

Home, Work and the Shifting Geographies of Care

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“The current crisis in home care suggests we must meet immediately to discuss how Ontario can best meet its commitment to all those who require home care services and to the workers who provide these services.” (August 2004, letter from Sharleen Stewart, president of the SEIU Local 1 Canada sent to the Ontario Minister of Labour).

“Ontario is facing a severe child-care crisis. Child-care services are fragmented, there simply aren’t enough spaces and most of them are not affordable.” (Elizabeth Ablett, *Toronto Star*, 27 March, 2007).

“(T)he current crisis is a product of a privatized and gendered caring regime in which families, rather than larger society, are responsible for caring and in which women (and other subordinate groups) are assigned primary responsibility for care giving” (Evelyn Nakano Glenn, 2000: 84).

A range of commentators, such as those quoted above, are raising the alarm about a mounting care crisis in Canada. Union representatives, journalists, academics and others besides express concern about the cost, quantity and quality of care for children, the elderly, and people with illnesses and disabilities, as well as about the well-being of the people who provide that care. The three quotes above address themes raised in this paper: the provision of child care and home care, the responsibilities of the state and ‘larger society’ in that provision, and the implications of assigning responsibility for care to “women (and other subordinate groups)”. In this paper I explore such themes in the context of the shifting geographies of care – one where the home and the families in them have become a more prominent site of care than has been the case in recent decades.

The crisis around care is having profound effects on the relationship between states, markets, households, and the volunteer sector. A key aspect of the care crisis has been the emergence of what Arlie Hochschild (2003) and others call a “care deficit”. Women have long held primary responsibility for providing care, in their homes, in their communities (as volunteers) and in the workplace. Changing social,

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economic and demographic trends have resulted in more women in paid employment, meaning they are less available to provide care at home and in their communities. This care deficit in the ‘private’ sphere is coupled with a care deficit in the public sphere following the withdrawal of publicly-funded cash support for families (like family allowance¹), and the dwindling supply of publicly funded or subsidized care. As Hochschild remarks, “recent trends... have expanded the *need* for care while contracting the *supply* of it, creating a ‘care deficit’ in both public and private life” (2003: 213–214, emphasis in the original). Cutting public funds that underpin care work may help balance the state’s books and win votes, but, Hochschild goes on to argue, “in reducing the financial deficit, legislators add to the ‘care deficit.’”

In the first section of this paper I review how feminist scholars have interrogated and troubled the concepts of care and work. Then I contribute to that analysis by exploring the gendered and spatial implications of Canadian social policy assumptions and expectations about who does care work, who is responsible for providing care, and where that care work occurs. As Hochschild, among others, suggests, the state has retreated from funding and providing ‘public solutions’ to the care crisis, further exacerbating the problem. This retreat, which can be viewed as part of a broader move towards neoliberalism, also signals a shift in responsibility for care from state-provided (or supported) care to care as a familial and individual responsibility. I focus in on the gendered dynamics of neoliberalizing social policy (especially for women), alongside the changing spatialities of care work and the increased significance of the home in the politics and processes of care provision. I bring these ideas to bear on two case studies of government programs where the site of ‘the home’ is pivotal to the state’s solutions to the care crisis. The first program is the provision and delivery of home health care in the province of Ontario, the second is the federal Government’s Live-in Caregivers Program designed to bring ‘qualified live-in caregivers’ (most of whom are women from the global South) to work in private homes in Canada.

Care, work and home

Care has re-emerged as a popular research theme for feminist scholars from a range of disciplines (for example, Folbre, 2001; Bakker and Gill, 2003; Mitchell, *et al.*, 2003). Care ethics is a well-established field in philosophy, law, and political theory, for instance. There is a growing interdisciplinary literature on theorising and expanding the concept of care, including using it as a broad framework for making moral, political and policy decisions (see for example: Tronto, 1993; Bubeck, 1995; Sevenhuijsen, 1998; Folbre, 2001; Held, 2006). In geography there are now calls to directly engage with care ethics to draw out the complex geographies associated with care sites and spaces of care (Popke, 2006; Lawson, 2007). Feminist theorists in general have long argued that women and men are embodied beings constituted through social relations. Joan Tronto (1993, 2005) extends that by arguing that caring is a species-defining activity for humanity and “care is a fundamental aspect of human life” (2005: 130). Throughout our lifetime, each of us needs, receives and provides various sorts of care, which, in turn, means everyone at some point is dependent on someone else. Care ethics challenge the existence of the autonomous,

self-contained rational individual who inhabits much of neoliberal discourse. Instead advocates of care ethics focus on human interdependence and argue that that people operate in socially embedded relational contexts. Thus, the individual, is far from autonomous, and only exists through and with others within networks of care (Kittay, 1999; Fineman, 2004).

