *Circles of Care: Work and Identity in Women's Lives*, eds. E.K. Abel and M.K. Nelson, 4-34 (Albany: State University of New York Press, 1990).
14. C. Solari, "Professionals and Saints: How Immigrant Careworkers Negotiate Gender Identities at Work," *Gender and Society* 20, no. 3 (2006): 301-331.
15. C.L. Stacey, "Finding Dignity in Dirty Work: The Constraints and Rewards of Low-Wage Home Care Labour," *Sociology of Health and Illness* 27, no. 6 (2005): 831-854.
16. S. Arteaga, J. Geiger-Brown, C. Muntaner, A. Trinkoff, J. Lipscomb, and L. Delp, "Home Care Work Organization and Health: Do Hispanic Women Have Different Concerns?" *Hispanic Health Care International* 1, no. 3 (2002): 135-141.
17. L. Delp, *Job Stressors among Home Care Workers in California's Consumer-Directed Model of Care: The Impact on Job Satisfaction and Health Outcomes* (Michigan: UMI Dissertation Services, 2006).
18. J. Geiger-Brown, C. Muntaner, K. McPhaul, J. Lipscomb, and A. Trinkoff, "Abuse and Violence during Home Care Work as Predictor of Worker Depression," *Home Health Care Services Quarterly* 26, no. 1 (2007): 59-77.
19. I.H. Kim, J. Geiger-Brown, A. Trinkoff, and C. Muntaner, "Physically Demanding Workloads and the Risks of Musculoskeletal Disorders in Homecare Workers in the U.S.A.," *Health and Social Care in the Community* 18, no. 5 (2010): 445-455.
20. J.V. Johnson and E.M. Hall, "Job Strain, Work Place Social Support, and Cardiovascular Disease: A Cross-Sectional Study of a Random Sample of the Swedish Working Population," *American Journal of Public Health* 78, no. 10 (1988): 1336-1342.
21. R.A. Karasek, Jr., "Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign," *Administrative Science Quarterly* 24, no. 2 (1979): 285-308.
22. B. Soderfeldt, M. Soderfeldt, C. Muntaner, P. O'Campo, L.E. Warg, and C.G. Ohlson, "Psychosocial Work Environment in Human Service Organizations: A Conceptual Analysis and Development of the Demand-Control Model," *Social Science and Medicine* 42, no. 9 (1996): 1217-1226.
23. Personal communication. Interview by Linda Delp with Wendy Duchen, Education and Research Director, Service Employees International Union (SEIU) 434B, June 23, 2005.
24. L. Smallwood-Cuevas, K. Wong, and L. Delp, editors, *Women's Work: Los Angeles Homecare Workers Revitalize the Labor Movement* (Los Angeles: UCLA Center for Research and Education, 2009).
25. L. Delp, S.P. Wallace, J. Geiger-Brown, and C. Muntaner, "Job Stress and Job Satisfaction: Home Care Workers in a Consumer-Directed Model of Care," *Health Services Research* 45, no. 4 (2010): 922-940.
26. U.S. Department of Health and Human Services. National Institute for Occupational Safety and Health. *NIOSH Health Hazard Evaluation Report: HETA # 2001-0139, Alameda County Public Authority for In-Home Support Services*, 2004.

