

Rethinking Commodification

*Cases and Readings in
Law and Culture*

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2. COMMODYING CARE

For Love nor Money

The Commodification of Care

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American politics has long engaged a lively debate about whether care can and should be commodified. The debate starts with rather more narrow economic questions: Is care a commodity and can it be produced and distributed like one? Should people who do informal, voluntary caregiving be paid for their efforts as they would be for other kinds of work? Should people who need or want caretaking have to purchase it like any other service? The term "commodification" usually refers to this economic sense. But the debate moves swiftly into the realm of politics: Is care a *political good*, and should it be organized like one?

In the political sense, commodification engages three issues. First, should society pay families for caregiving? That is, is it ever proper or necessary to pay parents and grandparents for raising their children, pay spouses for caring for each other, or pay adult children and grandchildren for caring for their elders?

Second, should caregiving count toward meeting the obligations of citizenship? This would mean that in the public economy, personal caregiving could be exchanged for public protection, in the same way that in the private market, personal paid labor can be exchanged for private and public protections. Should public income support programs such as public assistance, Social Security, and health insurance, credit caregiving in the same way they now credit paid work toward eligibility for membership in these collective social safety nets?

Third, is care itself a basic human need, like income, food, and shelter, that ought to be collectively guaranteed to citizens at some minimum

level? Is the assurance of adequate care one of the purposes of government? Should government be in the business of provision, production, and distribution of care?

Meanwhile, despite the apparent tentativeness and openness of the debate, much care has already been commodified in both the political and economic senses. To some extent, modern states have answered all three of these political questions in the affirmative. And care has been an economic commodity for a long, long time. We have paid child care, health care, disability care, and elder care in a plethora of forms. A few public programs even pay relatives to take care of their own.

So a puzzle arises: why are we so reluctant to bring care even more into the political economy? Why, as citizens, do we resist paying relatives for home health care, giving allowances to single mothers who care for their kids, giving pensions to women who raise families and iron shirts, and insuring elders for long-term care? These debates are animated by lots of unexamined fears and assumptions. My purpose here is not to address the policy questions but, rather, to skulk around the political and philosophical underground of these care debates to understand the sources of our inchoate collective resistance to commodifying care.

In thinking about these issues, I treat care in a broad sense. I include ordinary child care, elder care, and care for the sick and the disabled. I include care for relatives, friends, and strangers, although, as I will insist, caregiving quickly makes intimates of strangers. For policy planning, it often makes sense to distinguish these different kinds of care, but for understanding what care means to people both psychologically and culturally, I think it is important to look for the commonalities across all kinds of care.

How Is Care Political?

Care is prepolitical. It is the ancient human activity of nurturing children, spouses, friends, parents, the sick and disabled, the elderly, the lonely, the poor, the miserable.¹ To ask about care is to descend below the macrolevel of political systems, below the intermediate level of political institutions, below the microlevel of civil society and social capital, on down to the molecular level of political sentiments, down to loyalty. Loyalty is that most elemental of political sentiments, for politics is all about alliances as well as conflicts.² And care is where the seeds of loyalty ger-

minate. People come to develop attachments and bonds in the act of caring for and being cared for. The parents who nurture their infant are no less bonded to it, driven by *its* needs, than the infant is bonded to them, dependent on them for its survival.

We could say care is the basic molecule of social capital. If social capital consists of “social networks and the norms of reciprocity and trustworthiness that arise from them” (as Robert Putnam defines it in *Bowling Alone*),³ care relationships are where trust, reciprocity, and mutual respect first grow. And it is precisely here, at the place where our deepest yet least understood connections to one another take hold, that the fears and fictions of policy debates begin to form. This is where we need to look to understand what’s going on above ground.

The reciprocity of care is not obvious at first; indeed, the word “giving” in “caregiving” suggests a one-way affair. It seems as if the caregiver ministers to physical and emotional needs, and perhaps even decides exactly what help the cared-for person needs before ministering. What, then, does the cared-for person give? Care is reciprocal in a different way than is “tit for tat” exchange. Joan Tronto includes “care-receiving” as a crucial ingredient of care: “The object of care will respond to the care it receives.”⁴ Put less abstractly, the cared-for person gives to the caregiver a sense of being needed and appreciated, and of making a difference—not a trivial gift. This kind of reciprocity may not be the calculated, premeditated exchange of markets, but care, conceived this way, is reciprocal nonetheless.

And caregivers do perceive this reciprocity. One aide in a nursing home explained to anthropologist Nancy Foner why she gets pleasure from her work: “You’re working here. You’re saving someone’s life. They can’t feed themselves, can’t dress themselves. I feel I’m helping them.”⁵ A day care provider told Margaret Nelson, “Cassie [a child] left the other day and told me she loved me. Things like that are the reward. What can you have more than a child who loves you?”⁶ One of my neighbors, a retired engineer who, among his many other volunteer activities drives a woman to dialysis once a week, an hour each way, once told me. “I get so much more from her than I give to her. I’m really just selfish.” The perception of rewards from caregiving is remarkably common. In Robert Wuthnow’s study of helping and caring, 91 percent of survey respondents agreed that “[w]hen you help someone in need, you get as much from it as they do.”⁷ The common formulation—“I get more than I give”—raises fascinating questions (why, for example, do people define themselves as selfish when

they are being their most altruistic selves?), but one thing it surely indicates is the common perception among people who care for others that caregiving is a reciprocal activity.