The actual concrete work of caring can be understood in a variety of ways. My focus is on the daily care of children, the elderly, and people with illnesses and disabilities, what Glenn (2000: 86) describes as “the varied activities of providing for the needs or well-being of another person.” Care work, especially daily care, is, of course, heavily gendered, both in terms of the discourses underpinning it and the people who actually provide it. Armstrong and Armstrong (2001: 1) point out that “care work is women’s work. Paid and unpaid, located at home, in voluntary organizations or in the labour force, the overwhelming majority of care is provided by women. It is often invisible, usually accorded little value and only sometimes recognized as skilled.” In this statement, Armstrong and Armstrong draw on decades of feminist scholarship that spotlight the gendered boundaries constructed around the concept of work and how different sorts of work get socially constructed and differentially valued as ‘men’s work’ or ‘women’s work’. This gendering of work has its ideological and historical roots in the social and spatial separation of waged work from social reproduction. ‘Work’ became constituted as ‘economically productive’ waged-labour that took place outside the home. Housekeeping, caring for family members and other ‘domestic’ activities became non-marketized ‘labours of love’ primarily associated within the private sphere of family and home, and assumed to be primarily the responsibility of wives and mothers. The construction of a socio-spatial boundary separating ‘work’-production-public from care-reproduction-private devalues and obscures activities defined as ‘women’s work’.²

Making visible the pivotal role of women’s unpaid domestic labour was the cornerstone of the domestic labour debate and feminists’ critique of Marxism starting around 1970 (see for example, Seccombe, 1974; for a recent review from a geographical perspective, see Mitchell, *et al.*, 2004). Domestic labour became framed as reproductive labour, “the fleshy, messy, and indeterminate stuff of everyday life” (Katz, 2001: 710) necessary for the daily and intergenerational reproduction and maintenance of ‘productive’ labour(ers). As Iris Young (1981: 52) argued “traditional women’s tasks such as bearing and rearing children, caring for the sick, cleaning, cooking, etc. fall under the category of labour as much as the making of objects in a factory.” Conceptualizing labour as something only occurring outside the household and as excluding domestic work was “one of the unnecessary tragedies of Marxian theory” (Young, 1981: 52). For the early domestic labour theorists, making social reproduction visible meant shifting the concepts of work, value and the economic away from the market and production towards a fuller, more dynamic understanding of the economy that recognized the necessary value of domestic labour. Or as Nancy Folbre put it more recently, recognizing that “the invisible hand of markets depends upon the invisible heart of care” (2001: vii).

Initially conceptualized as something unpaid and occurring in the family home, care work is now being revised to bridge unpaid and paid work in response to the increase in women in waged work. On the one hand, many women work as paid care workers in other people’s homes, these woman are disproportionately women

of colour, many of whom are also recent immigrants. On the other hand, other often privileged women in professional and managerial jobs employ paid care workers (cleaners and nannies, for example) in their homes as part of their work-life balance. This opens up opportunities for provocative analyses of the porous boundaries between paid and unpaid work as well as public and private (sectors and spheres). For instance, Pei-Chia Lan (2003: 189) uses the concept of “continuity of domestic labour” to describe “the affinity between unpaid household labour and waged domestic labour – both are feminized work attached with moral merits and yet undervalued in cash”. The idea of continuities rather than dichotomies is appealing because paid and unpaid care work are wrapped up with both emotional value *and* monetary (or market) value. Each is culturally devalued as ‘women’s work’ (even when it is performed by men), and each is financially undervalued because it gets represented as a naturalized ‘labour of love’ in which the intrinsic satisfaction associated with doing care work brings its own (psychic dollar) reward. So an argument can be (and indeed, is) made that care and love are demeaned by their commodification, thus ‘justifying’ the low pay for paid care work (Folbre and Nelson, 2000; Folbre, 2001).

The concept of ‘work’ (whether care work or not, whether paid or not) is further shaped by the gendered sites where the work is being performed. The continued implications of the social and spatial separation of waged work from social reproduction means that the home is valorised as a putatively private place marked by intimate, nurturing social relations and of a sense of love, comfort and belonging. Paid work in the home unsettles these idealized notions of home. At the same time, because the home is viewed primarily as a site of ‘non-work,’ any waged work occurring there is liable to be viewed as secondary or supplemental. For example, rural Appalachian women home-workers told Ann Oberhauser (1995) that their work is often not considered ‘real work’ by their families and even their clients, precisely because it takes place in the home and because many of their wage-earning activities draw on traditionally feminine skills and activities. The gendered constructions of home as a domestic, feminized space means that women’s paid work in homes, even when it is in someone else’s home, is further devalued not only discursively but even monetarily. For instance, Ontario’s home care nurses generally receive lower pay and fewer employment benefits, and enjoy less social status than their institution-based colleagues (Baumann, *et al.*, 2001).

These sorts of issues demonstrate both the multiple meanings of home, as well as the fluidity of various public and private boundaries associated with the home (see Ahrentzen, 1992). Increasingly home is understood by scholars as a complex, multidimensional, even contradictory concept (see, for example, Blunt and Dowling, 2006; Mallett, 2004). Home is both a material location *and* a symbolic site. There are also contradictory experiences of home. As Shelly Mallett (2004: 84) points out, home “can be associated with feelings of comfort, ease, intimacy, relaxation and security and/or oppression, tyranny and persecution.”

Woven through this complex terrain of home is state power. Recent feminist theorising about state power suggests that rather than being some reified entity acting upon society and individuals, state power is mutually constituted with a range of social relations and materialized through spatialised social practices in a variety of scales, sites and spaces (Larner, 2000; Brodie, 2002; Kingfisher, 2002; Mitchell, *et al.*, 2004).

Thus, among other things the home is an important site and space of state control and one where numerous state institutions, practices and procedures are enacted and reproduced on a daily basis. The home then is the location of set of contradictory discourses and practices. It is an apparently private, domestic place marked by intimacy. Yet it is also a site of increasing statization as demonstrated by the increased scrutiny of welfare recipients and ongoing debates about the role of the state in the 'private' matters such as reproductive freedom and domestic violence. And the home is also becoming a key site where functions previously undertaken by the state (like health care and child care) increasingly have to occur. In the context of the shifting responsibility for the provision and financing of care work in Canada, these multiple, paradoxical understandings of home have been put to work as part of a broader neoliberal agenda aimed at increasing economic efficiency and reducing government spending. The cases of home care and live-in caregivers exemplify that the spatialities of care have shifted towards the home and that the home has become a more significant site of care in the recent evolution in Canada's social policies.

