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Recognizing careworkers' contributions to improving the social determinants of health: A call for supporting healthy carework

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Abstract

Workers engaged in reproductive labor—the caring work that maintains society and supports its growth—contribute to societal health while also enduring the harms of precarious labor and substantial work stress. How can we conceptualize the effects of reproductive labor on workers and society simultaneously? In this commentary, we analyze four types of more relational and less relational careworkers—homeless shelter workers, school food workers, home care aides, and household cleaners—during the COVID-19 pandemic. We then make a case for a new model of societal health that recognizes the contributions of careworkers and healthy carework. Our model includes multi-sectoral social policies supporting both worker health and societal health and acknowledges several dimensions of work stress for careworkers that have received insufficient attention. Ultimately, we argue that the effects of reproductive labor on workers and society must be considered jointly, a recognition that offers an urgent vision for repairing and advancing societal health.

Keywords

social determinants of health, carework, marginalized workers, societal health, work stress

Introduction

How do careworkers contribute to societal health? And how might we better conceptualize their health and well-being in the context of societal health? These questions have troubled us throughout the COVID-19 pandemic, as the often-invisible contributions and challenges faced by many marginalized workers rapidly became national news. We are a group of researchers studying occupational stress in various kinds of "reproductive labor," meaning the caring work that maintains society and supports its growth.[1] Historically, this work has been constructed—culturally, economically, and politically—as women's unpaid and "natural" labor, undervalued in contrast to paid work.[1,2] More recently, low paid carework has paved the entry of some women into the "valued" work force, as dual-earning families have become normalized.[3] We focus this article on paid reproductive labor particularly, which has historically been devalued due to its association with these forms of unpaid, yet crucial, labor.[4] Specifically, we have studied workers in homeless shelters,[5] school food workers,[6] home care aides,[7,8] and household cleaners,[9] among others. While these groups may seem very different, they share several important characteristics that can help shape our view of the value of paid reproductive labor to society, and the importance of supporting this critical workforce: their work helps to fill critical policy gaps to improve the social determinants of health; they face extreme job precarity; and the interplay between their social and occupational marginalization creates stressors that may harm both their own health and the health of those that their work supports.

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To varying degrees, these four groups of workers we study engage in more relational (i.e. typically involving face-to-face services) and less relational (e.g. cooking and cleaning) carework.[10] Less relational careworkers, like household cleaners and school food workers, do what is sometimes called the "dirty work" of reproductive labor, and as a result, they tend to be low-paid and are more likely to be people of color.[1,10] This stems from a history of racist, sexist, and exclusionary labor and economic policies, though a full examination of these policies is outside the scope of this article.[10,11] Some carework scholars have argued compellingly for the inclusion of less relational labor in definitions of carework since an exclusive focus on relational care may reinforce racial inequities and reduce opportunities for broader movement-building.[4,10,12] The historical transfer of domestic cleaning labor, for instance, from white women of the middle and upper-middle class to poor women and women of color enabled the career advancement of white women,[4] and now helps middle and upper-middle class women more broadly (including in meeting the needs of elderly or disabled family members). Excluding this less relational carework would obscure what this labor makes possible, as well as who performs it (i.e. mostly women, but also some men, of color).[10] We attend to this rationale and also acknowledge that even within relational forms of reproductive labor, there is a hierarchy of precarity.[4] In this paper, we highlight examples of more precarious forms of relational carework, alongside these critical jobs in less relational carework. Finally, whether labor is home-based or institution-based has important implications for work organization, worker support and protections, and work stress. As such, we intentionally include examples of both home- and institution-based labor. Figure 1 shows where each of these careworker categories falls in terms of degree of relational labor (approximate as all of these forms of work involve both relational and non-relational labor) and location.