Care is a realm of touch, tears, frustration, love, anger, fear. We associate caregiving with maternal instinct of the natural world; with families and neighborhoods and face-to-face relations; with intimacy and the feeling of security that comes with intimacy; with spontaneous response to need and suffering, unmediated by rules and rationales. Although much care has already been formalized, both economically and politically, care is still the last bastion of this prepolitical social life, the part that has only relatively recently been hit by “-ization”: industrialization, marketization, rationalization, bureaucratization. Thus, caregiving is to the contemporary American psyche what the wilderness and the frontier were to the late nineteenth-century American psyche, and as we see this frontier disappearing, we, too, are gripped with angst.

One set of fears has to do with nostalgia, with what we are losing and have lost—namely, all that is precious about care and that, like wilderness, nurtures us against the noise and policies of modernity. Another set of fears is dystopic and full of dread—dread of all the ways we are capable of neglecting and exploiting on another, just as we have done to our wilderness.

So what *are* the fears? And are they real?

The Fear That Money Will Extinguish Love

Feminist theorists—and others—worry that money will change the very essence of care. Commodifying care might change the relationship between caregiver and cared-for because it would add economic relations to a prior noneconomic relationship. And since the essence of care is the relationship, commodification might also change the nature and quality of the care itself. After all, as theorist Elizabeth Anderson writes, market transactions “leave the parties free to switch trading partners at any time,” hardly the kind of loyalty one expects in a caregiving relationship. Perhaps more frightening, in market relations, “Each party is expected to take care of herself,” for the market assumes self-interested behavior.⁸

If care is brought into the market economy and caregiving is recast as wage labor, the motivation of caregivers might change. They might possibly do it for money instead of for love. If care is motivated by altruism,⁹

by a concern for the welfare of the other (and culturally, we certainly wish it that way, even if scientifically we understand that care is sometimes motivated by guilt, necessity, or darker motives still), commodification, we fear, would introduce the motive of self-interest. Caregivers might put their own financial aspirations above the needs of the people they care for. Worse, they might downright abuse their charges, who are now the raw material of their income-producing activity. Writing in the *Wall Street Journal* about a trend toward paying adult children for elder care, Sue Schallenbarber warns, “But there’s a vast dark side to this trend. Paid caregiving setups underlie a good chunk of the financial abuse suffered by the elderly. In California, where many aged and disabled people are allowed to pay family caregivers, it’s surprisingly common for relatives to take the money and fail to provide the care.”¹⁰ The fear here is that in markets, money drives out other more honest and virtuous motivations. People will take the money and run. Markets, we fear, suppress our best natures and evoke our worst.

Experience with care markets demonstrates something extraordinary: Even when people get paid a pittance for taking care of utter strangers in the most physically and emotionally demanding jobs, love creeps in. Study after study of nursing home aides, home health aides, child care workers, nannies and *au pairs*, even domestic workers finds the most amazing alchemy. People who care for strangers, no matter what the pay, commonly fall in love with the people they care for and come to consider them family. They say they love their clients. Even though they have been trained by their teachers and warned by their supervisors and their friends to keep their emotional distance, they inevitably get close to clients and they say things like “You get attached to them,” and “You can’t help it.”¹¹

Paid caregivers often come to regard their charges as kin, and commonly say they feel as if the person they take care of is their own mother, sister, brother, child.¹² A family day care provider described her relationship with the children she cares for: “And these children, they are so close to you. You’re like a second mom to them. And you being there when they come home after school—you listen to the different little things they want to talk with you about. It becomes a personal thing, where, you know, they can’t get to mom right away. But they can get to you.”¹³ Family day care providers (women who take children into their own homes for pay) might be expected to portray themselves as professional, yet in fact the vast majority see their work as being “like a mother” to the chil-

dren in their care. They describe their relationships in mother-child terms: "They are my part-time kids"; "I'm like a second mom"; "I think of them as extended members of my family"; "These guys are like my own kids."¹⁴ One nanny told Cameron Macdonald, "I felt those kids were mine."¹⁵ Another nanny, a Filipina working in Washington, D.C., told the *Wall Street Journal* that she calls her American family's child "my baby," and that "I give [her] what I can't give to my children. . . . She makes me feel like a mother."¹⁶ Clients and their families often come to feel the same way about hired caregivers. When I first told the chair of my political science department, Sidney Milkis, about my research on home health care, I expected him to ask me about its connection to political science. Instead, he told me a story. He said his mother had had a home health aide for a long time before she died. At his mother's funeral, he insisted that the aide ride in the limousine with the family. "She was my mother's best friend, the most important person to her, and I wanted her to have a place of honor." When researchers Emily Abel and Margaret Nelson had to decide where to locate their father as he was dying—close to his children, or in his own home with a paid caregiver who had been caring for him for years—they chose to leave him with the person whose relationship at that point in his life was far closer to him than their own.¹⁷ One employer of a domestic told Judith Rollins why she kept employing a woman who routinely came late and didn't clean very well. "It's worth much more to me to have her loyalty and her trust. And know if I'm sick, she'll come and take care of me, know I can count on her being there."¹⁸