The state, care and gender in Canada

Canada has an elaborate network of laws, policies, and institutions structuring social policy. The Constitution of Canada divides the responsibilities of the government into federal and provincial jurisdictions, and allows for provincial governments to delegate some of their responsibilities to municipalities. Powers between the federal, provincial, and local jurisdictions are clearly articulated and carefully guarded. Among the federal government's responsibilities are trade regulation, money and banking, transportation, and, of particular importance for my paper, citizenship and immigration. Among the provinces and territories responsibilities are labour and employment issues, education, health, and welfare. The federal government sets national standards for certain aspects of social policy (health care, for instance) and has some fiscal responsibility through federal-provincial cost-sharing which, in the context legislated national standards, allows it to exert pressure to harmonize delivery standards across the provinces.

Like several other liberal democracies, Canada has restructured its welfare state and retreated from holding primary responsibility for the collective well-being of its citizens. In the process, Canada has reconfigured the roles, responsibilities and governance arrangements between the household, the state, the market and the voluntary sector. The balance between these four sites, the so-called 'responsibility mix', describes the relative contribution of the state's responsibilities (including the fiscal obligations) compared to those of families, communities and the market (Jenson, 2004). The responsibility mix is not fixed. The creation of a social liberalism inspired welfare state involved a mix where the state played a larger role than previously, with the state intervening into social reproduction through redistributive policies for example. The more recent shift to neoliberalism involves rebalancing and redrawing the boundaries between the state and the other sites, often under the mantra of 'less government'. As Janine Brodie (2002: 90) remarks:

For the past two decades, Canadians have been mired in complex and multiple processes of fundamental change. Among other things, the post World War II

consensus about the role of the state, the nature of citizenship, and popular understandings of the appropriate relationship among the public and the private and the collective and individual have been incrementally and progressively recast into a model of governance which would have been inconceivable a half century ago.

Half a century ago, Canada's 'model of governance' was one of social liberalism or liberal progressive welfarism. The state-market relation was reconfigured around greater state intervention to regulate and alter market forces to meet the goal of social equality. Social ills, such as poverty, were seen as structural and thus social programs were built around a consensus of social rights and collective responsibility to provide for the basic social needs and economic security of Canadians. Canada's welfare state developed around the political rationality of social citizenship and collectivised entitlements to social welfare services. In recent decades, that post-war consensus has been "recast into a model of governance" infused with neoliberalism, underpinned by economic liberalism calling for privileging the market, privatization, and reducing government spending (especially on social welfare programs). In the process, as Brodie observes, the parameters of the role of the state, citizenship and popular understandings about the public/private and the collective/individual relations have altered significantly. The mantra of 'less government' translates into stemming the growth of the state, especially the welfare system, and restoring the logic of the market to areas of everyday life that were replaced or altered by social liberal state interventions (O'Conner, Orloff, and Shaver, 1999).

Neoliberalism, like social liberalism before it, is socially produced and contextual; it is "a human invention, the artefact of particular historical and material practices and struggles" (Kingfisher, 2002: 14). Neoliberalism involves actually existing people engaged in situated, grounded practices and governmental technologies that produce particular places and particular outcomes in those places. By extension, neoliberalism is spatially varied, playing out differently in different places in articulation with the particular cultural, economic and political trajectories in those places (Larner, 2000; England and Ward, 2007). Thus in Canada's version of the neoliberal state, some elements of social liberalism are retained, although key facets like state regulation, social citizenship rights and commitments to formal equality have been eroded. Since the mid-1980s Canada has narrowed the scope and extent of the state's responsibilities to civil society. The federal and provincial governments are divesting responsibility for social provision for their citizens' social and economic needs. Increasingly social policies echo lessons learnt from neoliberal economic rhetoric – privatization, decentralization and economic efficiency. Neoliberalized social policy is marked by reduced benefits and restricted entitlements in the name of fiscal austerity and increased privatization and marketization of public functions and services (O'Conner, Orloff, and Shaver, 1999; Brodie, 2002; Kingfisher, 2002). Discourses of citizenship, formerly configured around collective responsibility, ameliorating social risk and social entitlements, have shifted towards the neoliberal values of possessive individualism, consumerism, and individual responsibility. In this neoliberalized frame, social problems are recast as failures of the individual rather than the result of structural inequalities, and the 'good citizen' is an atomized

market player, self-reliant and who does not look to the government for help (Rose and Miller, 1992; Larner, 2000; Brodie, 2002).

Under social liberalism, state intervention into civil society also extended into the home as the state underwrote many processes of daily and generational social reproduction (like education and health). An enormous amount has been written on the relationship between the state and the normativised gender division of paid market work and unpaid care work, and that supposedly universal notions of 'work', formal equality and citizenship are, in fact, heavily gendered (see for example, Patemen, 1989; Kessler-Harris, 2001; Brodie, 2002). The architects of the Canadian welfare state put in place a system that privileged the male wage earner as the 'worker-citizen' making market wage related contributions to the system. Most women and children were to benefit from the state indirectly at home as economic dependents in working men's families. The male normativised breadwinner/female caregiver family type was encoded into social policy. Canada's welfare state was built around assumptions about the heterosexual nuclear family, supported by a husband earning a 'family wage' in the market and sustained by his wife's unpaid care work in the home. Canada's welfare state reinforced women's economically dependent (on their husbands) roles as wives and mothers and only acknowledged them in a very limited way as wage-earners (and even then they faced marriage bars and a narrow set of occupational possibilities).