COVID-19 has highlighted the societal importance of this work, both in protecting the health of other marginalized groups and in buffering privileged, often white populations from the effects of the pandemic. Policies, however, have largely failed to protect these workers from the intersecting health impacts of COVID-19 and existing labor conditions. This is particularly important when considering the precarious qualities of these jobs, including flexible labor markets, chronic job insecurity, contract or temporary work, low wages, limited social protection and labor rights, low control over schedules, and lack of non-wage compensation such as paid sick leave, vacation, retirement plans, and health insurance coverage.[13] In this article, we argue these workers make it possible for many others to benefit from critical social determinants of health and therefore need broad social movement support in order to secure labor and health protections. Through their labor, these workers are compelled to compensate for limited and often underfunded social policies which fail to sufficiently address homelessness, food insecurity, underinvestment in programs supporting older and disabled populations (including both home care and house cleaning), and the burden of invisible domestic labor that falls disproportionately on women. The under-resourcing of these forms of labor and sectors are perpetuated by neoliberal approaches to social services and the stigmatized nature of both the labor and populations served by the labor, among other factors.

	Institution-based	Home-based
More relational	Homeless shelter workers	Home care aides
Less relational	School food workers	Household cleaners

Figure 1. Worker types by degree of relational labor and location.

Harm to these workers causes harm to societal health: it both further widens structural inequities affecting worker populations and jeopardizes the labor that supports societal health. In considering how engaging in these forms of labor shapes worker health, we are particularly interested in the role of work stress, especially given the ways that combined work and personal stress have forced many people out of the work force during the COVID-19 pandemic, and given the important impact of stress on physical and mental health. Traditional models of work stress have focused on the psychological demands and interpersonal stressors (e.g. bullying, harassment, discrimination) faced by workers, and the control, support, and job security they may have to help them deal with stressors.[14,15] More recently, more detailed aspects of precarity have been added to work stress models.[13] However, these models insufficiently address some of the particular complexities of relational and non-relational carework that are integral to our understanding of societal health and how to nurture it.

This commentary illustrates how the pandemic has affected these groups of workers and the people they care for by layering new stressors on top of existing work stressors; how workers perceive the value of their work to society; and the limited policies supporting the critical societal roles these workers play. We then propose a model of societal health that recognizes the contributions of careworkers broadly defined and suggests policies and systems that protect their physical, emotional, and economic health. While we do not intend for these groups of workers to represent all careworkers and the varied challenges they face, we hope that highlighting these diverse groups leads to a broader understanding of what reproductive labor entails and contributes.

Approach

As a collaborative of occupational stress and carework researchers trained and working in public health, we have

expertise in studying each of the occupations discussed. In developing this analysis, we drew on the research literature, our own ongoing research, and personal communication with workers and others knowledgeable about these issues. Our descriptions explicitly characterize the experience of workers in New York City (NYC) where we are based, though our analysis is meant to speak to these and other precarious careworkers more broadly. The choice to include workers providing both more and less relational care in both institutional and home-based settings contributes to the potential transferability of our analysis. However, NYC's elevated racial ethnic diversity, income inequality, and high levels of collective bargaining as compared with most of the US also may need to be taken into consideration when exploring the relevance of our framework to other contexts.

How the COVID-19 pandemic has shaped the experiences of shelter workers, school food workers, home care aides, and household cleaners in NYC

Below we briefly describe the four focal types of work, and particularly careworkers' experiences on the job during the pandemic. Table 1 adds to these descriptions of key factors shaping each group's labor experiences, including national policies, demographics, industry structure, worker-specific policies, forms of organizing, and resulting outcomes.