If anything, caregivers resist letting money affect their relations with the people they care for, and even try to deny that money is part of the relationship. They want to pretend money isn't there. In my study of home health care, a retired public health nurse, who was still consulting for a home health agency and was very aware of the current state of the field, told me that when she was in practice, nurses would never discuss money with clients, and never had to. She thought that one of the most difficult features of home health nursing today was that even on the first visit, and often on subsequent ones, nurses are forced into discussing just "how much" care they will be able to provide. They have to go over the patient's insurance and talk about what is covered, for how long, and more painfully, what *isn't* covered, and how quickly the care might terminate. From the get-go, they have to discuss withholding care. Almost every nurse and therapist I interviewed said she hated having to discuss eligi-

bility and time limits with patients. They hate having to puncture the pretense that their caring is unlimited.

Paid caregivers, even the most lowly paid, don't just talk the language of love. They often sacrifice their economic self-interest for the sake of the people they take care of. In my research on home health care, many aides—earning in the neighborhood of \$7–10 an hour—told me about purchasing food or other necessities for their poverty-stricken clients, and of visiting and helping clients after hours, on their own time, without pay. Family day care providers often continue to care for children whose parents can't or don't pay because they love the children and can't abandon them.¹⁹ Nannies and *au pairs* sometimes stay in jobs they loathe, accept poor pay and working conditions, and decline to confront their employers because they love "their children."²⁰ Domestic workers sometimes continue in financially nonsensical jobs out of attachment to their employer. One Chicana domestic explained to Mary Romero why she continued working for an elderly woman despite low wages and a long commute: "I guess you can say she needs companionship. I feel sorry for her, you know. . . . I go once a month to her house. I like to go early so I can sit and talk to her."²¹

The point is not that all paid caregiving relationships are rosy and loving but that many of them are. These stories are legion, and they suggest that experience contradicts some of the mythology about how market motivation displaces other motivations. Money may distort some caregiving relationships in some ways, but it doesn't have to. Much of the time, despite the fact of pay, people take care of their clients exactly the way they take care of their relatives. And they love them, too. Maybe not exactly the same way, but so often they say they love their clients as if they were "my own."

To be sure, paid caregivers remain acutely aware that they are *not* family. Their relationship with the people they care for could be severed at any time. They do not have claim to ties with their fictive kin in the same way people can usually claim ties to real kin. In her study of family day care providers, Nelson found that many providers develop an attitude of "detached attachment" to protect themselves from the pain of separation and loss when a child is removed from their care. "I reserve something, knowing that they're not mine"; "I hold back a little"; "I don't want to get too attached."²² And yet, despite this self-conscious reserve among people who care for pay—what Nelson calls "the emotional labor of creating a distance"²³—what's striking is not the holding back itself but

what caregivers feel they must hold back. They don't feel they have to check their avarice; they feel they have to check their love.

The Fear That Love Will Trump Self-Interest

This triumph of love over money leads to another feminist fear, one that is paradoxically precisely the opposite: that money *won't* extinguish love. Put another way, altruism will triumph over self-interest and become self-sacrifice. According to law professor Robin West, women's classically nurturing, altruistic, care-taking personalities are a fearful response to patriarchal oppression; women care because they don't feel they have other choices, and in their altruism, they betray their autonomous selves.²⁴ In this view, the "care ethic" celebrated by Carol Gilligan and the "different voice" tradition²⁵ are really the manifestation of repressed ambition.

Robin West's is an extreme view, but much of the feminist writing on child care and health care workers notes that women care workers "don't feel right" about asking for more money or treating their work as a job, so they allow themselves to be exploited. Although they need their wages, they accept the cultural norm that women are supposed to care "out of love," and they fear that asking for more money will lead others to think worse of them. Raising issues of pay or working conditions makes the economic aspect of the work visible and brings it to the forefront.

Child care researcher Marcy Whitebrook found that most paid child care providers were unwilling to advocate for pay increases for themselves; however, when told that pay increases would reduce staff turnover and create higher quality care for the children, they were willing to join the political fight.²⁶ In other words, when the issue was cast as fighting for their own self-interest, they demurred; when it was cast as altruism, they joined. Since care workers' job is to care for people in both the psychic and practical senses, they fear that if they allow themselves to be seen as economic actors, their image as caregivers will be tarnished. Indeed, love undermines money, not vice versa.

