

# Women and the Crisis of Care in the United States

By Larry J. Polivka

Women, who still provide much of the caregiving needed in the United States, will be adversely affected by any cutbacks to support systems.

Women are much more involved in long-term care (LTC) than men, as caregivers and care recipients. This is true in the formal system of paid care and in an “informal” system that relies upon unpaid caregiving by relatives and friends, most of whom are women. Until approximately thirty years ago, it was mainly wives, daughters, and daughters-in-law who provided LTC through the informal system.

Since the early 1990s, however, the Medicaid program increasingly has been used to support community-based LTC programs (Polivka and Luo, 2017). This shift has played a significant role in reducing dependence on the informal system and made formal care more available for families that do not have the ability to pay out-of-pocket for care (Janus and Doty, 2017). Public LTC funding, more than 80 percent of which comes from Medicaid, in 2016 reached \$150 billion and is projected to almost double by 2050 due to the dramatic rise of the ages 80 and older population (Ortman, Velkoff, and Hogan, 2014).

Expanding formal paid care within the LTC system has greatly augmented the caregiving labor force. From 2000 to 2014, the number of direct care workers in LTC has doubled, reaching almost 2.6 million (PHI, 2017a, 2017b). These workers, overwhelmingly women, are mostly low-wage employees having meager benefits.

Now there are signs that the movement toward publicly funded formal services is slowing and may be ending. As a result, the formal care system now meets about one-third of the need for care in the United States (National Alliance for Caregiving and AARP Public Policy Institute, 2015).

## The Growing Need for Care Versus Insufficient Funding

Florida, the oldest state in the nation, has a rapidly growing population of people who are ages 65 to 85 and older. Thus Florida represents a good example of what happens when states support this trend of slower growth in formal care services. In 2013, Florida moved from a nonprofit, aging

**→ABSTRACT** The need for long-term care (LTC) services has been growing, and is escalating with the aging of the baby boomers. Women are the main providers and recipients of care in the formal (paid) and informal (family) LTC system, meaning they bear the brunt of the gap between the need for care and available resources. Without strong public resistance, this gap is likely to be filled by relying upon family care, mainly provided by women. This re-familization of care could turn our crisis of care into a catastrophe for low- and middle-income families. | **key words:** *crisis, care, women caregivers*

network-based, Medicaid-funded home- and community-based services system of LTC services to a for-profit, HMO-administered managed LTC (MLTC) system. Since then, the number of people eligible for Medicaid LTC (but on the wait list for services) has increased substantially each year; from 2015 to 2016, the number grew from 40,000 to 47,000 (Department of Elder Affairs, State of Florida, 2017). The main reason given by legislators for the 2013 move to the for-profit administration of Medicaid LTC services was to create a system better designed to stabilize and reduce costs of care, which, due to the projected doubling of Florida's older population, threaten to expand enormously by 2040.

Florida has historically been a comparatively low Medicaid-expenditure state, but tax cuts since 2000 have reduced the state's capacity to meet its residents' social, health, education, and other needs generated by relentless population growth. As a result, the state has attempted to cut or reduce costs for virtually all of its programs, including Medicaid LTC services. Achieving these legislative and gubernatorial priorities (tax cuts and minimal annual budget increases) has led to the widening gap between people's need for LTC services and service availability, creating long wait lists for the Medicaid-funded LTC program.

Florida has, in effect, contracted with for-profit HMOs to have them play the major administrative role in containing LTC costs, while protecting the state from pressure to augment LTC funding in the face of accelerating levels of unmet need. Whether this strategy will succeed is unclear; it has encountered resistance in other states, including in Iowa and Kansas, which have attempted to contain LTC costs through MLTC programs (Dickson, 2016).

One of the methods HMOs may feel compelled to use in managing the tension between the growing need for care and insufficient funding is to offload caregiving onto the informal care system—spouses, children, and other family members—again, mostly women (Koh and

Miller, 2015). This method is limited, however, by the declining availability of informal caregivers as couples have fewer children, more people remain or become single, and more families are dependent upon wives remaining in the labor market to make ends meet.