Homeless shelter workers

Shelter workers, including case managers, social workers, housing specialists, security and maintenance workers, and residential aides, maintain the safety and environment of the homeless shelter and provide case management and social services to residents in a variety of settings that serve individuals, families, and specific populations (e.g. survivors of domestic violence, people with HIV/AIDS, and gender non-conforming people).[16] Tasks associated with these jobs range from those that attend to mental health and well-being for individuals and families, those aimed at skill building to support future independence, and those concerned with monitoring safety and cleanliness. Shelter workers help residents address a range of needs, such as food, income, health care, job training, and access to permanent housing. Many are extremely committed to the people whom they serve; a 2015 study of NYC homeless shelter workers found that 87% believed in their program's mission and 88% felt their work made an important social contribution.[5] During the spring 2020 COVID-19 outbreak in NYC, all NYC shelter services except security and maintenance were converted to remote resident contact; even after shelter staff returned to work, resident contact remained via cell phone (Joseph Esheyigba and Jhossana Mateo, oral communication, December 2020). As noted in interviews with shelter staff, lockdown markedly heightened resident stress in multiple ways, exacerbating already difficult working conditions. Services that residents relied on, such as food parcels and pantries, were disrupted, and community referrals for social services were unavailable. The lockdown also resulted in job loss among residents, closing of child care options, and the need for children to attend school at home in the shelter, often without adequate space, computers, and Wi-Fi.[25] Multiple problems experienced by shelter residents meant that shelter workers' workload both increased and intensified. Since many shelter workers lacked paid time off and came from communities with a high burden of COVID-19, short-staffing magnified the stress of trying to meet residents' needs with few resources. Security and maintenance workers on site were directly impacted by potential workplace exposures, lacked sufficient personal protective equipment (PPE), and were brought into tasks, such as moving residents' belongings, that intensified their exposure risk.[26] Despite the contribution of shelter workers to the well-being and safety of NYC's many homeless individuals and families—including securing food parcels, helping to make sure children had laptops and Wi-Fi to attend remote school, and counseling people in emotional crisis—shelter work remains largely invisible and stigmatized by its association with poverty and mental illness.[27] Unlike other parts of the country, NYC has a "right to emergency shelter" established though an historic court ruling. However, funding for this sector is contested, leaving wages lower and working conditions harsh.[28] These policy challenges were exacerbated by stressful conditions and increased workload during the COVID-19 pandemic.

School food workers

School food workers prepare, serve, and clean up breakfast, lunch, and dinner for students in public and private schools at the K-12 and higher education levels. They meet students' nutritional needs through physically demanding labor involving preparing large amounts of food, lifting heavy pots and trays, and frequent heat exposure. They also often attend to students' emotional needs, both a draining and rewarding aspect of the work.[19] During the pandemic, many public-school cafeteria workers participated in their municipality's emergency food response and were classified as essential, meaning that they would help to maintain critical services through in-person work.[29] Workers shifted to curbside pickup and contactless delivery of grab-and-go meals, involving increased packaging and disinfecting, while losing close interaction with students.[30–33] They risked SARS-CoV-2 infection through work in small, poorly ventilated kitchens and exposure to the public without additional training or consistent access to PPE.[20,33,34] Some workers saw their hours reduced, were furloughed without pay, or were laid off.[20,30] Some have been called back as schools

Table 1. Determinants and outcomes of careworkers' labor experiences.

	National policy environment	Worker demographics	Structure of industry	Worker-specific policy protections and concerns	Forms of organizing	Effects of carework on careworkers	Effects of careworkers' labor on society
Shelter workers[16–18] (based on NYC data)	Lack of systematic living wage, paid leave, affordable health care, worker health and safety policies and regulations, etc.	African–American, Caribbean–American, Latinx; Majority women in direct carework; Majority men in maintenance and security; Median annual salary $53,818/$25.87 for hourly case manager, Department of Homeless Services, $35,652/$17.14 per hour for contracted workers (NYC data, 2020)	Public sector and non-profit contractors; 20 contractors run most shelters in NYC; mix of city, state and federal funds depending on population and services	Policies for residents and services determine access to resources for basic needs for residents and working conditions for staff; Federal homeless service policy, social safety net policies, food, Medicaid, TANF, and policies related to undocumented immigrants; Undocumented immigrants have access to shelter in NYC, but lack access to other benefits like food and income assistance	Shelter workers in programs under public funding are a part of the public city workers union; Fewer shelter workers employed by contracted non-profits are organized, and unions are weaker where they exist	High levels of work stress; Negative health, economic & social effects for workers (still under study for specific worker types during COVID)	Some needed care is provided; Underinvestment leads to gaps in care; High burnout & turnover for workers; Movement away from health, economic, & social equity
School food workers[19–22] (based on US data)		Majority women, many Black and of color in certain states, some immigrants; Compared to whole workforce, slightly older, more likely to have children under 19 at home, fewer years of education; Median hourly wage of $12.38 for K-12, $14.43 for colleges and universities (US data, 2019) Most work part-time and only during school year; Many rely on public food assistance	Highly variable employment arrangements; Workers in public, self-operating schools are public sector workers; Those in schools with outsourced food services are employees or contractors of private firms, ranging from small, local businesses to large national and multi-national corporations.	Policies governing funds for school food labor (National School Lunch and Breakfast Programs, Summer Food Service program) at federal level; Policies regulating food services training at federal and state levels; Policies determining school food procurement at federal and state levels	Public sector workers in K-12 schools and some on college campuses are unionized, but unionization rates are low		

