Filipino Home Care Workers: Invisible Frontline Workers in the COVID-19 Crisis in the United States

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Abstract
Filipino home care workers are at the frontlines of assisted living facilities and residential care facilities for the elderly (RCFEs), yet their work has largely been unseen. We attribute this invisibility to the existing elder care crisis in the United States, further exacerbated by COVID-19. Based on quantitative and qualitative data with Filipino workers before and during the COVID-19 crisis, we find that RCFEs have failed to comply with labor standards long before the pandemic where the lack of state regulation denied health and safety protections for home care workers. The racial inequities under COVID-19 via the neoliberal approach to the crisis puts home care workers at more risk. We come to this analysis through Critical Immigration Studies framing Filipino labor migration as it is produced by neoliberalism and Racial Capitalist constructs. Last, while the experiences of Filipino home care workers during the pandemic expose the elder care industry’s exploitation, we find that they are also creating strategies to take care of one another.

Keywords
Filipino migrants, Filipino caregivers, care work, social reproduction, racial capitalism, critical immigration studies

While there has been much attention on health care frontliners in the fight against COVID-19—mainly doctors and nurses working in hospital settings in the United States—numerous frontline workers who provide health and other kinds of

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essential care labor have largely been unacknowledged in their roles as essential workers. Broadly, Filipinos are overrepresented among health care workers in a range of health care occupations in the United States (Allard, 2011). The pandemic’s demand on these workers have disproportionately affected deaths in the Filipino American community (McFarling, 2020). In California, Filipino care workers are at the frontlines of assisted living facilities, residential care facilities for the elderly (RCFEs) and as personal attendants to chronically ill and differently abled people (Tung, 2000). Because of the crisis in elder care in countries like the United States and Canada—the lack of a federal system providing long-term care for the aging populations (aged 65 years and older)—the growth in for-profit long-term residential care has increased since the 1990s (Armstrong et al., 2020). Filipinos have thus answered the call to work in the increasingly privatized elder care industry, especially in the San Francisco/Bay Area, a traditional port city for the Filipino immigrant population.

Still Filipinos in nonhospital settings working in care-related jobs have not yet captured the social imagination as a sector of care workers who are in need of support in their work against the COVID-19 pandemic. Currently, Filipino care workers’ health outcomes and mental well-being while providing care under the pandemic has been invisible, thus making their needs to provide this essential care properly imperceptible. Based on preliminary data collected by the Bulosan Center for Filipinx Studies at University of California at Davis, nearly 40% of respondents report that a member of their households work in health care, yet only 3% of respondents report having been tested for COVID-19. Additionally, 13% of respondents report that their employers do not provide adequate personal protective equipment. Filipino home care workers bear the brunt of this pandemic evidenced by their precarious positionality: there is a high demand for their labor, but they remain invisible due to the conditions of their work in nonhospital settings. In this article, we argue that this process of invisibilization has to do with the existing crisis in elder care in the United States, further exacerbated by the global COVID-19 pandemic.

Our findings are based on quantitative and qualitative data: (a) the Filipinx Count! Survey, a national Filipinx health survey with over 1,100 respondents; (b) a pilot study with Filipino home care workers with an N = 102; and (c) kwentuhans, or talk stories, with care workers before and during the COVID-19 crisis. We analyze our data through a critical immigration studies framework that situates Filipino labor migration in the context of neoliberal racial capitalism. We echo scholars who have argued that racial exploitation and capital accumulation is mutually constitutive (Robinson, 1983), in other words, the neoliberal design for profit seeking is contingent on the exploitation and dispossession of people of color and immigrants in the United States. Additionally, we contextualize our research about Filipino caregivers in the historic and contemporary demand of domestic care from Black women and immigrant women of color (Glenn, 1992). We underscore that the ascribed gendered work in social reproductive occupations (e.g., caregiving, domestic work) are seen as disposable by employers and by the U.S. administration because of the lack of labor standards extended to this sector of workers (Chang, 2016).
RCFEs, often called “assisted living” or “board and care” facilities, are nonmedical facilities that provide care and assistance around daily living. These facilities have notoriously failed to comply with wage and labor standards long before the COVID-19 pandemic (Shah, 2017). Since the uptick in the privatized nursing home industry—a neoliberal response to the inability of the U.S. government to prioritize the health of its elders in lieu of government spending, the rapid expansion of RCFEs has seen little governmental regulation of these facilities shifting the responsibility for its patients and workers largely to the private owners and employers of the elder care labor force. These underregulated facilities have contributed to a lack of safety protections for their health care workers, making these facilities “hot spots” for COVID-19 to spread to both workers and patients. Reports of employers telling workers to “reuse” single use personal protective equipment are key examples of this. For Filipinos who work as home care workers, such as caregivers, health and safety protections are rarely enforced, if at all. Notably, under the California Division of Occupational Health and Safety, home care work is deemed as a “domestic service” and is thus excluded from basic health and safety protections, leaving workers at a loss for reporting grievances. The experiences of Filipino home care workers during the COVID-19 pandemic broadly expose the elder care industry’s exploitation of racialized migrant workers and the government’s neglect in protecting them. To this end, this article’s research aims are to understand the barriers that Filipino care workers in the United States face in terms of workplace protection and safety during the COVID-19 pandemic; reflective of the existing contradictions in the elder care industry that leaves Filipino care workers vulnerable and precarious. The dearth of data around the experiences of workers in the privatized nursing industry is attributed to the lack of industry regulation, reporting processes, and the invisibilization of this type of care work—a gap we aim to address through this article.