Under the social policies of social liberalism, women's place was firmly soldered to the private space of home, whereas neoliberal ideology on the other hand, is seemingly mute about gender (and other axes of difference). Nevertheless it is a profoundly gendered governing project. As Sue Roberts (2004: 137) points out, neoliberalism is "not somehow gender neutral – in either the discursive or the more obviously material practices with which they are associated." Neoliberalism is as a set of discourses and spatialised social practices that differently situate and impact women compared with men. The erosion of many public provisions and subsidies (for example, child care vouchers and family/child allowance) has far greater repercussions for women than men. In Canada, neoliberalism gained currency at a time when feminist activism was especially strong, and the commitment to formal equality was an important social goal. Throughout the 20th Century feminists struggled to erode normative expectations about 'women's work' to gain recognition as *individual*, independent wage workers eligible for economic rights, regardless of their caregiving responsibilities at home.

Under neoliberalism there is indeed recognition of individual workers, but not in ways that feminists intended. People's roles as wage earners are exulted, but their caregiving roles are ignored. The ideal neoliberal subject is the self-governing, autonomous market player. What this ignores, of course, is what is central to feminist care ethics: human life is deeply implicated in the inter-dependence of people who need and give care. As the likes of Kittay (1999) and Fineman (2004) remind us, workers are not autonomous market players; they are unavoidably dependent on others, and far from being self-sufficient they are entangled in relational networks of care. In fact every day they require care in order to even be capable of paid work. Ignoring care work and privileging paid work denies the human necessity of care, but it also means bracketed off care as something of no market value and thus irrelevant in neoliberal calculations. Possessive individualism and privileging the market means

that economic, and even social policies now assume and even promote the *genderless*, economically rational, self-reliant worker who survives and thrives in a fast-moving market. Yet just like social policy formation under social liberalism, neoliberal social policy relies on families (and homes) to be available to provide care. As Tronto (2001: 65) says:

Neoliberals presume that the free market will always step in to fulfil whatever human needs exist. In reality, though, few people have been paying attention to where the burden of caring work actually falls . . . (Thus) the neoliberal state, frees itself from the burden of recognizing who now does the various forms of caring work as the state reduces services.” (Tronto, 2001: 65)

And those doing the various forms of caring work, contrary to neoliberal logic, are not disembodied and genderless, but more often than not, flesh and blood women. Seemingly women have become genderless workers and rational economic actors right at the moment when the many social programs supporting social reproduction and care work have been dismantled (Bakker, 2003).

As social policy gets neoliberalized, the boundaries between public and private are redrawn as governments shift the burden of responsibility for their citizens’ well-being away from state institutions to the ‘private’ space of home *and* to the private sector of the market. Thus two types of privatisation are pivotal to neoliberalism. The one receiving the most attention is the shift to private *sectors*, as in marketizing and privatizing public sector resources and services. Yet for neoliberalism to operate, the second more hidden type of privatization also has to occur – responsibilities for social reproduction are shifted from the public spheres (i.e. the state) to the private sphere where they become the ‘private’ responsibilities of individuals and families (Clarke, 2004). This second privatization from the public to private sphere has far reaching implications for the home as a material and symbolic site. Given that neoliberalized social policy is, in part, about narrowing the scope of the state’s responsibility for care, Isabella Bakker (2003) refers to the *reprivatization* of social reproduction to capture how social reproduction is being repatriated to the private sector (the market) and the private sphere (the home). Thus *reprivatization* is a double movement: one “returns the work of social reproduction to where it ‘naturally’ belongs, the household” (2003: 68); the other where care work is commodified in the market.

The two examples I explore next, Ontario’s home care system and the federal government’s Live-In Caregivers program, illustrate how Canada’s neoliberal inspired remixing of the responsibilities of the state, market, communities and households profoundly affects the relationships between paid work and unpaid work, workplaces and home places, as well as citizens and various levels of government. The shift in the responsibility mix for care away from the public sector to the private sector (as in ‘the market’) and the private sphere (as in the community and the home) is deeply gendered. It disproportionately impacts women because, whether acknowledged or not, the remixing is founded on profoundly sexist assumptions (and even expectations) that women, in particular, are willing and able to assume this burden of responsibility.

Home Care in Ontario

In a range of national contexts, health care reform is a pivotal aspect of many states' restructured responsibility mix. Neoliberalised health care policy includes privatization, marketization and decentralization to make health care more 'cost-effective' and 'efficient'. In many instances, this means the erosion of health care as a public good, and increased market-oriented, for-profit delivery mechanisms. Canada has a federally sponsored, publicly funded universal health care system (often known as Medicare). It was put in place with the 1966 Medical Care Act, and later strengthened with the 1984 Canada Health Act. Medicare became the centre piece of Canada's welfare state, enacted during the "post World War II consensus" Brodie (2002: 90) described, at a time when many Canadians believed that welfarist measures could be instituted to address social and economic inequalities and construct a more equitable society.