(continued)

Table 1. Continued.

	National policy environment	Worker demographics	Structure of industry	Worker-specific policy protections and concerns	Forms of organizing	Effects of carework on careworkers	Effects of careworkers' labor on society
Home care aides[60] (based on US data)		Disproportionately women, people of color, and immigrants; Median age of 46 Median hourly wage of $11.52, but inconsistent, part-time hours; Over 50% use some form of public assistance; 38% receive employer-sponsored health insurance (US data, 2019)	Highly fragmented industry structure and thus difficult to regulate; Employers include for- and non-profit agencies reimbursed through Medicaid, Medicare and private pay (taking a variety of organizational structures), as well as people paying aides directly out of pocket	Policies/decisions governing how home care is structured at the state level; Policies governing reimbursement levels for aide care (e.g. Medicaid); Policies governing worker training requirements at state level	Some aides have access to collective bargaining but there is limited unionization nationally, and even with unions, effects on wages limited		
Household cleaners[24] (based on US and NYC data)		Disproportionately women, people of color and immigrants; Median age 47; Median wages $11.89 (US data, 2019); Inconsistent part-time employment without benefits; 49% lack health insurance in NYC metro area	Primarily solo self-employed with a small proportion working for agencies; Employment arrangement usually informal with no written contract or benefits, can be terminated without notice	Household cleaners are not covered by many federal labor laws such as occupational safety and health; As of 2019 nine states have passed domestic worker bills of rights that guarantee overtime pay and other labor rights	Lack of access to collective bargaining rights; Nongovernmental organizations such as the National Domestic Workers Alliance have advocated for improved federal, state and local labor regulations developed		

have reopened, but varying access to paid sick leave, ambiguous vaccine eligibility, and limited affordable child care have forced workers to choose between remaining employed and caring for their families.[20] While much attention is given to the quality of school food, during the pandemic, there has been a continued undervaluing of the people preparing and serving it. No coordinated federal workplace protection standards were implemented, and shifting school policies and unexpected closings without income supports harmed workers' wages and access to benefits.[20,35] Yet, school food workers, knowing the social value of their labor, continued to support the food security of students and their families, particularly low-income students relying on the National School Food Program, while creating a sense of normalcy in unstable times.[20,33,35] Those unable or unwilling to work lost their income but also the satisfaction many derive from the job; for some, these benefits were outweighed by the stress, anxiety, and physical health risks associated with working, especially without adequate protections.[36]