Mary Romero and other scholars of domestics, nannies, and low-wage caregivers emphasize how employers can exploit these intense emotional connections to extract labor without paying its true worth. The feminist fear that women in paid caregiving are easily exploited is a real concern. But the mere fact of payment is not the cause of exploitation, nor does

paying for caregiving necessarily lead to *underpaying* for it. Unions and other forms of collective organization are one answer to this problem. When care is acknowledged as paid work, real work, the new framework actually enables workers to feel legitimate about asking for decent pay and benefits. The goal of the Service Employees International Union (which organizes home care workers among many others), the Worthy Wages campaign for childcare workers, and the Domestic Workers' Association in Los Angeles is to create the culture change that enables workers to resist exploitation, and to create the political bargaining power to back up their demands.²⁷ And these organizations do in fact succeed in raising wages and sometimes in getting benefits.²⁸

The Fear That Care Will Stifle Real Work

A standard feminist complaint is that care work is regarded as lowly work, and for a long time, the standard feminist answer has been to recast care work to reveal its essence as highly skilled labor.²⁹ This revisionist literature on the "invisibility" of women's work is based on the premise that if social scientists show how much skill and complex knowledge go into caregiving, society will recognize the value of care work and pay up. For example, here is the sort of claim meant to convince that caregiving is skilled work: "Attending to others involves not only abstract learning and reasoning but relational intelligence, social learning and skilled knowledge."³⁰ This literature assumes that care work is devalued in part because women are devalued in general, and in part because the men and few women who hold the power to value work don't appreciate the difficulty and complexity of care work.

There's another, perhaps more potent reason markets and politics don't value care work: Care is so full of love, and anything that involves love can't be real work. All the warm, fuzzy, personal, relationship "heart stuff" is recreation, not work. It is fun, not virtue. Real work is hard, exhausting, depleting, and disciplining. It is physical and mental but not emotional or spiritual. There's a Calvinist bent to our conception of work—you save your soul in the future by punishing and depriving yourself now.

Care challenges this notion of work. It is everything that work is not supposed to be. Just as conservatives have always feared that helping people on the basis of need might undermine their motivation to work,³¹ in-

dulging the desire to care seems to threaten the work ethic. Care, as Suzanne Gordon says, often necessitates “being with another human being, not necessarily doing for him or her. But in our culture, we value doing, not being.”³² If people had the choice, we fear, they might sit around caring all the time, basking in feelings instead of doing something harder and more productive. Current debates are suffused with fear that care is shirking real work.

Nowhere is this fear more evident than in TANF (Transitional Assistance for Needy Families) rules about child care. Assistance programs will assist women who take care of other people’s children for pay, but not those who would take care of their own instead of working for pay. Consider the case of Regla Belette, a client of the New York Department of Human Services.³³ She and her partner, Angel Martinez, have three children. They could not make ends met, to say the least. To qualify for assistance, Ms. Belette had to be working for money, so instead of taking care of her own children, she was assigned by New York City to take care of her sister’s three children, and paid to do so, while her sister worked in *her* workfare assignment. How, you might wonder, did Ms. Belette and Mr. Martinez care for their own children? Presumably, they had to pay someone else to look after their children while Ms. Belette looked after her sister’s; or they had to get a relative to do it for free; or maybe New York City paid another workfare recipient to mind the Belette-Martinez kids; or perhaps they reluctantly just let their children hang out on their own. Ponder for a minute what a convoluted way the state assures care of children, just to avoid counting care of one’s own kids as honest work.

Caregiving of every kind entails many ways of being that don’t easily fit our instrumental notion of “doing.” Care workers consciously seek to build trust at the start of their relationship with clients, deliberately sacrificing more instrumental goals. Home health aides, for example, are often supposed to help clients bathe, but most clients are reluctant to let someone help them with bathing. So the aides don’t even try to give a bath in the first few weeks; they spend their time instead talking, listening, and building up the comfort level while doing other, less intimate tasks. They spend time doing things that look like waste to efficiency-minded managers, things like chatting, fooling around, hanging out, sitting and gabbing.

Once care becomes a market commodity, purchasers begin to think in terms of getting their money’s worth. Several employers of domestics told Mary Romero that their maids were like therapists. But one white woman

candidly acknowledged that she couldn’t see paying black maids for that kind of skilled labor: “It got where what they [two domestics] could produce for \$3.39 an hour wasn’t worth it. I just couldn’t afford to have a black—I called them my black psychiatrists. They were ‘my black people who came,’ and we chatted and had a good time. I couldn’t afford to pay them for that.”³⁴ Purchasers of care also think they have to discipline caregivers, making sure they don’t slack off “doing” for the pleasures of “being with.” While working as a nurse’s aide in a nursing home, sociologist Timothy Diamond stopped to sit and talk with a patient he’d found crying in her bed; before he could find out why she was crying, the supervisor came by and reprimanded him for not doing his work, which at the moment was supposed to be taking vital signs, not getting intimate with a patient.³⁵