The escalating tension between the need for care, declining public funding, and greater efforts to offload care onto the informal care sector will become much more intense if the Trump Administration and Republican legislators achieve their tax cuts and program reduc-

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tion priorities. Proposed Medicaid cuts alone are more than \$1 trillion across a ten-year period (Van De Water, 2017). This unprecedented reduction in the Medicaid program, if the proposed budget passes, would occur at the same time that older impaired populations and the need for LTC services will be higher, requiring huge bumps in the Medicaid budget just to retain current levels of unmet needs for LTC. This would be a major shift from the formal care system—mainly the already inadequately funded Medicaid LTC program—to the informal care system reliant on unpaid care provided mostly by women.

**The Re-Familization of Care**

The greatest threat from these trends may be the rising number of older persons with LTC needs who are neglected or abandoned as public support for services fails to keep up with demand and the availability of informal resources declines. President George W. Bush's Bioethics Task Force in 2005 expressed this concern in its report on long-term care in which they identified the intensifying "... danger that some old people will be abandoned or impoverished, with no one to care for them, no advocate to

stand with them, and inadequate resources to provide for themselves” (President’s Council on Bioethics, 2005).

Interestingly, the issue of re-familization (Saucier, Burwell, and Gerst, 2005) has received greater attention in Europe than in the United States, which already relies more upon its informal care system than European countries with wealth levels close to ours, such as Germany, France, and Scandinavia. These countries’ attention to re-familization may be because they already have more developed and extensively available public LTC systems than the United States, have higher percentages of older adults, and face fiscal challenges that by some measures (percentage of GDP devoted to public welfare programs and stagnant economic growth) surpass those in America (Gori, Fernandez, and Wittenberg, 2016).

LTC familization has not gained traction among policy makers in most European countries and where it has, the changes (reductions in access) have been minor (Greve, 2017). In fact, the most economically advanced countries have continued to make enhancements in their LTC programs, including expanding access as the population needing care has burgeoned (Ranci and Pavolini, 2013).

Advocacy around aging and other health- and welfare-related issues remains stronger in Europe because of stronger popular institutions, like labor unions and political parties, and longer, more embedded traditions about the public sector’s role in meeting vulnerable populations’ needs. These advocacy assets have been used to effectively resist the re-familization of care, even though several European countries already spend two to three times as much as the United States on LTC relative to GDP (Organisation for Economic Cooperation and Development, 2013). Europeans may talk about the need to pursue austerity budgets, constrain LTC spending, and ask more of family caregivers, but so far, with the exception of southern European nations, Europe has done little policy making and budgeting to make re-familization a major part of its LTC programs.

## The Larger Forces Affecting Long-Term Care

In Europe, public policy neoliberalism has emerged via policies designed to enhance consumer choice and provider competition, a small but expanding for-profit presence, and austerity-oriented budgets prioritizing social, health, and pension programs, including LTC (Ranci and Pavolini, 2013). Marketization, corporatization, and constraints on LTC funding are far more advanced in America.

Much higher LTC funding levels have allowed several countries, especially the Scandinavian nations, Germany, and France, to develop largely universal LTC entitlement programs that provide the level of community LTC services that is available to some residents in the small number of U.S. states having comprehensive and cost-effective public LTC systems (Reinhard et al., 2017). But even in these states, access to Medicaid-funded programs is limited by means-testing that allows only low-income citizens with little wealth to receive LTC services.

As re-familization of care in the United States increases and informal care becomes less available, neglect and abandonment are emerging, but go largely unnoticed in the media and in policy debates. The failure to identify this looming threat to care availability and to women who are likely to find their life options limited by the growing expectation that they provide such care cost-free, reflects the erosion in the past several years of aging and gender justice advocacy in the United States.