Since the 1970s, however, there have been concerns in Canada about the escalating costs of health care and how to 'contain' and minimise public expenditures in this arena. This stands in stark contrast to earlier times, when social liberalism prioritized collective responsibility for social risks so that 'meeting needs' and expanding the flow of resources into health care were the principal concerns of policy formation (McDaniel and Chappell, 1999; Evans, 2000). Cutting health care costs happened at both the federal and provincial levels. The federal government negotiates health plans with each of the provinces/territories. It plays a critical role in terms of financing via federal-provincial cost-sharing which, in the context of the Canada Health Act, allows it to exert some pressure to harmonize delivery standards across the provinces. However, the management and delivery of health care is a provincial responsibility. In the mid-1990s, the federal government announced major cuts in cash transfers to the provinces for health care, education and social services. Several provinces introduced major cuts in health spending. Some provinces cut services or introduced user fees, deductibles and co-payments, or de-listed certain health services by making them ineligible for coverage under the public health insurance system.

Home care has become an important aspect of these "cost effective" health reforms. At least initially publicly funded home care in Ontario increased while the number of beds available in hospitals decreased (in part due to a round of hospital closures and mergers) and hospital stays became shorter as patients are released ("quicker and sicker") to complete their convalescence at home supplemented by some publicly funded home care (Abelson, *et al.*, 2004; Cloutier-Fisher and Skinner, 2006).

Thus, the home has become an increasingly important part of the landscape of health care reform. In the context of my argument in this paper, what is crucial here is not merely the growth in home care, but the discursive and material place of home within the broader health care system. Canada's regulatory framework of health care policy was initially formulated in the 1960s when medical care was generally provided by doctors and the principal site of care was the hospital, and law makers wrote that into the Health Act. The result is a regulatory framework where services provided in the home (rather than hospitals) or by health professionals other than physicians are not *specifically* covered by the Canada Health Act. In other words, the same care financed by Medicare in hospital may be de-listed when it takes place in the home (Baranek, Deber and Williams, 1999; Armstrong and Armstrong, 2003).

The provinces and territories decide on the parameters of formal home care provision without federal oversight, because home care is not included in the Canada Health Act. So there is wide variation across Canada as provinces and territories can decide on the eligibility for and the delivery mechanisms of home care provision in their jurisdiction (Coyte and McKeever, 2001). In the mid 1990s, Ontario became unique in Canada for being the first province to shift from delivering home care mainly through the public sector to ‘experimenting’ with private sector management techniques in the home care system. The restructuring of Ontario’s home care system was introduced as part of a wider set of neoliberal-oriented social policy changes introduced by the then recently elected Conservative provincial government. Reforming home care was one of their campaign promises, so they zeroed in on the internationally fashionable market-oriented health policy already at work in other countries: managed competition. The attraction of managed competition (or competitive bidding as it came to be known in Ontario) is that it creates ‘quasi-markets’ in the public sector with the goal of simulating private-sector type competition to generate cost-saving of public funds and offer ‘consumers’ more ‘choice’ (Light, 2001; Dolfsma *et al.*, 2005). Home care was restructured around a process of competitive bidding for contracts from home care service providers, not only from the non-profit sector, which had traditionally delivered the services, but also the for-profit sector. This was later accompanied by restricting eligibility, delisting some services, privatizing others and rationing the hours of publicly paid home care provision (Parent and Anderson, 2001). As one Ontario home care nurse³ pointed out:

The hospital is covered by (Ontario health insurance) and it’s covered by the government. They don’t want to do that in the community anymore. They don’t want to have that under one umbrella where the government has to pay for most of it. What the government is trying to do is get out of there and have people in the community, more and more people in the community pay for their own services.

Managed competition is not only put into practice at the level of policy making, it also impacts upon the paid care workers who come into the home and those family members and friends who provide informal care. Reforming home care is profoundly gendered because it is a female-dominated industry and because most care is informal home care (estimates are usually between 80 to 90 percent) which is provided primarily by women family members and friends. According to the National Canadian Women’s Health Network (2002: 3):

Hidden in the household and done mainly by women who do a range of other domestic work, care work is often invisible. Yet this invisible work accounts for the overwhelming majority of care provided today. More care is paid for now by public health care plans, by insurance companies and by individuals compared to a decade ago. However, such care is understood as a *supplement to*—rather than a *substitution for*—care by family, friends and volunteers, as a way to fill in the gaps in unpaid care.

Generally paid home care workers find their work rewarding, but the introduction of managed competition meant more and different work for workers, increasing workloads and increasing stress (Aronson and Neysmith, 1997; Armstrong and Armstrong, 2003). Neoliberalizing home care has to be put into actual everyday practice by those who provide care to care recipients in their homes. For example, on paper 'cost-savings' can be achieved by reducing the number of visits by home care workers and reducing the duration of those visits. But it was left to home care workers to explain to their clients why, for example, they can no longer have as many baths a week as they used to get, and to explain why 'tea and sympathy' visits could no longer happen. One of nurse nicely captured this and even framed her argument around scale and the relationality of different sites of responsibility, when she said.

It's filtered down - the misery has come down from the government to the upper echelons of the (home care regional coordinating units) and has now filtered down to the coordinators who have to carry out what the bosses say and now it's coming down onto us and our clients.