In many care occupations, caregivers believe that their relationship with clients *is* the service they provide, or at least, the most important thing they give, above whatever instrumental tasks they are paid to provide. They believe intimacy, closeness, friendship, company, trust, security, and love are what the clients really need, never mind what supervisors prescribe or payers authorize. They redefine their jobs, sometimes consciously, sometimes less so, elevating the relationship to the foremost goal. Family day care providers, according to Margaret Nelson, tend to think that intellectual stimulation and learning activities are secondary goals and emphasize instead building a certain kind of relationship with the children in their care, such as giving the children “a sense of family” or “offering closeness and security—my own motherhood.”³⁶ Physical therapists are trained and paid to provide physical therapy, but, as several of them told me, “sometimes the client just needs someone to talk to.” One physical therapist explained how the requirement to document her services in fifteen-minute increments interfered with her work: “I let [someone] cry on my shoulder for fifteen minutes because things aren’t going as well as she wished they were . . . or she has some concerns . . . or she’s worried about whether her husband’s going to be able to take care of her and can she stay here [at home].” This kind of care, the physical therapist conceded, “may be social work [i.e., NOT physical therapy and therefore not reimbursable], but right now *I’m* there, and she needs *me* to listen.”³⁷

No wonder, then, we fear treating care as a political and economic commodity. I have been using “we” in a deliberately ambiguous way, for the complexity of “we” is a major reason why commodification of care is

an issue. People who care for a living, no less than those who care without pay, have their own definition of the work, and it is one that is deeply at odds with what “we”—when we’re not caring ourselves—deem work and how we regulate it in the rest of our economic lives. As caregivers ourselves, we fear having an alien conception of care imposed on us. As purchasers of care and as taxpayers, we fear being forced to pay for that infinitely combustible mixture of human need and compassionate response.

The Fear That Bureaucracy Will Extinguish Care

In my study of home health care, it became obvious that money—the fact of getting paid for caregiving—wasn’t the great transformer of caregiving. Rather, *the political and managerial control of money* is what restrained and changed the way nurses, therapists, and aides cared for their patients. In the private sector, once patients (or children or clients or anybody else) become the raw material out of which profits are made, the entrepreneur is dedicated to keeping costs down. In an economic sense, the cost of care is almost all in the labor, so keeping costs down means suppressing care. When care is a market good, its essence—the human component, the relationship—has to be minimized because it is an input, and efficiency requires getting the most output for the least input.

There’s a similar dynamic in the public sector. Once citizens become the users of publicly financed services as patients, children, clients, or any other type of beneficiary, they also become budget expenditures. Government, as a payer itself and as the representative of taxpayers’ interests, quickly gets dedicated to keeping down expenditures, and hence care. That is the paradox of public services (or one of them): while the political mandate and intent is to *provide* services, there is a simultaneous political imperative to *minimize* them.

Whether care is a market commodity or a public good, the impact is the same. Private producers need to minimize care because every provision eats a little bit more profit, and with it, investors’ goodwill. Public providers need to minimize care because every provision eats a little more budget, and with it, taxpayer-voter support. Thus, when we commodify care, money enters care relationships not through the caregiver’s purse. Money walks into the relationship because third parties—payers—force their way in. They enter the care relationship by trying to count it, mon-

itor it, define it, and limit it. These managerial processes are the same whether conducted by private entrepreneurs or public payers.

How, then, does commodification change the nature of care? First, once care becomes a commodity, there is pressure to reduce it to its most mundane, physical, countable elements. If care is to be managed (and I don’t mean HMOs here), managers need to transform it into something they can measure. They must extract observable, countable tasks out of inherently invisible and fluid relationships. In health care, that tends to mean reducing care to the physical, “hands-on” tasks—giving medicines, taking vital signs, changing bandages, assisting people with eating, bathing, moving, and dressing. Care plans for home health aides typically include a menu of about fifty things an aide might be asked by the supervising nurse to do for a client. Not one of them is “talking” or “listening.”³⁸ As Timothy Diamond wrote about the time he was reprimanded for taking time to console a crying patient, her blood pressure was probably high that day because she was upset. But, he noted acerbically, “[T]here was a place [in the chart] to record her high numbers, but not her crying.”³⁹

Home care aides, when asked what is the most important thing they do, usually say something like “I make her smile,” or “I give him something to live for,” or “making them happy,” or “making them feel good.” Both aides and clients would say that the chitchat surrounding the physical tasks is what gives care its value. In the talking and listening, clients get to express who they are and to preserve their identities as something other than sick, declining persons. Aides get to give clients their lives back and to make a difference—which is far more important to them than, say, giving a bath or a meal.⁴⁰ None of these things is what home care planners and payers measure (or pay for). What caregivers aim to do and what people who receive care value are not the same things that managers count as outputs.

Second, once care is a commodity, caregivers have to be accountable. Accountability means showing results. Results, in our culture, mean progress, increases, growth. Caregivers come under enormous pressure to demonstrate progress and good results. Under Medicare’s rules for home health services, clients are no longer eligible if they cease making progress or are incapable of making further progress. In the realm of caring for very sick, disabled, or frail elderly people, progress is hard to come by, so care providers have to devise clever strategies to appear *as if* they are producing progress. (Being happy or feeling better doesn’t count as progress.)

