‘I don’t think they were clapping for me’. Home care workers during the covid-19 pandemic.

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Abstract

This chapter explores the ways in which the pandemic and Brexit have exposed and intensified long term crises within social care provision in England. I focus on home care workers who provide care to older, disabled and chronically ill people in their own homes. First, I examine how gender, class and race hierarchies have been historically embedded within home care work, reproducing it as a low status, low wage occupation within post World War Two welfare capitalism in the UK. I then focus on a case study of home care workers in southern England during 2020-2021, examining the impact of the pandemic emergency on their working conditions and experiences.

> Luke: When you turn up to a client, you can’t walk in sweaty, stressed out, and anxious about the coronavirus. I mean it was a very anxious time, you know? There wasn’t the vaccination at the beginning, nobody knew where it was going to go. Would I catch it? Would I pass it on? … What if I had this and I walked into an elderly client’s house and, yes I'm wearing a mask, … but if they caught covid how would I live with myself thinking I’d passed it onto someone who could then die of it…? [But]… you can’t have that on your face … you have to walk in, you’re smiley, you’re bubbly, ‘Morning how you are you?’ and …that in itself is an added strain.

Luke was a home care (domiciliary care) worker whom I interviewed in 2021, one of relatively few men in a highly female segregated workforce. He had been new to the

job when the pandemic hit in spring 2020 and had agreed to work additional shifts to cover for shielding colleagues. With little previous experience, he found himself confronting the daily occupational risk that he might be exposed to covid-19 infection or unwittingly infect a client, likely to be someone in later life, with higher clinical vulnerability to serious illness or death from infection with the coronavirus. Luke found this highly stressful, but like other home care workers, he tried to maintain a calm, professional demeanour during visits to clients. He sought to stay abreast of the regularly changing guidance of how to wear, use, and dispose of personal protective equipment (PPE) to mitigate infection risk. For doing this pressured and demanding work during a public health emergency, Luke and his home care worker colleagues earned a little over minimum wage, working insecure employment contracts with no guaranteed hours, and minimal protections or benefits.

Graham Scambler has likened the coronavirus pandemic of 2020-21 to a 'breaching experiment'; a "disruption… to social order [providing] rare insights into the day-to-day practices, or artful accomplishment, of ordered living" (2020, p.141). The pandemic both exposed and further strained existing fractures and fissures in neoliberal capitalist society in the UK, among them the widening wealth divides and growing precarity of working- and middle-class populations. In this chapter, Scambler's broad thesis guides my analysis of English home care workers during the pandemic. Covid-19 made health and care workers visible to the wider public in new ways. New public health measures restricting movement and the lockdown of much of the economy which promoted public awareness of 'essential workers': people doing jobs that could not be locked down as they were essential to the daily maintenance of life. More specifically, the alarm and vulnerability many people felt about the frightening new virus stimulated a powerful collective gratitude towards front line health and care workers, expressed in the weekly 'Clap for Carers' through 2020. The pandemic has been said to have raised awareness of the salience and indispensability of care (Wood and Skeggs 2020). Yet, as I argue in this chapter, if it promoted greater recognition of the importance of caring work in general, the pandemic also intensified the precarious, flexibilised, and low waged working conditions which home care workers have long endured in the UK. I

explore how the historic undervaluing of home care work shaped the experiences of home care workers during the pandemic.

This chapter draws on findings from a qualitative study of care giving at home, in a coastal region of southern England, during the pandemic of 2020-2021. Media coverage focused heavily on the pandemic's frequently devastating impact on hospitals and care homes but gave much less considered attention to households as a sites of intensified care provision in the context of pandemic emergency, recurring lockdowns, and social distancing regulations. My study investigated the experiences of three groups all involved in caring for other adults at home – home care workers, carers, and volunteers for community pandemic support initiatives. The care provided by all three groups is crucial to the functioning of the social care system – that loose and varied set of waged and unwaged provisions which support people with chronic illness, physical disability, mental ill health, or frailty with their day-to-day living. This chapter focuses on home care workers.

Lockdown conditions through 2020-2021 limited the possibilities for exploring home care work using the face-to-face ethnographic methods that I would usually use in my research as a social anthropologist. Instead, I developed an exploratory, qualitative methodology, entailing in-depth semi-structured online or telephone interviews alongside secondary research of reports and briefings from central government, local government, home care agencies, and non-governmental organisations. I conducted most of the interviews between the autumn of 2020 and early summer 2021, at a point when my home care worker research participants already had some distance from the earliest and most acute phase of the pandemic (Spring / Summer 2020), and could reflect upon it, but also when covid-19 infections were rising and further lockdowns loomed or had already been imposed. I initially approached the owners and managers of a number of home care providers across the study region, eventually securing the cooperation of three businesses to take part in the study. Two of these employed home care workers directly, whose jobs entailed visiting clients to provide care in their homes. The third operated as an agency matching self-employed 'live-in' home care workers with clients and assisting with the negotiation of their contract, for a fee. The registered managers of the home care employers[i], and the owner of the