Literature Review

Filipino Migration to the United States: Exporting a Labor Force of Care

Filipino labor migration to the United States can be traced to U.S. colonization over the Philippines in the early 1900s. We trace the racialization and gendering of Filipinos as laboring care workers, from nursing to domestic work, to this era. In Choy’s (2003) *Empire of Care*, she remarks how U.S. colonization in the Philippines created an Americanized training hospital system to prepare Filipinos, particularly Filipinas, to be nurses for U.S. hospitals. This program included instilling English language fluency, Americanized hospital norms, and gendered notions of care work in Filipina trainees. In the 1950s and 1960s, the U.S. Exchange Visitor Program continued to perpetuate these hierarchies through a labor brokerage program that sponsored Filipina nurses to work in U.S. hospitals. The program was used as a way to fill the country’s labor shortages in care industries like nursing. The Exchange Visitor Program left nurses exploited as cheap labor with many experiencing housing difficulties and discrimination.
These colonial beginnings gave way to the Philippine’s sophisticated system of labor export. As a result of global neoliberal restructuring in the 1970s, the Philippines went into debt toward international financial institutions such as the International Monetary Fund and the World Bank (Lindio-McGovern, 2003). These conditions left the country in mass joblessness and economic inequality. To remedy the country’s debt, President Marcos installed the Labor Export Policy. As Filipinos were forced to migrate due to dire economic conditions, the Labor Export Policy brokered, and continues to broker, Philippine citizens to work abroad and fulfill labor shortages around the world (Rodriguez, 2010). Much of these jobs are racialized and gendered with care work as a key example (Guevarra, 2009). In return, the Philippines receives remittances to make up for the debts accrued.

Scholars have written extensively on the export of Filipinas to meet the U.S. demands for care labor (Choy, 2003; Espiritu, 2005; Parreñas, 2001; Rodriguez, 2008; Tung, 2000). In the past few decades, the American Baby Boomer population (born between 1946 and 1964) has grown exponentially, causing an increasing need for elder care. At the same time, the rise of women in the Global North in professional work and the decline of welfare resources has contributed to difficulties in obtaining affordable and quality family care. The U.S. and Philippine government has responded to this crisis of care through a strategy of labor brokering. Filipinas are gendered and racialized as “ideal” for care work because of their “gentle and servile” nature, ability to speak English, and familiarity with American hospital systems. These characterizations are bolstered by both the Philippine and U.S. government through marketing materials, labor diplomacy, and bilateral agreements that “sell” Filipina migrants as care workers using racial and gendered tropes (Guevarra, 2009).

Yet the lived realities of Filipino home care workers in these neoliberal processes are tenuous. Migrant workers are often sponsored by recruitment agencies on a temporary work visa to work in institutions of care: from day care centers to care homes for the elderly (Lindio-McGovern, 2007). Employers are able to skirt providing benefits, livable wages, and meal and rest breaks because of the historical exclusion of domestic workers from national labor standards across the United States (Nadasen, 2015). Thus, workers are vulnerable to wage theft, long working hours, and in extreme cases, human trafficking. For some workers, temporary visas may not be renewed by their agencies, rendering workers undocumented with little to no options for employment (Francisco & Rodriguez, 2014). As a result, Filipino care workers are caught in a precarious situation in being forced to migrate from their home country while being legally unprotected in their destination country, both as care workers and overseas migrant citizens of the Philippines.