Even non-profit agencies began to increase the work loads of their workers, which for many meant more stress and less job satisfaction. The competitive bidding context meant that community nurses and personal support workers no longer had a sense of job security and experienced deterioration in working conditions (for instance seeing more clients in a day and much more paperwork to fill out). And, at least for nurses, the pay and benefits differential compared with their hospital-based colleagues was further exaggerated in an environment of intense competition among agencies (Aronson and Neysmith, 1997; National Canadian Women's Health Network, 2002; England, *et al.*, 2007)

Introducing private sector home care providers and reprivatizing care to the home also has repercussions for the families and homespace of care-recipients. Neoliberalized home care raised the workload of informal caregivers. As Janine Wiles (2003: 191) remarks, "Families, particularly daughters, may be strongly encouraged or pressured to be 'available' whether they are willing or feel able, or not." This suggests a strong normative expectation that families will step in and provide care at home in instances where in the past the care recipient would likely have remained in hospital. Reprivatizing care to the home can mean both care recipients and their informal caregivers feel isolated in part because of the sheer hard work of the caregiving relationship, but also separated from information channels that seem to flow more easily through institutionalised settings like the hospital. Further cuts to funding meant more stringent eligibility requirements and limits on the extent of service provision further increases the workload of informal caregivers and increasing demand for volunteer community services.

Shifting financial responsibility for home care onto individuals may be potentially cost-saving from the perspective of the state, but not from the viewpoint of the home. Relying on family caregivers comes with costs to that household in terms of paying for supplies and additional services that might be available were the care occurring in a hospital under a physician's care. Beyond this there are also the costs borne by the informal caregiver, costs that are financial, psychic and emotional. Many 'informal

caregivers' either leave their paid jobs or reduce their hours in order to provide sufficient, quality informal care. This not only undermines their immediate earning capacities, but can also impact their subsequent options for retirement. The additional stress of caring for their family member is added to already existing responsibilities for social reproduction in the home.

These sorts of costs and home-based care are all too easily invisibilised once they are not included in calculating the state's budget for home care. Reprivatising care to the home has become an increasingly important aspect of health care reform because it can be slotted into the neoliberal frame of self-care and individual and family responsibility. The entire home care policy is built on the assumption is that there is (or should be) a 'family caregiver' or 'informal carer' available at home to provide care and basically act as a privatised safety net. This, in and of itself reveals how neoliberalism is far from self-sufficient, and depends on cultural assumptions about home and the hard work of women in the private sphere in order to work.

Live-in Caregivers Program

For the second example, I turn to one of the federal government's home-centred solutions to the care crisis around child care. The demand for child care within Canada increased along with the rise in women's paid employment and the growth in two-earner couples (especially as women moved into higher-status professional and managerial occupations). However, the demand for child-care continually outstrips the supply of child care and there is an ongoing shortage of affordable, quality, regulated child care. The *Toronto Star* journalist quoted at the start of my paper summarized the situation: "Child-care services are fragmented, there simply aren't enough spaces and most of them are not affordable." (Ablett, 27 March, 2007). Cut backs in the federal and provincial government funding, regulation and provision of child care has exacerbated an already difficult situation at the same time as there is an increasing cost of child care that is left to the market. As women have moved into the paid labour force (apparently as genderless, rational economic workers), social programs supporting social reproduction have diminished producing "a 'care deficit' in both public and private life" as Hochschild puts it (2003: 214).

For decades, Canada's child care policy has followed a meandering path on and off the political agenda of the federal and provincial governments. Despite successive government promises and extensive activism, there is still no national childcare policy or legislation in Canada, and limited financial and program support on the provincial level.⁴ Given the lack of national policy (unlike healthcare, education and social services) there is currently no mandate for child care services, so as with home care, there is tremendous variation across the country. Some jurisdictions offer subsidies to lower-income families and generally there is very little publicly delivered childcare provision.⁵ Despite recent public debate in Canada about introducing a national child care system, child care is still marked by a commitment to individualisation of choice and family privacy. Unlike education, for instance, the view has long been that parents, not governments are responsible for child care. Indeed there is more than the occasional whiff of neoliberal rhetoric to arguments that leaving child care provision to the market increases individual families' choice.

Some better-off families have turned to a particular sort of privatized solution to the child-care crisis: a live-in paid caregiver. In the Canadian context, the federal government offers this 'solution' via the Live-In Caregivers Program: a work visa program that brings temporary residents (primarily women from the Global South) to Canada to provide care for children, seniors or people with disabilities in private households. This solution to the care crisis is privatized in a double sense; it occurs in the private sphere (i.e. the home) and is financed in the private not the public sector (i.e. by individual families). The home is literally written into the program: "live-in caregivers must live in the private home where they work in Canada" is stated prominently on the official website about the program.⁶ For the women⁷, primarily from the Global South, who enter Canada under this program the attraction is that after working for at least 24 months as live-in caregivers in their first three years in Canada, they can apply for permanent resident status. If they receive permanent residency they can eventually apply for Canadian citizenship and begin the process of bringing their family members to Canada.

From the perspective of the employing family, a live-in caregiver offers several advantages. If the employing family has more than one child, it can be cheaper to hire one live-in caregiver than to pay for several child-care arrangements outside the home. Having a caregiver right there 'at home' means that the parents are not chauffeuring their children to different locations (care provision for children of different ages is often at different locations). Also having a live-in caregiver means the parents have more flexibility in scheduling work obligations (other child-care arrangements have fixed hours and even a live-out caregiver usually arrives and leaves at specified time). Indeed, the live-in caregivers give their women employers the opportunity to tuck away their maternal roles and act in the neoliberalised labour market as though they are atomized, independent workers able to fit into the long hours culture of the workplace.