home care agencythen shared an advert written by me with all other care workers in their organisation, explaining the aims of my research and inviting them to contact me directly to take part in the study. In total, I I interviewed two self-employed care workers, 1 home care agency owner, five employed care workers and two registered managers. Interviews lasted for one to two hours, taking place on the phone or by telephone, at a time chosen by the care workers. I had hoped to speak to more care workers in this study (up to 15 including managers/owners) but was unable to find willing participants. I attributed this to my partly to inability engage with them face to face, as well as the stressful and fragmented nature of home care workers' working day - a point I return to shortly. In what follows, I begin with a description of some of my research participants, showing how their working conditions reflected certain broader characteristics of the home care workforce. I then analyse how and why home care work has been historically undervalued in the UK, before considering home care workers' experiences of working through the pandemic.

An undervalued workforce

Magda[ii] (see Note 2) was a single, 45-year-old, white woman, who 15 years ago had moved from Poland to England, to take up a job in social care, a sector in which she had continued to work for much of her time living in the UK. During 2020-2021, her home care employment contract was zero hours, meaning no guaranteed hours. Her working patterns and hours of work changed from week to week. She was only paid for the hours spent visiting clients and travelling to them, but not the hours in between. Client visits clustered in early morning, lunchtime, and early evening blocks. Magda thus worked 'part time', on average for 30 hours a week, yet her working day could begin in the early morning and end in the early evening. She worked most days of the week, including weekends.

Susie was a single, British, 53-year-old, white woman, working as a self-employed live-in carer. She worked two weeks of every four, during which she lived with and provided 24/7 care to her client, a frail, single man in his eighties with blood cancer. Her annual income was under £20K per year. As she had self-employed status, Susie had no

entitlement to sick pay or holiday pay, which meant that if she became ill, she did not get paid and struggled to pay her rent.

Magda and Susie's demographic backgrounds and working conditions illustrate certain key characteristics of home care work. Currently in adult social care in England, there are over half a million home care workers in the UK, comprising around 43% of the total social care workforce and providing care to people in their homes (Skills for Care 2023b). 82% of this workforce identifies as female and the average age of a home care worker is 44 (Skills for Care 2023a).

Like Magda, around half of home care workers in England are on insecure (zero hours) employment contracts that provide no legal guarantee of paid hours. Typically, these workers are only paid for hours when they are visiting clients, plus a nominal amount for travel time between clients. A working day may include paid hours for visits to a number of clients clustered in the early morning, lunch time, and late evening periods, with non-visiting hours in between unpaid (Rubery et al. 2015; Atkinson and Crozier 2020). Home care also encompasses 'live-in' arrangements whereby care workers, like Susie, live with clients for defined periods of time, and may be directly employed by them. Home care workers' pay averages around minimum wage (Skills for Care 2023a; Johnson and Rubery 2021).

Overall, the pay, status, and working conditions of home care workers is strikingly low, in comparison with nurses, teachers, social workers, occupational therapists, and other broadly equivalent caring occupations in Britain. Yet the job of looking after an older, chronically ill or disabled person within their home is not of inherently less skill or value than the core tasks of other so-called caring professions. That social care workers should be so undervalued gained more public attention the context of Brexit. During the UK-EU referendum campaign, and in the years following, social care was pushed to the media fore by parties on both sides of the debate. Those supporting Remain, or close economic ties between UK and EU post-Brexit, pointed to the reliance of social care employers on EU workers and the likely recruitment challenges that would result should these workers be prevented from taking up care jobs in a so-called 'hard Brexit' scenario (Read 2020; Read and Fenge 2019; Independent Age 2016). In response the UK government reiterated its position that employers should cease their over-reliance

on ‘cheap’ EU migrant labour (Home Office 2020). The debate expanded public awareness of the social care recruitment crisis but illuminated little about its causes. To analyse why home care labour (from the UK, the EU, and beyond) has historically been so undervalued, we need to see it as part of social reproduction.

Why is home care undervalued? Home care as social reproduction

For Marxist and left feminists, social reproduction comprises manifold processes through which human lives are maintained and re-created on a daily and intergenerational basis. Social reproduction occurs across households, communities, markets, commercial, and public organisations, and is integral to economic production (Bhattacharya 2017; Fraser 2022; Ferguson 2020; Mezzadri 2021; Vogel 1983). Nonetheless, the spatial and ideological separation of production and social reproduction is a feature of capitalist society. Life-making practices, particularly in non-commodified form, are designated as external to the economy proper, even though the practices of care and co-operation among kinship groups and communities, including but certainly not limited to the biological production and rearing of children, is essential to the day to day and generational renewal of labour power (Dalla Costa and James 1972; Vogel 1983).