Shortfalls in funding for public LTC in the United States are compounded by the increasing tendency of states, with strong encouragement from the federal government, to shift administration of the Medicaid program from state agencies and private nonprofit organizations that make up the aging network, such as the area agencies on aging, to proprietary managed care organizations run by major insurance companies (Polivka and Luo, 2017). This shift could result in already insufficient funds being further reduced by high administrative costs driven by the need to generate profit.

These fiscal, organizational, and demographic scenarios make it difficult to imagine how greater reliance on the informal LTC system and the domestic sector can be avoided without a shift in ideological perspectives and policy priorities. As these scenarios unfold and interact, LTC increasingly will be commodified through management by proprietary firms and off-loaded onto the informal care system. Furthermore, funding for LTC services is more and more often failing to keep up with accelerating growth in the number of people who need care, which will also put greater pressure on families, primarily women, to provide more care. The widening gap between the need for care and the available resources to meet that need is especially punishing for women, who sacrifice income and benefits when they take time off from work to provide care, and also, as care recipients, receive less formal care than they need.

Nancy Fraser, feminist and professor of Political and Social Science at the New School in New York, has analyzed the historical context for this emerging care crisis. She focuses on how “social reproduction,” which encompasses private care functions in the family and formal care functions in the broader community, has been shaped by and subordinated to economic production. This process has been part of the evolving forms of capitalism, from the free market liberal capitalism of the nineteenth and early twentieth centuries, through the managed welfare state that existed from the New Deal period to about 1980, up to the neoliberal, highly financialized capitalism dominant since then (Fraser, 2013). The current crisis of care is primarily a product of the neoliberal era of American capitalism.

Neoliberal capitalism has been marked by the rising dominance of the finance sector at the expense of the productive economy (manufacturing, retail, etc.) as profits shift from investment to shareholders and executives, economic growth slows, wages stagnate, inequality increases, labor union power declines, taxes on wealth and high income are slashed, and funding for public pro-

grams is cut (Harvey, 2007). These cuts include those made to programs providing LTC services, primarily Medicaid, in the face of high need. These cutbacks are one of the major reasons for the expanding crisis of care for older impaired people, two-thirds of whom are women.

### **A Return to the Past?**

Changes in the fundamental structure of capitalism and their impact on the institutions responsible for social reproduction may return the United States to conditions that prevailed under liberal capitalism from the late nineteenth century until the Great Depression. The New Deal that followed led to a much greater role for government in managing the economy along Keynesian lines, based on policies designed to boost demand and limit corporate power, especially finance. These policies generated the highest sustained economic growth, employment, and wage rates in U.S. history, dramatically reduced

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inequality, and shifted the economy away from speculative finance to investments in the productive economy.

This was the golden age of American capitalism (the 1960s and 1970s), when more people prospered, including minorities (Polivka, 2012). Profits, wages, and worker benefits grew together to a greater extent than ever before in U.S. history. This era is often referred to as the Fordist economic regime, named after Henry Ford, who gave his workers regular raises so that they could afford to buy his cars each year. Many male workers in the Fordist era, especially those in manufacturing, received enough in wages and benefits to allow only one earner to support a family with two or more children. A wage high enough to permit families to live well with one earner was

referred to as the family wage, which permitted a spouse, almost always the wife, to stay at home and perform the family's domestic tasks, including caregiving for children and older relatives.

The family wage arrangement was only an aspirational ideal for many families, but most wives from the end of WWII till the late 1960s and 1970s remained at home doing unpaid domestic work, sustained by their husbands' wages and benefits (Cooper, 2017). This system was hardly ideal, as it consigned middle-class women to the role of the economic dependent (Friedan, 1963), and did not apply to families, many of them minority, to whom employers did not pay men a family wage.

The New Deal Fordist era of equitable prosperity began to decline in the early 1970s and was largely over by the mid-1980s, when wages began to stagnate and decline and wives felt ever more pressure to supplement family incomes by going to work, which they did in ever-larger numbers. Their move into the labor market coincided with the emergence of second-wave feminism in the late 1960s, which pressed for greater gender equity in the labor market and greater opportunities for women in every institution of American life (Fraser, 2013).