However, the live-in requirement can also make the caregiver vulnerable to unacceptable, even abusive work conditions (including those that violate the program's rules) precisely because the caregiver is legally tied to an employer's private home. Thus from the perspective of the live-in caregiver the advantages for the family can present the potential for deeply problematic, even exploitative working conditions. For example, Felicity⁸, a Jamaican woman working in Toronto remarked:

I knew it wasn't going to be easy living in someone else's home. What I didn't prepare myself for was the subtle abuses Living-in means they come in at 5:30 pm, but you keep the kids until they've finished supper. Then you clean up, after you clean up, they might decide they want to go for ice cream or coffee, but you are still working. When you even mention that you're supposed to get overtime pay, they say 'You're a trouble-maker.' They say no one ever asked for that before.

Felicity points to several "subtle abuses" that arise from her place of residence and workplace being located in her employer's home. The lack of a clear work time schedule meant Felicity often faced an ever expanding workday, without clearly

defined start or stop times. Her employers expected her to baby-sit the children (without overtime pay) in the evening while they went out. When she complained, she was dubbed a trouble-maker. Felicity had astute observations about her situation and those of other live-in caregivers:

They pay you to be in their house. That makes it even worse; you become nothing in their eyes. What I can't deal with is the idea that because I mop their floors, I'm stupid. They don't have to respect you, but they come with this disguise, 'Oh, you're part of the family.' They hug you. I don't want to be hugged! For God's sake, I'm your employee, treat me like an employee! But that's their way of trying to outsmart you. It's emotional blackmail. You're meant to think, 'This nice white lady, she's hugging me.' Then I'm supposed to take everything they dish out. I don't want that. I just want to be respected as a worker, with an employer-employee relationship.

Felicity's comments reflect the devaluing of care work and her employers' lack of respect for her skills. She clearly despises the "part of the family" rhetoric which she interpreted as a strategy of extracting further unpaid physical and affective labour, without the genuine caring and respect associated with actual familial relationships. That these fictive kinship ties are located in the private home, supposedly a site of love and familial intimacy, obscures the asymmetrical class relations associated with the live-in paid care work relation. Being "part of the family" as Felicity suggests, can amount to "emotional blackmail" that puts the caregiver in a weaker bargaining position as an employee asking for fair wages and reasonable working conditions. Felicity wants her employers to see her as their employee, and, in light of her comments about overtime, to take seriously their responsibilities as her employers.

As Felicity's remarks demonstrate, actually living in the employer's home produces ambiguities around the spatial and social boundary between being at 'work' and not being at 'work', as well as around 'work' and 'care'. The sorts of "subtle abuses" and the "part of the family" discourse experienced by Felicity have also been extensively documented by scholars (see for example, Pratt, 2004; Zaman, 2007) and live-in caregiver advocacy/research organizations like INTERCEDE in Toronto and the Philippine Women Center in Vancouver. Some employers scheduled overnight trips, given that the caregiver was "at home anyway" and the children would be sleeping. There are cases where live-in caregivers' supposedly private living space is used as a 'guest room' when they are away and others where the caregiver had their duties extended to include caring for additional family members (in some instances in different houses) and even pets. These are violations of the Live-in Caregiver Program. These and other problems are linked to the live-in requirement. After years of activism and advocacy, and in the face of mounting evidence of all sorts of exploitative work situations faced by live-in caregivers, the federal Government now expressly informs live-in caregivers of their rights on arrival in Canada and through a government website. For example, abuse is defined and examples are given (sexual assault, verbal mocking and scare tactics are included) that violate either the criminal or human rights code. Live-in caregivers are informed that "You have the right to privacy in your home. For example, you should ask for a

lock on the door of your room as well as a key to the house where you live and work. You may spend your non-working hours as you wish. Your employer cannot insist that you spend your non-working time in her or his house. You can refuse to do work that is not in your employment contract.” Until recently none of this information was freely available to live-in caregivers, and at one point live-in caregivers spatially and socially isolated in private homes could not get good information about where to turn for advice and support. Provincial governments, which are responsible for employment standards, have been resistant to including live-in caregivers in even the most basic labour protection legislation like minimum wage. This is changing, slowly. The reluctance is indicative of the devaluing of care work as not ‘real work’ and thus, by extension live-in caregiver as not ‘real workers’. These important changes are the result of years of activism by live-in caregivers and other advocates. However, the federal government remains adamant about retaining the ‘live-in’ requirement despite repeated and continued attempts by activists groups to get it removed. Not living-in may disqualify caregivers in the program and can even be grounds for deportation.

Although the program is clear that “live-in caregivers must live in the private home where they work in Canada” and that it is the individual responsibility of the family themselves to complete all the paperwork to hire someone, it has the appearance of a private arrangement in a private home. Yet the state plays an active and extensive role in the process. For example, the employer must meet requirements laid out in the program (such as providing “acceptable accommodation in your home”). The legally required contract must be approved by Citizenship and Immigration Canada, and yet another department (Human Resources and Social Development Canada) must be furnished with evidence that a reasonable effort was made to hire someone already in Canada. If a work permit is issued then the “caregiver will be carefully screened by a Citizenship and Immigration Canada visa officer before they enter Canada”.⁹