Capitalist production thus crucially depends on these socially reproductive relationships, yet the capitalist class must also limit the potential of life sustaining practices to absorb time, resources, and energies in ways which threaten profits. That is, capitalists and the capitalist state must find means of subordinating social reproduction, so that workers, families, and communities absorb and bear the costs of reproducing themselves as far as possible (Ferguson 2020). Capital’s need to transfer costs of sustaining life may be met with organised working-class resistance. This inherent tension in capitalist society is continually playing out, under different historical, social, and economic conditions, with varied outcomes (Vogel 1983). In order to investigate how this general process shapes particular arenas of social reproduction, we must examine the specific practices, institutions, and ideologies that are engaged in the process of sustaining lives, in a given historical and social context.

As explained above, home care is support with daily living provided at home to people with chronic illness, disability, mental ill health, and frailty (particularly in later life). Of course, the people who need home care today are not a historically stable category of people, but one that has been hugely impacted by industrialisation, post-industrialisation, medical advances, an ageing population, and greater numbers of women in employment, amongst other things (Humphries 2022). For example, during industrialisation in England, the spatial reconfiguration of workplaces caused the exclusion of many disabled people from work (Oliver 1990; Clifford 2020), and promoted their greater material dependence on kinship, charity, and state support in order to sustain their lives. In more recent times, demographic ageing in the UK has increased the numbers of people in older age needing assistance with day-to-day living. Thus, social reproduction in this arena (as in all others) is a dynamic historical process which is impacted by and generative of economic development. To analyse the undervaluing of home care specifically, we need to identify how the costs of reproducing life amongst this (historically changing) group of people in the UK have been distributed and subordinated within a particular conjunction of welfare capitalism, patriarchy, and racism.

A short history of home care in Britain

In the social democratic period following the end of World War Two, the UK capitalist state expanded its role in coordinating social reproduction. New legislative programmes assured more direct state management over key domains of the economy - national infrastructures and industries, as well as universal health, education, and social security provisions (pensions, sick pay), amongst other areas (Means and Smith 1985). The state's direct intervention in supporting the day-to-day and intergenerational maintenance of the population, which had been increasing through the earlier part of the century, now reached a new peak. At the same time, the heterosexual family was consolidated as a key nexus of social reproduction, especially in the daily nurture and socialisation of children as well as the care and maintenance of adult family members, in or beyond employment. These activities were designated the core duties of adult women, whilst men were to engage in waged work (Finch and

Groves 1980). As social reproduction feminists have pointed out, the household labour and nurture carried out by women was not only conditioned by patriarchal social relations, but also central to the organisation of capitalist production (Dalla Costa and James 1972; Ferguson 2020; Vogel 1983).

Post-war legislation for social care provision presumed that the day-to-day care and assistance of older, disabled, and chronically ill people would be provided in the first instance by the family. Unlike other universal social protection created at the time (e.g., the National Health Service), post-war social care was established on a residual principle that the state would only absorb the costs of providing support in the absence of other kinship or other private means of providing it. Care of adults that were not in the labour market, or excluded from it, due to disability, chronic illness or frailty, was demarcated as a private matter for families to resolve (Means and Smith 1985, Means et al., 2002, Means et al., 2008, Lewis 2001). The key legislation addressing public provisions for older, disabled, and chronically ill people - the 1948 National Assistance Act – gave local government authorities the duty of providing "residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them" (Means et al., 2008). Yet no services for the daily care and maintenance of frail, disabled, and chronically ill adults within their own homes and communities were created.

The social democratic welfare state of post-war Britain thereby delegated significant duties for socially reproducing segments of the population to the private family, sparing capitalist employers, private companies, and the state the necessity of committing public resources (e.g. taxes on profits) to sustain the lives of older, disabled, and chronically ill people. This arrangement found support in and helped reproduce a conservative, patriarchal ideology of family life, in which care for older, ill and disabled people was the moral duty of women. Through the 1950s and 1960s, politicians, policy makers, and professional health and welfare practitioner groups even debated whether the 1940s welfare expansion risked undermining "the willingness of the 'family' to take on [caring] obligations" for older family members (Means and Smith 1985, p.221). This view dominated public social policy discourse until the 1980s,

in spite of popular second wave feminist campaigns, and increasing numbers of women in employment.

At the same time, however, the inadequacies, low quality and, above all, significant cost of residential care for older, disabled, and chronically ill people was increasingly scrutinised (e.g. Townsend 1962; Means et al 2008). Support amongst politicians and policy makers for alternatives to institutional care grew through the 1960s and 1970s. Care delivered in 'the community' came to be framed as the solution to the rising costs of taxpayer-funded care in institutions. Yet, as feminists pointed out at the time, this often amounted to little more than a reiteration of the conservative ideal of women's duty to undertake unpaid care of their families and communities (Finch and Groves 1980, p.498).