The cultural and political achievements of second-wave feminism were substantial and enduring. But at the same time, the economic pressure on families grew steadily as wages stagnated. Multiplying downward pressures on the single earner (family) wage made it more necessary for wives to enter the formal paid labor market.

As wives entered the paid labor market, much of the unpaid domestic labor, including caregiving, had to be paid for to whatever extent families could afford; care was provided without pay by wives or other family members when they could (or, more rarely, by friends), or neglected. By the early 2000s, the combination of stagnant and declining wages, outlays for childcare and eldercare, and the costs of holding a job had pushed up family living expenses to the point where two-earner families had less discretion-

ary income than single-earner families had in 1976 (Warren and Tyagi, 2003).

In many European countries, these types of economic pressures on families are ameliorated through family assistance cash benefits and publicly supported childcare and eldercare programs. Few such provisions are available in the United States, as the emergence of a pro-corporate neoliberal policy agenda since 1980 has precluded any serious consideration of pro-family policies designed to support two-earner families, who have been required to rely upon whatever private resources they can cobble together (Estes, 2014).

The limited availability of financial and caregiving supports compared to other developed nations is now on the cusp of being reduced further by tax (revenue) cuts and associated cut-

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### ***Will the American public accept a steady increase in the number of frail elders and other impaired persons whose care needs are not met?***

backs in support programs, including Medicaid. The Trump Administration and the Republican Congress are calling for as much as a \$1 trillion reduction in Medicaid over the next ten years, a cut that, if passed, could reduce support for LTC services by about the same amount that Medicaid needs to be increased in response to ever-higher need (Van De Water, 2017).

The Republicans' fiercely conservative, anti-public sector policy agenda is fully evident as the trends of stagnant and declining wages, rising costs for essential family needs, and diminishing public supports interact and undermine U.S. families. If these scenarios continue over the next decades, American families in working- and middle-class communities will begin, as many have already, to experience economic, social, and psychological stresses characteristic of family life in the pre-New Deal period of liberal capitalism, when virtually no public safety net was available.

This could mean women will be expected to seek paid work to avoid even greater economic hardship, and provide for or arrange for childcare and eldercare as caregiving need escalates and public services and supports decrease (Holstein, 2015). It is almost unimaginable that this situation would be unfolding now, almost fifty years after the emergence of second-wave feminism and the peak of high-growth, welfare-state capitalism, but the trends described earlier indicate that this is so.

## Conclusion

The crisis of care in the United States is exigent for women, especially those who are poor or in the working and middle classes. Men must be a major part of any solution to this crisis by being willing to take on a more equal share of the caregiving burden and more actively supporting efforts to gain much greater private and public support for caregiving work involving children, younger impaired persons, and older adults (Gri-goryeva, 2017). Men are gradually playing a larger role in caregiving, but there must be a major cultural shift toward the expectation that every competent adult can be a primary caregiver.

Greater gender equality in the caregiving realm, however, will not resolve emerging contradictions between growing needs for caregiving over the next three decades, shrinking public funding for care services, and declining availability of informal care resources. Neither women

nor men can afford to take significantly greater time off from work to provide care for older relatives, even with improved employer eldercare benefits—benefits which can help employees provide more care, but are insufficient to cover the demand for care that will arise in the near future.

The fundamental question generated by these trends is whether the American public will accept a steady increase in the number of frail elders and other impaired persons whose care needs are not met, even as more informal care is provided; or will the public insist upon more public funding for LTC services to contain the emerging crisis of care and avoid the neglect and abandonment of growing numbers of impaired persons.

A campaign to address the crisis of care through a range of professional and activist organizations, including political parties, will be necessary to reverse the deterioration in the U.S. LTC system and to overcome the neoliberal threat to use the privatization and refamilization of LTC—a threat that would return women to levels of unpaid domestic labor not seen for decades. Such a campaign must be launched now before more ground is lost to neoliberal retrenchment in public support for caregiving and to keep the crisis of care from becoming a catastrophe. 

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