Home care aides

Home care aides provide services that help older adults and people with disabilities stay in their homes. They support clients' activities of daily living, like eating, toileting, bathing, and moving, and in some cases, limited clinical tasks under supervision. Aides' work involves multiple forms of stress, including physical strain (e.g. from lifting patients) and emotional strain from navigating client relationships that can be both rewarding and challenging.[37] During the pandemic, aides experienced added responsibilities and dramatically increased stress. New tasks included monitoring clients and themselves for COVID-19 symptoms, more frequent cleaning, managing clients' anxiety and isolation, assisting with telehealth and care coordination, additional errands, and procuring PPE.[38,39] Aides faced large numbers of clients refusing service, reducing hours and pay for many.[40] Aides' potential exposure to SARS-CoV-2 on the job also increased stress, as did aides' concern that they might expose clients or their own families to the disease.[39] As a result of these risks, many aides considered whether to keep working in home care during the pandemic, but stopping work amplifies economic stress.[41] Many aides find their jobs immensely meaningful, and see themselves as contributing to societal health by allowing their clients to age safely in place and supporting family care givers.[42] However, during the pandemic, aides' labor continued to be devalued and largely invisible. Although they were classified as essential workers by government bodies for the purposes of continuing services, they did not receive substantive protections such as reliable access to PPE in the earlier phases of the pandemic, systematic "hazard pay" or bonuses,[43] or widespread early access to vaccination.[43,44] Aides received varied levels of support from employer agencies in terms of information about COVID, training, and PPE.[39,40] In spite of this, many aides continued to work at significant risk to themselves and their families to keep their clients safe and out of hospitals and nursing homes that may have increased their risk for SARS-CoV-2 infection.

Household cleaners

Household cleaners help maintain households. They clean kitchens and bathrooms with commercial cleaning products and also vacuum, dust, sweep and straighten up homes. Cleaners have indicated that pride in performing their job well is an important dimension of how they value their work.[9] Anecdotal reports by cleaners suggest that they view themselves as playing a key role in creating a "healthy home", a concept that may stem from intertwined hygienic and morally based values about households. Some have extended this view by acknowledging that their own work frees up their clients', particularly women's, time to work or participate in other household tasks and therefore should be valued by society at large. Nevertheless, cleaners have expressed that their primary concern is to earn a living.[9] The stress of finding and procuring work that is low paid is one of several work stressors they experience, including but not limited to the use of toxic cleaning chemicals, withstanding abusive clients, and wage theft.[45] During the pandemic, many cleaners became unemployed, though their legal and employment status prevented them from qualifying for unemployment benefits.[46] There are also several studies suggesting that the use of disinfectants in homes increased during the pandemic in ways that may have further endangered the health of cleaners.[47,48] Finally, the number of people present in the home during cleaning likely increased, posing both greater risk for infection with SARS-CoV-2 and potentially increasing work demands. Our research in progress (IC and SB) may confirm anecdotal reports that these additional risks were present among cleaners who did return to work during the pandemic.

We see several themes that cut across these diverse types of carework. First, despite the urgent way in which these jobs help to improve the social determinants of health, these vignettes confirm that prior to COVID-19, precarity was structured into how these forms of work are arranged and that existing social and worker-specific policies (identified in Table 1) primarily contributed to this precarity and failed to mitigate its effects. In particular, the Occupational Safety and Health Administration (OSHA) and state and local agencies have not systematically protected these workers to help ensure their health and safety, largely due to the exclusion of domestic work and the lack of enforcement of these laws.[49] Some states, however, are attempting to address the worst forms of wage and hour abuses through new laws, such as the New York State Domestic Workers Bill of Rights.[50] The neoliberal and austerity policies behind the historical rise in employment precarity in the US and other wealthy nations are, in our view, the most important levers

shaping worker health, safety, and well-being.[51] In addition to direct harms to workers' health from employment insecurity and income and benefit inadequacy, the other key feature of precarity—lack of rights and protections—limits workers' ability to organize and demand better conditions and policies that would protect them and improve their ability to do this important work.[52] Second, we see that during the COVID-19 pandemic, stressors have intensified for all of these forms of carework, either due to the increased work demands posed by the pandemic and COVID-related restrictions or as a result of increased precarity associated with the pandemic's economic toll. Third, in spite of these amplified tasks, risks, and stressors that careworkers are typically not trained to navigate due to broad under-resourcing of this work, many workers in all of these groups have continued to demonstrate extraordinary commitment to their jobs. This is likely due to a complex mix of factors including financial need, few alternatives, as well as a fundamental understanding of the value of their work to their clients.