Large scale growth in home care provision occurred after major legislative reform to social care in the form of the 1990 NHS and Community Care Act. This aimed to cut the ballooning costs of residential social care by supporting more people to remain living in their homes with community care-based alternatives (Lewis 2001). This was achieved through neoliberal restructuring of social services departments in local government, incorporating the privatisation of existing (mostly residential) social care provision and the creation of a market of private, independent home care and community service providers which, it was claimed, would be more responsive to individual clients' needs than local government-owned and run provisions. Service users were to be empowered by having more choice in the range of options available to them. Local government social services departments became purchasers, rather than direct providers, of local social care services, commissioning from a market of private and independent social care providers (Means et al., 2002, Means et al., 2008).

This reform stimulated the growth of independent home care organisations, employing workers to provide care to individuals in their homes. This kind of provision grew rapidly as a proportion of all social care services: from providing 2% of total contract hours in 1992, to 73% in 2005 (Means et al 2008; Ware et al 2001). As private social care providers began to compete for local authority contracts on price, the pay and working conditions of employees providing direct care to clients were inevitably squeezed - an outcome which was recognised, and opposed, by trade unions and

some local government officials alike from the early phases of the Act's implementation (Means et al 2002, p111. See also Ware et al 2001).

In sum, teaching, nursing, and other professions shaped by the post-war expansion of the British welfare state in the 1940s had gained through this period significant protections and as well as dense trade union memberships. By contrast, home care was brought into existence as a waged occupation under the neoliberal restructuring of the welfare state during the 1980s and 1990s. The creation of a competitive social care market of private sector providers has mostly suppressed wages and created barriers to collective organisation for improved pay and conditions. Low density levels of trade union membership in the home care workforce have remained fragmented across many competing small to medium sized employers. In addition, local government is directly involved in entrenching low pay and poor working conditions in this sector, through its monopsony position as a purchaser of social care services, allowing councils to drive down the prices they pay for it (Rubery et al 2015; see also Johnson et al 2021).

By the mid-1990s, new community-based social care service providers were already experiencing significant problems with recruiting and retaining care workers, with over 75% of domiciliary care providers in one study reporting problems hiring suitable staff (Ware et al 2001, p.339). The challenges of recruiting and retaining home care workers have remained ever since, with vacancy rates in home care consistently higher than other those of comparative industries, and currently at just under 13% in England (Skills for Care 2023a). The Low Pay Commission has defined social care as a low wage industry every year since its first report in 1998. Recent trade union campaigns have made some gains for home care workers, through exerting pressure on employers' associations and local government bodies to commit to 'raising the bar' through outlawing the most egregious pay and working conditions (such as paying at rates below national living wage or not paying for travel time between clients). However, a recent evaluation found that these gains are modest and piecemeal in a sector in which low pay and insecure employment contracts remain the norm and trade union membership is thin (Johnston et al 2021).

Home care employers rely upon recruiting workers willing to accept poor pay and conditions; these are disproportionately women and migrant workers. There is evidence that migrant and minoritised home care workers experience racism, discrimination, and poor treatment (Turnpenny and Hussein 2022). In 2023 in England, it was estimated that 79% of home care workers are British, 8% are from EU countries and 14% are from non-EU countries (Skills for Care 2023a; see also Read and Fenge 2019). The proportion of EU nationals working in home care has remained broadly the same since 2016-2017, whilst the numbers of non-EU workers has increased by 5% during this period (Skills for Care 2023a). These figures indicate that despite the UK government's claims to the contrary (Home Office 2020), the post-Brexit period has seen no decline on employers' reliance on migrant workers in home care, even though these workers face punitive visa requirements around minimum salary levels and restrictions on settling in the UK with their family members (Gov.UK 2024).

The foregoing discussion has explored how the undervaluing of home care in the UK from the mid twentieth century has been produced within welfare capitalism in combination with gender and race hierarchies. Post World War Two social democracy in the United Kingdom was predicated on delegating significant responsibility for the social reproduction of children and adults – including older, chronically ill, and disabled adults – to adult women within patriarchal family arrangements. Home care later emerged as a low waged, flexibilised occupation in the context of a broader neoliberal restructuring of the welfare state. Patriarchy and racism are structural conditions making it more likely that women and minoritised or migrant workers accept the low pay and challenging working environment of home care work. This point is developed further in the next section in relation to my study of home care workers during the pandemic.