One strategy is to accept as clients only those people who are very likely to make progress in the first place, which means, of course, to withhold care from those who most need it. Another strategy is to define objectives down or divide them into baby steps that look like progress. For example, a sample care plan developed by a management consulting firm for home health agencies offers some achievable “outcomes” for patients whose “prognosis is death”: “Long-term criteria: anxiety reduced, as evidenced by avoidance of anxiety-producing situations; client verbalizes fears and concerns.”⁴¹ Yet another strategy is to document predictions of progress in lieu of the real thing. For example, when home health nurses visit patients with skin wounds, they are required to write down a date by which they believe the wounds will have healed.⁴² Thus do pressures for accountability in bureaucratized care lead to a well-known phenomenon in human services. Instead of measuring real results, evaluators specify process standards. Service providers then hustle to document that they have leapt through all the procedural hoops.

Even in child care, where individual progress is the normal course of things, there are pressures to translate care into educational progress.⁴³ In their political quest to make child care a public commodity, child care advocates recast child care in terms of progress. They specify developmental goals, describe day care in terms of learning activities, and document children’s progress toward goals (which sometimes means simply writing down that children have “participated in a learning activity”). As Lucie White notes, “Child care is now referred to in policy circles as EEC—early education and care; the effort to make child care a politically palatable public issue takes the form of transforming care into education.”⁴⁴ Mere care isn’t good enough.

Third, if society is going to underwrite care, to guarantee it as a legal right and accept it as a collective financial responsibility, the vague, undefined, and ambiguous relation of care has to be made well-defined, concrete, and limited. It has to be rendered into a contractual relationship because contracts are the essence of legal relationships. Yet, few people, when raising a child or caring for their ailing spouse or parent would conceive of their relationship as a well-defined set of tasks, planned in advance: “Okay, I’m going to do this, this and this for you, no more, no less.” Instead, people care by responding to another person’s requests, to their own assessment of the person’s needs at the moment, and to their vision of what it *means to be* a parent, a child, a spouse, or a friend. Contracts tend to prohibit that kind of flexibility and responsiveness, or at

least discourage it. To be sure, most contracts for professional services leave a great deal of room for the professional to use her or his judgment, and legal scholars have elaborated a notion of “relational contracts” that are designed to permit flexibility. However, entrepreneurs and governments seek to minimize flexibility, for they are acutely conscious of the downside risk—that the consultant will advise greater expenditures.

Once care is commodified, it has to become contractual, in spirit if not in law. Contracts are the legal expression of limited relationships, the exact opposite of familial and love relationships. Once caregivers have contracts with payers, the substance of care must be rendered into a contractual language. Caregivers’ relationships to the people they care for then have to be squeezed to fit into the caregivers’ relationship to the payer. For example, several physical therapists told me they try to help patients accomplish their own personal mobility goals. However, Medicare’s rules permit them to work with a client who has lost walking ability only until the client can safely exit the house in an emergency and walk twenty-five yards. One therapist said this rule prevented her from helping a woman walk to the corner bus stop, which would have enabled her to visit her husband in a nursing home; another said the rule prevented her from helping a man learn to walk downstairs to his basement workshop. Thus, the care relationship has to mirror the contractual relationship. Much of the fluidity, responsiveness, and flexibility are lost, not to mention dialogue and mutual influence in deciding what care shall be given. Perhaps, too, the bureaucratic impulse to define relationships contractually is why policy makers want to separate parents from their own children before paying them for child care. Policy makers are human enough to know that parents are unlikely to observe the bounds of a contract in their relationship to their children.

Last, and perhaps the most important consequence of bureaucratization of care, is the transfer of power from inside to outside of care relationships. Payers, as third-party overseers of care, remove the power to decide what to do from the caregiver. *The payer’s power over the caregiver, far more than money’s influence on the caregiver’s motives, changes the way a caregiver cares.* This is one way to interpret the struggles over health insurance and managed care. Payers, whether private or public insurers, fear the budgetary impact of unrestrained compassion. Payers know all too well how caregivers, at the bedside, often wish to do everything possible for their patients. They can’t stop, they can’t let go, they can’t say “enough is enough.” Payers try to contain compassion by

setting caps on reimbursement. The prospective pay systems introduced first into the hospital sector, then into outpatient care, nursing homes, and home health care, are all designed to stem the outpouring of uncontrollable compassion that caring for sick and dying people unleashes.⁴⁵ This new third-party relationship is the source of the classic caregiver lament: "I wish I could do that for you, but I can't. Insurance, Medicare, The Department (take your pick) won't let me." Read: how I care for you is not my decision to make. When care is paid for by third parties instead of by care recipients themselves, the *recipients* also cede power to the payers. They lose the power to define and shape the care they receive. In all the goal-setting and rule-making by payers, recipients' goals count for little.