Ultimately, Filipino care work in the United States is rooted in histories of U.S. colonization over the Philippines and the ways in which racial and patriarchal capitalism has organized Filipino laborers to fulfill U.S. demands for care work. Neoliberal government policies and cultural discourses are used to assign gendered and racialized values of disposability onto migrant worker bodies in order to address this crisis of care (Harvey, 2007).
Various studies have demonstrated how home care workers are rarely protected by local, state, and federal legislation particularly because of the abjection of care work and care workers (Kaur-Gill et al., 2019; Müller, 2019; Riley et al., 2016). For instance, Singapore has used the othering of care workers’ bodies as a way to respond to its crisis of care through discourses of gender and nationality. Elderly care work is deemed as dirty and demeaning (Huang et al., 2012). In Canada, even after home care workers receive legal work permits, a step closer to obtaining legal immigrant status, they are unable to find upward economic mobility because of their past experience as live-in caregivers negatively biased their applications to jobs outside of care work (Tungohan et al., 2015). These cultural discourses have contributed to making legal protections for care workers limited.

In the United States, this is particularly true when it comes to caregiving in both RCFEs and care work in private homes, and these links can be traced to the historical racism toward Black and immigrant working women. After the Civil War, Black women were siphoned to work as cooks and domestic workers due to the inability to find available employment after the end of slavery. Domestic work was seen as dirty and degrading, with White women often avoiding such jobs. Housework was often relegated to Black women because White families thought of them as “inept” and “promiscuous” (Davis, 1981). These racist myths continued on to the passage of the 1938 Fair Labor Standards Act (FLSA), which established minimum wage, overtime pay, and other employment standards. To cater to the racist motivations of Southern lawmakers in keeping Black workers out of federal labor protections, domestic workers were purposefully excluded from the FLSA (Perea, 2011). These historical injustices continue to reverberate into the experiences of care workers now (Nadasen, 2015). Home care workers are 62% people of color, many of whom are Black and immigrant women, and their median income is $16,200.¹ This devaluation of care work has translated to a dearth of protections and regulations toward an ever-privatizing care industry.

In RCFEs, those employed may not be formally categorized as “health care workers” even though they provide vital forms of care labor such as movement therapy, round-the-clock delivery of medicine, and assistance with daily living activities. Home care workers, such as caregivers to the elderly, personal attendants, and home health aides (HHAs), are considered essential workers, and provide in-home care for the most vulnerable populations without sufficient protections for themselves. Although caregivers carry out critical care assistance, RCFEs have been noted to violate various tenets of the FLSA. This has included denying workers’ wages and forcing caregivers to work beyond their contracted hours. There is currently no requirement that RCFEs must have skilled licensed staff onsite or on call as well as no staffing ratios (Shah, 2017). In California, for example, the Department of Labor and California Labor Commissioner’s Office have found rampant wage and hour violations. Since 2011, caregivers have filed 526 wage theft claims with the Labor Commissioner’s Office. Of those cases that went to hearings, workers were found to
be owed $2.5 million dollars. However, approximately 71% of the judgment amounts due ($1.8 million) remain unpaid (Shah, 2017).

These limited legal protections extend to home care workers. Domestic workers have been historically excluded by the National Labor Relations Act of 1932. In California, though Cal/OSHA’s standards require employers to protect their workers from health and safety issues, workers who provide “household domestic service,” which is related to the home care work provided by caregivers, are excluded from these protections.

Limited labor protections greatly affect the health and safety of RCFE and home care workers. In a study in Boston, Massachusetts, domestic workers faced several health risks. These risks included chronic back pain and exposure to hazardous chemicals, high stress levels on the job, and housing and economic instability (Delgado et al., 2017). Another study focused on workers’ psychological health in long term residential care homes, which revealed how mental health issues were caused by difficult working conditions, disrespect, and discrimination in the workplace (Braedley et al., 2018). Workers reported health issues from witnessing the suffering and death of their patients and the overload of work due to time pressures and interpersonal demands.

These health hazards extend beyond the workplace. Job insecurity is a common issue for workers because of funding challenges in long term residential care. Additionally, for immigrant care workers, the lack of labor protections leaves little recourse for workers to file grievances against their employers. Studies have indicated that for migrant care workers, there is a fear of speaking up and being at risk of being fired and deported (Delgado et al., 2017).

The dearth of legal protections for home care workers has worsened under COVID-19. During May of 2020, a Florida case revealed how HHAs were fired because they complained that they were not receiving the necessary personal protective equipment in their workplace. Before the pandemic, HHAs have had difficulties in sending grievances within their agency, with many experiencing job loss. The current public health crisis has exposed these gaps in legal protections that have left both home care workers and their patients at risk.