Home care workers in this study

The historical conjunctions explored in the previous section shaped the biographies and socio-economic circumstances of the home care workers in my study. Of the ten home care workers I interviewed, all aged between 45 and 69, nine home care workers

were women and one was a man. One woman (Magda, aged 45) was white and Polish, another (Diana, aged 59) black and South African, all the rest were white British. Many care workers had a background of caring in their private and family lives. Eight of the female care workers had children for whom they had been the primary caregiver. Susie (aged 53), Shannon (47) and Diana (59) had done this as single parents, whilst Carys (61) and Adele (52) were in dual earner households, with husbands who earned significantly higher salaries. Caring duties also extended beyond raising offspring. Most home care workers had been significantly involved in caring for adults within their families, typically of their parents' generation. Susie had cared on a daily basis for her uncle who had dementia, until his death six years previously, and at the time of research she was looking after her aunt. Adele used the free hours between client visits on most working days to shop for and visit her frail step-mother. Carys regularly checked on her father-in-law, whilst Sandra lived with and was the main carer to her 96-year-old mother, who also had a dementia diagnosis.

Thus, most home care workers had extensive experience of caring outside of paid employment, and these obligations had in different ways led them to consider employment in the care sector. Susie had previously worked in retail and administrative jobs, but it had been the experience of caring for her uncle which led her to feel she had a particular aptitude for care work. Shannon grew up in a single parent household with two disabled siblings whom she looked after for much of her childhood. She felt this experience had left her well-disposed for employment in care. Carys had started working in care earlier in life when her children were young. She took up regular night shifts in a care home as it allowed her to look after her children at the end of the school day.

Social reproduction feminist analysis understands class in analytical rather than identitarian terms (Vogel 1983; Ferguson 2020). From this perspective, all women in this study were working class, in that all had to work to make a living. In addition, most lacked the education and professional qualifications to secure highly paid employment. Although three home care workers had higher education, seven had left formal education aged 16 or 18, and had previously been employed in retail, sales, and

administrative work. Their choices to enter home care was influenced by the range of job options open to them in these circumstances.

A home care worker's visit to a client may encompass a wide range of different activities, including personal care, administering medication, preparing and serving meals, and other household tasks, typically undertaken within a fixed time period of between 30 and 90 minutes. Home care workers were not paid for visits that take longer than the contracted time period. Clients may have a wide range of needs, relating to physical disabilities, frailty, dementia or a combination of these. Clients may have mobility issues, be unable to get out of bed or out of a chair; they may have few visitors other than a home care worker in the course of a day. Home care workers are expected to juggle the pressures of competing expectations that they be highly attentive to client's individual needs, on the one hand, whilst simultaneously completing a series of practical tasks, within a limited period of time. Shannon spoke of a public misperception that home care was not demanding work:

> they just say [home care workers] just sit down and have a cup and tea and chat, and I'm like, 'I bloody wish!' I don't think so, you know, we're giving out medication, we're ordering medication, we're washing, we're cleaning, we're preparing meals, you could be doing housework, you could be doing ironing or you could just be there for that security call, checking they are not on the floor … you're the eyes, the ears, you do absolutely everything, do you know what I mean? You're looking out for changes in health, you're contacting people, doctors, nurses do you know what I mean? You are everything really.

For example, Adele regularly visited a client who began behaving out of character, which Adele suspected was caused by a urinary infection. She reported her concern to the client's doctor, who carried out a test which confirmed this diagnosis. Adele's daily familiarity and attentiveness to the client led her to notice the symptoms of this health condition, which, left unchecked, could have had more serious health consequences.

This mix of practical efficiency and respectful attentiveness to clients was what home care managers were looking for in recruiting of new staff, but they depicted this in

familial terms. Irina, a home care manager, said that when interviewing applicants, she was asking herself 'Would I trust this person to look after my parents?'. This gendered framing of care worker competencies, often identified in academic research on care workers (e.g. Atkinson and Lucas 2013), is part and parcel of what also ensures their continued misrecognition and undervaluing within patriarchal capitalism. The highly sought-after capabilities of an adept home care worker are placed 'beyond' the wage, in the moral realm of kinship, thereby leaving untroubled the low remuneration and demanding yet precarious conditions of the job itself.

As indicated by the brief profile of two home care workers at the beginning of the chapter, home care workers in this study, like most in the UK, were both poorly paid and insecurely employed. The ten research participants were recruited from three separate home care providers in the research location. Best Home Care (see Note ii) employed 54 home care workers, all on zero hours contracts, whilst All Care employed 245 care staff, of which 50-60% were zero hours. Home Angels operated as an agency matching live-in care workers with clients, with around 25 self-employed home care workers on the books at the time of the research. Research participants worked long and anti-social hours. Rates of pay across all three organisations were hovering at or just above minimum wage levels (£10-£14 per hour). Two home care workers said that they worked full time but earned no more than £20K per year – a particularly low annual salary. Those with higher annual incomes typically had their wages from home care supplemented by a partner's salary, or by their own pensions, asset incomes, or part time work in other sectors.

The discussion so far has illuminated the historical processes that ensure that home care work is undervalued and shown how they were lived in the biographical circumstances of home care workers in the study. I now turn to a discussion of how the pandemic operated as a breaching experiment, by intensifying these effects of these conditions.