27. T. Scherzer and N. Wolfe, "Barriers to Workers' Compensation and Medical Care for Injured Personal Assistance Services Workers," *Home Health Care Services Quarterly* 27, no. 1 (2008): 37-58.
28. C.L. MacDonald and D.A. Merrill, "It Shouldn't Have To Be a Trade: Recognition and Redistribution in Care Work Advocacy," *Hypatia* 17, no. 2 (2002): 67-83.
29. L.M. Rivas, "Invisible Labors: Caring for the Independent Person," in *Global Woman: Nannies, Maids and Sex Workers in the New Economy*, eds. B. Ehrenreich and A.R. Hochschild, 70-84 (New York: Metropolitan Books, an imprint of Henry Holt, 2002).
30. S.P. Wallace and V.M. Villa, "Caught in Hostile Cross-Fire: Public Policy and Minority Elderly in the United States," in *Critical Gerontology: Perspectives from Political and Moral Economy*, eds. M. Minkler and C.L. Estes, 237-256 (Amityville, NY: Baywood, 1999).
31. S. Buchanan, P. Vossenas, N. Krause, J. Moriarty, E. Frumin, J.A.M. Shimek, F. Mirer, P. Orris, and L. Punnett, "Occupational Injury Disparities in the U.S. Hotel Industry," *American Journal of Industrial Medicine* 53, no. 2 (2009): 116-125.
32. H.J. Lipscomb, R. Argue, M.A. McDonald, J.M. Dement, C.A. Epling , T. James, S. Wing, and D. Loomis, "Exploration of Work and Health Disparities among Black Women Employed in Poultry Processing in the Rural South," *Environmental Health Perspectives* 113, no. 12 (2005): 1833-1840.
33. E. Boris and J. Klein, "Labor on the Home Front: Organizing Home Based Care Workers," *New Labor Forum* 17, no. 2 (2008): 32-41.
34. A.E. Benjamin and R. Matthias, "Work-Life Differences and Outcomes for Agency and Consumer-Directed Home-Care Workers," *The Gerontologist* 44, no. 4 (2004): 479-488.
35. M.P. Aranda and B.G. Knight, "The Influence of Ethnicity and Culture on the Caregiver Stress and Coping Process: A Sociocultural Review and Analysis," *The Gerontologist* 37, no. 3 (1997): 342-354.
36. P. Dilworth-Anderson, I.C. Williams, and B.E. Gibson, "Issues of Race, Ethnicity, and Culture in Caregiving Research: A 20-Year Review (1980-2000)," *The Gerontologist* 42, no. 2 (2002): 237-272.
37. S.M. Neysmith and J. Aronson, "Working Conditions in Home Care: Negotiating Race and Class Boundaries in Gendered Work," *International Journal of Health Services* 27, no. 3 (1997): 479-499.
38. M. Ibarra, "Emotional Proletarians in a Global Economy: Mexican Immigrant Women and Elder Care Work," *Urban Anthropology* 31, no. 3-4 (2002): 317-350.
39. G. Chang, *Disposable Domestics: Immigrant Women Workers in the Global Economy* (Cambridge: South End Press, 2000).
40. M. Harrington, *Care and Equality: Inventing a New Family Politics* (New York: Alfred A. Knopf, 1999).
41. P. Hondagneu-Sotelo, "The International Division of Caring and Cleaning Work," in *Care Work: Gender, Labor and the Welfare State*, ed. M.H. Meyer, 149-162 (New York, NY: Routledge, 2000).
42. P. Hondagneu-Sotelo, "Blowups and Other Unhappy Endings," in *Global Woman: Nannies, Maids and Sex Workers in the New Economy*, eds. B. Ehrenreich and A.R. Hochschild, 55-69 (New York: Metropolitan Books, an imprint of Henry Holt, 2003).

43. E. Boris and J. Klein, "Organizing Home Care: Low-Waged Workers in the Welfare State," *Politics and Society* 34, no. 1 (2006): 81-108.
44. B. Phillips and B. Schneider, "Commonalities and Variations in the Cash and Counseling Programs across the Three Demonstration States," *Health Services Research* 42. no. 1.2 (2007): 397-413.
45. C. Ungerson, "Whose Empowerment and Independence? A Cross-National Perspective on 'Cash for Care' Schemes," *Ageing and Society* 24, no. 2 (2004): 189-212.
46. L. Foster, S.B. Dale, and R. Brown, "How Caregivers and Workers Fared in Cash and Counseling," *Health Services Research* 42, no. 1.2 (2007): 510-532.
47. L. Simon-Rusinowitz, K. Mahoney, and A.E.T. Benjamin, "Payment to Families who Provide Care: An Option that Should Be Available," *Generations* 22, no. 3 (1998): 69-75.
48. J.V. Johnson, "Collective Control: Strategies for Survival in the Workplace," *International Journal of Health Services* 19, no. 3 (1989): 469-480.
49. C. Muntaner and C. Schoenbach, "Psychosocial Work Environment and Health in U.S. Metropolitan Areas: A Test of the Demand-Control and Demand-Control-Support Models," *International Journal of Health Services* 24, no. 2 (1994): 337-353.
50. D. Stone, "Why We Need a Care Movement," *The Nation*, March 13, 2000.
51. E.K. Pavalko and S. Woodbury, "Social Roles as Process: Caregiving Careers and Women's Health," *Journal of Health and Social Behavior* 41, no. 1 (2000): 91-105.

Direct reprint requests to:

Linda Delp
UCLA-LOSH
10945 Le Conte Ave., Suite 2107
Los Angeles, CA 90095-1478
e-mail: ldelp@ucla.edu