Despite the patina of being a private arrangement, the Live-In Caregivers Program is an intricate set of regulations that shows that the Canadian state is willing to intervene into the labour market to ensure a supply of cheap, live-in child care. This is not something left to the ‘invisible hand of the market’. Certainly the program can be interpreted as part of the growing globalization of care work, where the transnational flows of what Ehrenreich and Hochschild (2002) call the ‘global woman’ serve the global economy. While some wealthier parents have benefited from the devalued labour of live-in caregivers, so has the Canadian government. The program reinforces ideas that child care is a private, family matter rather than a public issue requiring a public solution. And even with the recent developments around national child care program, the existence of Live-In Caregivers Program means the state can diffuse demands to take more responsibility for childcare by placating at least some middle-class families. The Live-In Caregivers Program may, in practical terms, be taken up by a relatively small number of families with child care needs. However, in the context of my argument its significance is that it lays bare state institutions, practices and attitudes about care and responsibility (and immigration) that are more commonly hidden. The Live-in Caregiver Program Canada exists in part because there are insufficient Canadian citizens or permanent residents available for this sort of work. There has long been a chronic shortage of

people willing to take live-in care work (even at times of high unemployment), not least because care work is devalued both in terms of low pay and poor status. An obvious solution would be to develop affordable child care options within Canada or improve live-in work conditions (for instance, legislate higher wages), yet the Canadian government continues to ‘import’ foreign-born women to work as live-in paid caregivers. Perhaps as Sedef Arat-Koç (2006: 88) argues, it is because live-in caregivers “are the ideal subjects of a neoliberal state since they are workers whose social reproduction is not just privatized in the home, but totally hidden, with the economic, social and psychic costs transferred to a different location and state. . . . (They are) concealing not only their own reproduction but also the needs and dependency of their employer.”

Conclusion

Normative expectations about home, domesticity and family are written into social policy. All governing philosophies (*laissez-faire* liberalism, social liberalism, and neoliberalism) involve particular configurations and negotiations of the fluid boundaries between public and private sectors and spheres. States are revisiting their responsibilities to civil society, and there is a shift in the responsibilities between the state, the market, communities and families. This has implications for where the boundary should be drawn between public (as in the state) and private (as in markets, communities and families) responsibility for care provision.

I have explored the gendered implications of the shift away from the post-Second World War consensus of state intervention, informed by social liberalism, to a more punitive, means-tested system underpinned by neoliberal ideology. In the process the federal and provincial governments have moved away from underwriting many of the costs of social reproduction, as well as decreasing the direct provision of care. Instead, other actors and institutions that are part of the network of care (the market, the family and the volunteer sector) are expected and encouraged to step in and take responsibility, and that has significant implications for the home. Using the examples of home care and the Live-in Caregivers Program, I addressed how the neoliberalisation of care work in Canada has had major effects on the relationalities of care, work and the spaces of the home. The individualisation, familialisation and market-based approaches associated with the neoliberal reforms to the care system in Canada have shifted the processes, politics and place of care to the home. Despite claims of gender neutrality, these shifts disproportionately affect women, as it is invariably they who step in and fill the gaps left by the decline of public services. The focus of neoliberal social policy on downloading responsibilities for care formerly provided by the state onto markets, individuals and families, increases the care work of women in homes, whether they are paid or unpaid caregivers.

Neoliberal projects are brought to life in deeply gendered ways. The associated policy agendas and their outcomes are far from socially neutral. Across Canada thousands of women are employed as paid caregivers in ‘private’ homes caring for young children, the elderly and people with disabilities. The boundary between the supposedly private space of home and the public spaces of the state and the market gets blurred when non-family paid caregivers provide care, which in turn destabilises the meanings of home. Similarly, the emotional complexities of trying to

simultaneously maintain both a personal relationship and a work relationship are thrown into sharp relief when paid employment occurs in 'private' homes. Home-based paid care work is a peculiar form of employment, with different sorts of work relations than the institutional settings of a formal child care centre or a hospital. The paid care work relation is already saturated with discourses about intimacy, affective labour and ideologies of home and family. When that paid care occurs in someone else's home – a site so deeply suffused with feelings, emotions and ideals – those discourses become even more potent.

Notes

¹ Canada introduced the Family Allowance in 1945. It was a monthly payment to all families with children regardless of income – i.e. a universal benefit, not means-tested. Beginning in 1978, the system was repeatedly restructured. A refundable child tax credit aimed at low and moderate income families was introduced, and family allowance to better off families was scaled back. By 1993, family allowance and the refundable child tax credit were replaced by an income-tested child tax benefit; the most recent version is the Canada Child Tax Benefit. This federal assistance to families with children is now delivered primarily through the tax system.

² The division also has important implications for women's paid work outside the home. As demonstrated by the gendered wage gap and the continued existence of gendered occupational segregation (into low-paying, less prestigious jobs such as clerical and sales jobs) (Fortin and Huberman, 2002).

³ This and other quotes in this section are from England, *et al.* (2007). They are from participants in a transdisciplinary study of home care in Ontario. Information on publications from this project can be obtained from the Principal Investigator, Patricia McKeever, at the Faculty of Nursing, the University of Toronto.

⁴ In 2005, the first beginnings of a national early learning and child care program were laid down (including bilateral agreements with provinces and territories), but this was later dismantled.

⁵ The important exception here is the Province of Quebec that introduced \$5 dollar a day highly-subsidized childcare 1997. It is now \$7 a day, but may increase to \$10.

⁶ See <http://www.cic.gc.ca/english/work/caregiver/index.as>.

⁷ The program is open to men as well, however only a tiny proportion of the participants in this program are men, although that appears to be on the increase. That may well be because the LCP, like its predecessors was developed as a solution to the child care crisis, but it also explicitly includes care for "elderly persons or persons with disabilities" and the men may well be employed in caring for elderly or disabled adults.

⁸ Felicity (a pseudonym) was a participant in a Toronto-based project about the Live-in Caregivers Program (see England and Stiell, 1997; Stiell and England, 1997, 1999).

⁹ See <http://www.cic.gc.ca/english/work/apply-how-caregiver.asp/>.

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