Pandemic flexibilisation

First, the pandemic destabilised the demand for home care services and the supply of workforce to meet demand. As I have shown, most home care workers are employed on contracts with no fixed hours. The already-existing requirement that they work flexible hours was further strained by the pandemic conditions. In Spring 2020, as infections rose and new public health restrictions were announced, home care employers faced the daunting challenge of managing major disruption to their businesses. As public fear of the virus mounted, the new lockdown furlough scheme made it possible for some people to care for family members directly in the place of paying for home care. Clients and their relatives opted to cancel, suspend, or reduce contracts with home care providers. There was also significant disruption to the hospital referral processes, which in normal times aided the transfer of people from hospital to home through liaison with home care providers. This cut off the supply of new business to two of the home care organisations in this study. Overall, there was a sharp drop in demand for their services in early Spring 2020. Carys, a home care worker in her early 60s, working on a zero hours contract, found that overnight, her weekly hours dropped from around 15 to around 8. Later that year during the summer, as infection numbers fell and restrictions eased, demand for home care increased significantly. Carys explained that "suddenly instead of getting in your diary 15 hours a week you'd get your diary with 37 on it from nowhere, it went the opposite yeah and it went mad for a while".

Home care provision during the pandemic was risky both to clients and home care workers. Home care providers needed to assess the health risks for their staff base, and ensure that those with underlying conditions which increased their vulnerability to covid-19 were furloughed. The two home care employing organisations in my study hired new staff or extended the hours of some existing staff to increase the supply of workers. Magda, an experienced home care worker, returned to direct care provision during the pandemic when her other work plans fell through (she had intended to take up a position as a trainer of newly recruited home care workers, but social distancing had made this position untenable). In need of wages, she worked all the hours she could, but was fearful of catching the virus:

> I didn't have regular availability during lockdown, I literally worked anything, sometimes I worked in the morning and in the evening, sometimes I worked in the morning and lunchtime and I finished … there wasn't any pattern but that was because I needed hours and obviously the coordinators have to cover the hours and there was that massive fear at the beginning what's going to happen if we all fall ill?

As 2020 wore on, test kits became more widely available and government advised that home care workers undertake regular asymptomatic testing for coronavirus. These arrangements remained throughout the second wave of the pandemic from Autumn 2020 into Spring 2021. Irina, registered manager of Best Home Care, reflected that Winter 2020-2021 was far more stressful than the first wave in Spring 2020, as increasing numbers of home care staff tested positive for covid-19 and needed to isolate. Her anxiety was that home care workers might have inadvertently infected clients:

> [The] first 3 weeks I think of January was horrendous, absolutely horrendous because we were just getting carers [home care workers] going off [work], another one going off, I think we had 5 in one week that went off with positive tests, and obviously their work needs to be covered. And you've got the added 'Oh God, which clients have they been to see?'. We've always been very high on our infection control training,… so we've managed to keep the clients clear [of infection] but it's kinda like the rolling stress when you get a carer that tests positive - you are then waiting to see if any of the clients start to show any symptoms …I think I held my breath for a month, it was horrendous.

As registered managers, Irina and Linda contended with clients' anxieties about contracting covid from home care staff, leading some clients to make requests that were not feasible for managers to implement. As Linda commented,

> clients were quite scared about it and [wanted to] limit the amount of people that were coming in to their home…we had clients that said you know I want to continue my care but I only want a care support worker

> that only goes to one other client, I don't want a care support worker that you know does a round of 4 or 5 clients.

Another unfeasible request from clients was to always have the same home care worker visiting them twice daily, not recognizing that home care workers have time off work. Overall, in a context in which loss of client demand was already damaging their business income, home care managers were under pressure to avoid losing more clients by accommodating their requests as far as possible. Yet there were limits to this, in a business model premised upon home care workers making multiple visits to different clients within a day.

Exposure and fear

Home care workers work in close physical proximity to clients, performing personal care which in the context of the pandemic placed them at high risk of exposure to covid-19. In the early months of the pandemic in 2020, there was little community testing, no vaccine, and the ways in which the virus transmitted was not yet fully understood. Linda, registered manager at AllCare, described how in these weeks, a small minority of home care workers refused to care for any client who had suspected or confirmed covid-19, whilst a larger group felt extremely uneasy about the prospect of doing so, even with additional PPE. As Magda explained further,

> I was receiving a lot of messages from my friends back then saying, 'are you not scared? Are you going to work, are you really going to go to work and do it?' At some point I got really, really cross and I started messaging them back saying 'Stop asking me if I'm scared! I cannot be scared, I can't, I have to go to work, I have to get up, get dressed and go to work… That's how I went through that initial period of time, it was literally like a machine - Go, go, go, go, I have to do it … generally [the] feeling was that there was an enemy out there that we can't see and it's trying to kill us but … we have to go to work and deliver care to those people.

The feelings of fear and stress described to me by home care workers align with those reported in other research on frontline healthcare workers (Nyashanu et al 2020).