These themes illustrate how policymakers and employers in most cases failed to provide even minimal systematic responses and support to these workers. As a result, we have seen a range of devastating outcomes for careworkers of these and other types including excess death[53,54] and elevated SARS-CoV-2 infection[55] on top of high existing rates of chronic illness, stress, and long-standing health and social inequities due to social policies that fail to support careworkers.[56]

Finally, our analysis highlights two aspects of carework that are highly relevant to societal health but missing from traditional models of work stress: (a) the centrality of caring relationships (including not only emotional demands, but potentially also positive relational outcomes for workers, like value and meaning), and (b) the importance of social (i.e. client or patient) health outcomes, not solely worker precarity and related adverse occupational health outcomes. Two other aspects of carework are deeply considered in the carework literature but need greater attention in models of work stress: (c) society's currently low level of recognition of the importance of carework, which leads to increased stressors (including precarity) for workers, and (d) the commitment of careworkers to their clients and to the social value of their labor.

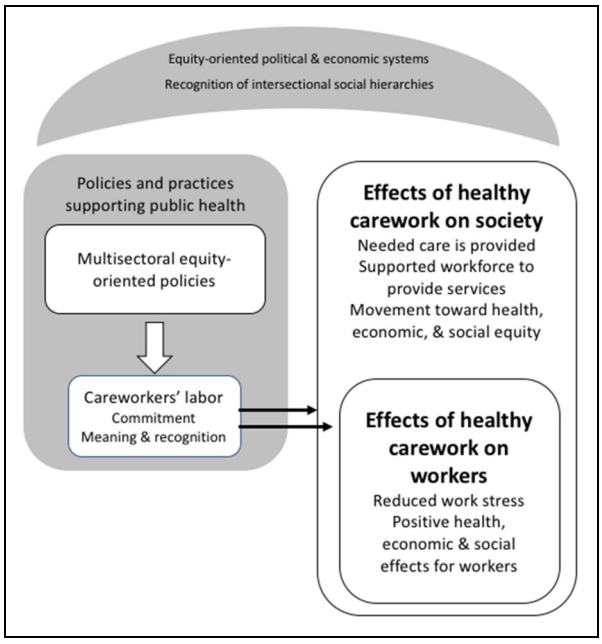

Figure 2. Model of societal health recognizing the contributions of careworkers and healthy carework.

Careworkers are integral to societal health outcomes

Our analysis suggests the need for a model of societal health that incorporates careworkers' labor, their commitment to this labor, and the products of their labor, and that makes visible their role in implementing social and public health policy. In the table and vignettes above, we illustrated our current system in which weak social and worker-relevant policies undermine carework and careworkers, and where this work is not conceptualized in terms of its contribution to societal health. We contrast this with a model of societal health (Figure 2) that makes visible the contributions of careworkers and healthy carework to a healthy society. Importantly, such a model allows us to shed the assumption that the uncompensated commitment of individual careworkers can fuel a durable model of societal health.[56]

Essential to a healthy carework system are multi-sectoral, equity-oriented policies that recognize and remunerate care in accordance with its societal importance. Such policies are much more likely to thrive and take shape in an environment of equity-oriented social and economic systems[23] where intersectional social hierarchies are recognized (e.g. gender, race, class, etc.).[57] Policies that support healthy carework most immediately include wage increases, affordable health care, paid leave, the ability to collectively bargain, strong worker health and safety policies, and increased training, some of which were captured, for some workers, in proposals like the Biden-Harris American Jobs Plan and American Families Plan.[58,59] However, we would argue that a healthy carework system depends on a suite of broader public health policies targeting inequities that shape carework and the community systems that support careworkers. Social movements stemming from public health, labor, feminist, and civil rights spheres should pursue living wages and reduced precarity for workers—as we have seen in the domestic worker bill of rights efforts—while also better funding these policies in support of societal health. Such policies include antiracist, feminist, and inclusive labor, education, housing, food, and immigration

policies and would more fully address the social determinants of health. Notably, these policies have the potential to also alleviate public health problems (e.g. homelessness and food insecurity) to a degree that would alter the demands and nature of carework. In closing, we believe that understanding how careworkers act on the social determinants of health offers a fresh and urgent vision for repairing and advancing societal health.

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