Thus, bureaucratization, it seems to me, is the most serious concern about commodifying care. The transfer of power from the caregiver-recipient dyad to some third party, be it a business, a government agency, or a legislature, is the real threat to care and care relationships. Corruption of motives by the influence of money, exploitation of women and low-wage workers, and loss of productivity are certainly genuine concerns, worth worrying about, but they are not the crux of the issue.

Experience with bureaucratic care makes us wary, and for good reason.⁴⁶ As people who are vulnerable, we fear that when we need care, we won't get all that we need. As caregivers, we have learned the pain of having to curb our compassion and the helplessness of losing our autonomy. Suddenly, we are thrust into the same condition as the dependent people who need our help.

In the novel *Talk Before Sleep*, Elizabeth Berg writes about four women taking care of a friend dying of breast cancer. These women, the friends as well as the sick one, are fighting a battle. Not a military battle or a political battle but a battle against death, despair, and the loss of meaning. This is the big one, and it seems impossible to win. But salvation, Berg writes in her preface, is "to be found in caretaking, whatever form that caring takes."

This, finally, is why care is political, even if it never becomes a political issue. Care is a way of fighting. It is how we fight when we are so powerless that defeat is certain, when fighting is the only thing that will preserve hope, and preserving hope is the only possible victory. It is the way we do whatever we can to make life better for the people we love, for the world, and for ourselves. Caring is what we do when our self-interest and our concern for others merge. Caring is the essential political act.

And here is perhaps the source of our deepest fear about making care into an economic and political commodity. Caring labor is sacred labor. When we treat it like productive labor, we might destroy its transcendent power and its power to give us hope.

NOTES

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1. Caregiving could just as well be applied to the way we tend pets, animals, gardens, crops, forests, and the natural environment, but I'll stick to the human-to-human domain. That's enough for one paper.

2. As E. E. Schattschneider so brilliantly observed, every conflict creates alliances at the same time as it creates divisions. E. E. Schattschneider, *The Semi-Sovereign People* (1970).

3. Robert Putnam, *Bowling Alone: The Collapse and Revival of American Community* 19 (2000).

4. Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* 107-8 (1992).

5. Nancy Foner, *The Caregiving Dilemma: Work in an American Nursing Home* 49 (1994).

6. Margaret Nelson, *Mothering Others' Children, in Circles of Care: Work and Identity in Women's Lives* 210, 215 (Emily K. Abel and Margaret K. Nelson, eds., 1990).

7. Robert Wuthnow, *Acts of Compassion: Caring for Others and Helping Ourselves* 56 (1991).

8. Elizabeth Anderson, *Value in Ethics and Economics* 145 (1993).

9. There is much debate about this, and a large literature that says even care of others is ultimately beneficial to the self, and probably motivated by self-interest, or at least determined by genetic self-interest at a nonconscious level. See Deborah Stone, *Help: The Good Samaritan Ethic in American Public Life* (forthcoming 2005).

10. Sue Schallenbarger, *Wanted: Caregiver for Elder Woman; Only Family Members Need Apply*, *Wall Street Journal*, June 20, 2002, p. B1.

11. See Deborah Stone, *Caring by the Book, in Care Work: Gender, Labor and the Welfare State* 89-111 and 315-17 (Madonna Harrington Meyer, ed., 2000).

12. Social scientists call this phenomenon "fictive kin," a term that comes from Carol Stack's study of helping networks in a black ghetto, *All Our Kin*

(1974). Tracy Karner applied it to the relations of home health care workers and their clients in *Professional Caring: Homecare Workers as Fictive Kin*, 12 *J. Aging Studies* 69 (1998). In my research with home care nurses and aides, “love” was a frequent part of their vocabulary. Stone, *Caring by the Book*, *supra* note 11.

13. Mary Tuominen, *The Conflicts of Caring*, in *Care Work*, *supra* note 11, at 112–35, 119, 317–20.

14. Quotations are from Nelson, *Mothering Others’ Children*, in *Circles of Care*, *supra* note 6, at 210–32, quotations on 215.

15. Cameron Macdonald, *Shadow Mothers: Nannies, Au Pairs, and Invisible Work*, in *Working in the Service Society* 244–63, quote on 255 (Cameron Lynne Macdonald and Carmen Sirianni, eds., 1996).

16. Quotations are from Roberr Frank, *High-Paying Nanny Positions Puncture Fabric of Family Life in Developing Nations*, *Wall St. J.* Dec. 18, 2001, A1, and cited in Arlie Hochschild, *Love and Gold*, in *The Commercialization of Intimate Life: Notes from Home and Work* 185–97 quote on 185 (2003). As Hochschild notes, a terrible sadness accompanies this devotion of immigrant nannies to American children, for if they have left children of their own in their home country, their love for their American charges is in large part displaced love, thwarted love.