Furthermore, some home care clients were unwilling to observe public health restrictions. Both registered managers explained that they had asked clients to observe these restrictions and not arrange for family or friends to be at home at the time of home care worker visits. Yet some clients ignored this advice. Carys described how one client continued to employ her cleaner and gardener at home, whilst another client's family continued to be present during her visits and did not wear masks. These clients showed little concern to limit the infection risk their activities posed to Carys. She complained to her manager but was told she had to put up with it - "that's how it is – that's how the family want to do it". She felt the employer did not want to risk losing the income from that client by insisting the family observe lockdown rules. In a similar vein, Saloniki et al's (2022) survey of social care workers also found that a high proportion of survey respondents reported having experienced abuse from client families during the pandemic, particularly amongst ethnic minority workers.

Home care workers on employment contracts who became infected with covid, or those needing to isolate due to exposure to it, were in most cases entitled to some sick pay whilst they were not at work. However, self-employed live-in carers had no entitlement to sick pay, and stood to lose all their wages if they could not work. Susie worked as a live-in carer to an 87-year-old client who had been advised to shield due to his blood cancer diagnosis. As a self-employed carer, Susie had no entitlement to sick pay. Had she been unable to work due either to herself or her client becoming infected and unwell, she would not have been paid. In addition, she would have become unable to care for her frail, single aunt dependent on Susie's presence when she was not working. In this context, she found her client's blasé attitude towards protecting himself from infection stressful. She tried to persuade him to stay home, in accordance with the government advice, but he insisted on accompanying her on shopping trips. She did not want the client to take unnecessary risks, but also worried that her assertiveness on the issue might lead to her losing the contract as his live-in carer. She resorted eventually to raising the issue with the client's daughter.

Managing covid-19 risks on the clock

As previously shown, home care work takes place on a set schedule and needs to be completed on time. The use of PPE added additional layers of tasks and planning, but home care workers received no additional time for their visits to take account of this. Given low levels of trade union organisation in this workforce, as previously explained, home care workers were not well positioned to make demands for extra time. PPE was a key mechanism for managing the risk of transmission of coronavirus. Home care workers already regularly used sanitiser, disposable gloves, and aprons. Pandemic guidance from public health and local authorities introduced face masks, visors, and full-length gowns. Instructions on how to wear, use, and remove these items in the course of visits to clients was updated every few days during Spring and Summer 2020. The advice also differed depending on whether the client had symptoms or a confirmed diagnosis of covid-19 infection. Registered managers recounted the challenges of sourcing supplies of PPE, especially in the early months of the pandemic, as demand and costs soared. They also needed to keep communicating changing guidance around PPE use to their staff remotely, via email or phone. Home care workers had different experiences of PPE. Live-in carers, as part of their clients' household bubbles, did not use PPE in any different way to normal times. However, among the employed homecare workers, Luke, the least experienced in the job, referred to the stress involved in using PPE correctly without extending the time of the visit. More experienced home care workers emphasized the discomfort of wearing PPE. Magda and Carys developed rashes and skin infections linked to perpetual hand washing, contact with sanitising gel, and mask wearing, and said that they could not see through the visors they needed to wear.

All home care workers spoke of the difficulties which the new masks and visors posed for communication with clients. Magda recalled that in spring 2020,

> I had one client who was end of life, literally in the last days of life and I couldn't communicate with him because I had a face mask and I had this visor …I was trying tell him something and he couldn't hear me, he couldn't understand me and I was like 'I can't do it, I just can't do it, it's not fair on

> the person'. …So at the beginning I wasn't really happy but then we all got used to wearing face masks.

Similarly, Shannon said,

> the fact that you're having to walk in someone's house with a mask on and they've got dementia - it just made it, it just made your job ten times worse - the fact that they couldn't have that facial recognition with you.

Adele also remarked that lots of clients dislike home care workers wearing masks as it made verbal communication difficult and created an unwelcome sense of distance and coldness:

> so there is that huge barrier there … if I know that they're a lip reader is I'll make sure that I am more than 2 metres away from them and I'll take my mask off if they still are constantly saying 'I just don't know what you're saying to me' … some of them still don't like you to wear masks but if you're doing personal care or and you're putting cream on their legs or helping them get dressed you have to have the mask on.

Despite being it was disliked by some clients, and uncomfortable to wear, home care workers needed PPE, not only to protect themselves from infection, but also the family members for whom they cared outside of their job.

Clapping for carers?

The weekly clapping for carers was ostensibly a mark of admiration for all caring professions during 2020. But home care workers viewed this display of appreciation through their experiences of being undervalued and poorly respected as workers, and having to endure the stress, fear and additional flexibility required of them during the pandemic. As a result, they expressed ambivalent and conflicted views about how far this ritual marked wider public recognition of their contribution.

Home care workers certainly felt appreciated and recognized by their immediate family, friends, and co-workers during the pandemic. Magda for example recalled how

home care workers sent each other WhatsApp messages of congratulations during the first Clap for Carers event. Carys said that her husband and son routinely expressed admiration and pride for her being a home care worker. Diana described how one family had shown their appreciation of her by making a generous gift, whilst Luke described how the neighbour of one of his clients thanked him personally one time, as he was taking off the PPE outside of the client's house, and that he felt touched by this.

However, home care workers felt disrespected by the wider public, or invisible to them. As Adele remarked, "people assume that because of the job you do that you're stupid or you're uneducated". During the pandemic, home care workers felt that their contribution as essential workers was routinely misrecognised and undervalued. Carys said despite all the fanfare around the then Health Secretary Matt Hancock's announcement that care workers would receive a new care badge, she personally never saw or received one, elaborating: "I think it was an overnight thing". She added that what would have really helped her in her job would have been to be treated as equivalent to other NHS and emergency workers in supermarket queues (see also Saloniki et al 2022). Yet this did not happen in her area:

> [Security guards at the supermarket] were allowing NHS workers in, whoever they were, they could have been, you know, an admin office [worker. They were also letting in] fireman and policemen straight away, but they did not let care workers in, even if you were there in uniform working, so doing shopping for someone, you were not allowed to go in. And in fact, the security guard at the front of Sainsbury's - cos I asked him once - he said 'Well there are so many of you in [this town], if we let you in there wouldn't be enough room for anyone else to do any shopping'.

Shannon recalled that a home care worker friend of hers was stopped by the police on suspicion of breaking lockdown rules, and that even when she produced the care badge to show she was working, she was not believed.

Other participants described their sense that people did not see home care workers as part of the care workforce, nor understand the importance of their work in keeping vulnerable sections of the population safe at home. The fragmented nature of the

sector made their collective identity much less visible than other essential workers. Susie for example felt that people were clapping for NHS workers, but not for care workers. Adele described an incident in which a neighbour reprimanded her for not clapping for the NHS:

> I came home from work one day … it was 5 minutes to the 8 o'clock and [my neighbours] were outside [ready to take part in the Clap for Carers] and they said 'we're going to be out clapping – will you be out clapping?' and I said to them 'I'm not being rude but I've literally done a 13 and a half hour shift, I want to have a wash and have a drink but I will clap but I won't be outside' and she got really quite funny with me because I wasn't showing my appreciation.

In a related vein and a pointed remark, Luke commented that the government endorsement of the clapping ritual was a way of distracting the public attention from the hardships faced by workers in health and care jobs.

Conclusion

Home care workers' experiences of the pandemic were shaped not only by the atypicality of this event, but also by the long-established conditions of home care work. Post-war welfare capitalism, in concert with gender and racial hierarchies, have ensured that the day-to-day sustenance of older, chronically ill, and disabled adults within homes and communities has been under-recognised and undervalued. Home care's growth as a significant social care occupation amid neoliberal privatisation in the 1980s and 1990s ensured that the work remained fragmented, low paid, and insecure, whilst patriarchy and racism have conjoined to perpetuate an overwhelmingly female and significantly ethnically, nationally, and racially minoritised workforce. Brexit further destabilised the availability of home care workers, paradoxically increasing social care employers' reliance on international recruitment and the flexibility of migrant workers who now face highly punitive and precarious conditions of settlement in the UK.

This chapter has contended that the pandemic operated as a breaching experiment, simultaneously exposing and further straining the profound contradictions in home care. During the pandemic, it became clear to many that the dedication and professionalism of this low waged, precariously employed group of workers was critical to the sustenance, safety, and wellbeing of a vulnerable segment of the population - people with increased vulnerability to serious illness or death from covid-19 infection. Yet home care workers were also expected to show extraordinary flexibility, providing their usual services for their usual pay, but in circumstances far more physically risky to their health as well as emotionally stressful and isolating. They were clapped and admired as care workers, but lacked the collective organisation as a workforce to collectively demand and achieve better protections for their pay and their health. They juggled the tension between caring for clients and caring for family members, carefully managing the risk that moving between these groups posed in terms of exposure to infection. In the aftermath of the pandemic, transformation of the structural conditions which conjoin to undervalue home care work (and other forms of social care work) seem unlikely to be achieved without collective action and mobilisation in favour of a better deal for care workers and carers alike.

Acknowledgments

I am grateful to all research participants. My warm thanks also to the guest editors for their helpful comments on earlier drafts of this chapter.

This research was funded by British Academy Special Grant COV19\200760.

Research project title: 'Staying home, connecting care: Infrastructures and experiences of home care and voluntary support given and received at home during the UK COVID-19 lockdown and beyond'.

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[i] A registered manager has responsibility for day to day running of the service and for ensuring that the organisation meets all legal and regulatory requirements.

[ii] I use pseudonyms for the individuals and home care organisations that took part in this study.