17. Emily K. Abel and Margaret K. Nelson, *Intimate Care for Hire*, *American Prospect*, May 21, 2001, pp. 26–29.

18. Judith Rollins, *Between Women: Domesticity and Their Employers* 120 (1985).

19. Mary Tuominen, *Exploitation or Opportunity? The Contradictions of Child Care Policy in the United States*, 18 *Women and Politics*, 53 (1997); Mary Tuominen, *The Hidden Organization of Labor: Gender, Race/Ethnicity and Child Care Work in Formal and Informal Settings*, 37 *Soc. Perspectives*, 229 (1994); and Margaret Nelson, *Negotiated Care: The Experience of Family Day Care Providers* (1990).

20. Macdonald, *Shadow Mothers*, *supra* note 15, at 253–4.

21. Mary Romero, *Maid in the U.S.A.* 107 (1992).

22. Nelson, *Mothering Others’ Children*, *supra* note 14 at 219–21, quotations on p. 220.

23. *Id.* at 221.

24. Robin West, *Caring for Justice*, 109–27 (1997); *Id.* at 120 (“What I wish to propose is that the giving self constituted through duressed private altruism becomes in a literal sense *incapable* of the self-regarding acts that are constitutive of the liberal self—and that *is* the harm that these acts occasion.”).

25. Carol Gilligan, *In a Different Voice* (1982).

26. Marcy Whitebook, Executive Director, Center for the Child Care Work-

force, Washington, D.C., personal interview, October 25, 1999; and Center for the Child Care Workforce, *National Childcare Staffing Study* (1989).

27. The video *Invisible No More: Home Care* produced by the Service Employees International Union (S.E.I.U.) (2000) documents this political consciousness of unionized home care workers. See also Deborah Stone, *Why We Need a Care Movement*, *Nation* 13–15 (March 13, 2000). On the Domestic Workers Association in Los Angeles, a part of the Coalition for Humane Immigrant Rights of Los Angeles, see Pierrette Hondagnu-Sotelo, *Sin Organizacion No Hay Solucion: Latina Domestic Workers and Non-traditional Labor Organizing*, 8 *Labor Stud. J.* 54–81 (1997).

28. Stu Schneider, *Victories for Home Care Workers*, *Dollars and Sense* 25 (Sept./Oct. 2003).

29. See, for a tiny sample of this genre, Arlene Kaplan Daniels, *Invisible Work*, 34 *Social Problems*, 403 (1987) (for women’s work generally); Paula England, *Comparable Worth: Theories and Evidence* (1992); Patricia Benner, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (1984) (for nursing); Marjorie DeVault, *Feeding the Family: The Social Organization of Caring as Gendered Work* (1991) (for grocery shopping, menu planning, and food preparation and meal orchestration); Ronnie Steinberg, *Emotional Labor in Job Evaluation: Redesigning Compensation Practices*, 561 *Annals of the Am. Acad. Pol. & Soc. Sci.* 143 (1999) (for client-oriented municipal work and nursing).

30. Suzanne Gordon, *Feminism and Caregiving*, *American Prospect*, Summer 1992, pp. 119–27, quotation on p. 120.

31. See Deborah Stone, *The Disabled State* (1984).

32. Gordon, *Feminism and Caregiving*, *supra* note 30, at 121.

33. Nina Bernstein, *As Deadline Looms, Answers Don’t Seem So Easy*, *N.Y. Times*, June 25, 2001, p. A1.

34. Romero, *Maid in the U.S.A.*, *supra* note 21, at 106.

35. Timothy Diamond, *Nursing Homes as Trouble*, in *Circles of Care*, *supra* note 6, at 176 (from Timothy Diamond, *Making Gray Gold* (1992)).

36. Margaret Nelson, *Family Day Care as Mothering*, in *Qualitative Research in Early Childhood Settings* 23–24, quotes on pp. 28–29 (J. Amos Hatch ed., 1995).

37. See Stone, *Caring by the Book*, *supra* note 11, at 99.

38. Deborah Stone, *Reframing Home Health Care Policy* 8 (2000).

39. Diamond, *Nursing Homes as Trouble*, *supra* note 35, at 177.

40. See Stone, *Caring by the Book*, *supra* note 11.

41. This language is taken from a care plan package designed by a home care consulting firm and offered for sale to home health agencies for their use in managing their care provision.

42. In interviews, nurses told me that Medicare requires this prognostication

as some kind of assurance that patients were indeed progressing. Nurses felt such predictions were pure guesswork.

43. I thank Professor Lucie White for this insight. Personal communication, August 21, 1998.

44. *Id.*

45. See Deborah Stone, *Rationing Compassion*, *American Prospect*, May 2000, 16–18.

46. As Francesca Cancian argues, “[M]arket relations and bureaucracy need not undermine emotional caregiving.” Francesca M. Cancian, *Paid Emotional Care*, in *Care Work*, *supra* note 11, at 136–48, quotation on p. 136. She and others find stories of hope in institutional settings where caregivers have devised ways to provide nurturing care in spite of market and bureaucratic pressures. But the larger point remains: we have good reason to fear.