**Critical Immigration Studies Framework and Racial Capitalism on Migrant Care Labor**

In this piece, we use a critical immigration studies framework to understand Filipino care labor in the United States. This framework does not only look at immigration as solely an economic and political process, where migrants enter and leave borders. It considers how race, gender, and histories of colonization shape immigration law, the processes in which people migrate, as well as the meaning of the borders crossed (Romero, 2008). As Evelyn Nakano-Glenn (2002) writes, migration and citizenship are the boundaries between those who are included in a society, which comes with entitlements to rights and protection, and those who are excluded from these rights; and labor as a way that places people in an economic order.
Given the historical and ongoing racism that shapes the care industry and the ways in which immigrant women take up these devalued jobs, we address Filipino labor migration in the context of neoliberal racial capitalism, particularly through the auspices of colonization and labor brokerage, and how it is illuminated in the invisibilization of Filipino migrants doing social reproductive work in the form of health and home care. Racial capitalism is the process in which bodies and resources are assigned value by the White elite to exploit and produce profit (Robinson, 1983). By neoliberal racial capitalism, we mean the present-day form of racial capitalism that is marked by privatized basic goods and services, financialization, and liberal trade practices. The care industry reflects neoliberal racial capitalism at work. Facilities, like RCFEs, privatize services like elder care and assisted living, especially during a time of an immense health crisis. Because care work is abjected in value, workers who are often racialized and assigned as lesser than are thus paid poorly and are rarely protected. Throughout this article, we draw on how cultural discourses and government policy, as well as the lack thereof, assign racialized and gendered values to Filipino care workers, and contribute to labor and migrant exploitation.

**Method**

This article draws from two mixed-methods studies on Filipino home care workers. In what follows, we will outline our collaboration and then discuss details of the individual studies. The authors began our collaboration after the COVID-19 pandemic ushered in a lockdown in the San Francisco/Bay Area in February 2020. Francisco-Menchavez’s pilot study was completed in 2019 and aimed to explore the health outcomes for Filipino caregivers to the elderly. In the midst of the pandemic’s shelter-in-place orders a survey entitled, Filipinx Count! Survey, a national Filipinx health survey led by the UC Davis Bulosan Center for Filipinx Studies, to collect data on Filipinx health on a national level. Slated to be distributed in 2020, the Bulosan Center decided on engaging topics of the national pandemic in the survey. Both, Nasol and Francisco-Menchavez, saw the unique opportunity to juxtapose the data on Filipino/x caregivers in the studies we had collected before and after the onset of the pandemic. Thus our work in collaborative data analysis for this article began.

Both of our studies engage mixed-methods approach in examining physical and mental health outcomes for Filipino home care workers. The projects were designed as such to be able to ascertain the occurrences of health inequities among Filipino home care workers in the Bay Area but also to understand the impacts and meanings of health strains. In the main, the studies utilized survey data to measure strain in mental health and physical health, and the impacts of care work on health. The Filipinx Count! Survey advanced measures to explore care workers adaptations to pandemic protocols (e.g., access to personal protective equipment, COVID-19 testing). Both studies used the method of *kuwentuhan* (Francisco, 2014), a Philippine cultural practice of storytelling that can facilitate the exchange of essential information among its participants. In *kuwentuhan*, a semistructured guide was followed but the conversation relied mainly on the Filipino cultural value of talk-story, wherein participants could pick up
and expound on themes that they deemed important. In *kuwentuhan*, researchers could explore deeply how Filipino care workers come to understand and act on their health behaviors at their workplace and in their lives, more broadly. These methods heed the call for a “culture-centered approach” (Dutta et al., 2018) that aims to examine the health outcomes of migrant care workers as situated in the structural determinants of their migrancy and labor, rather than merely reflective of their individual choices and decisions. Rather, demarcating culture and its contexts in our methodology allowed us to consider how Filipino cultural values become integrated in how Filipinos assign significance to their health as they work, especially under a pandemic. We choose to center culture because we believe it is a mediator in how Filipino home care workers build a work ethic that sometimes can be detrimental to their own health.

Between 2017 and 2019, Dr. Valerie Francisco-Menchavez led the mixed-methods study called, The CARE Project, at San Francisco State University, that examined stress levels among Filipino caregivers in the San Francisco/Bay Area before the COVID-19 pandemic. A total of 102 care workers who lived in the San Francisco/Bay Area, with ages ranging from 35 to 44 years participated in the surveys and 19 caregivers participated in *kuwentuhan*. Survey questions from validated measures sought to collect data on symptoms of depression, anxiety, and stress in the workplace for health workers. However, since there was a lack of measures that brought together migration status and transnational contexts for care workers, *kuwentuhan* was used to explore the themes of caregivers’ health, work, and their transnational relationship to the Philippines. Participants were contacted through community events, festivals, and fairs through tabling and the completion of the survey and interview was incentivized.

Beginning in mid-2020, the Filipinx Count! Survey has over 1,100 respondents from Filipinx all over the country, led by the UC Davis Bulosan Center for Filipinx Studies, the first center in the country devoted to the study of Filipinx America. The survey data questions included topics such as health, immigration, employment, mental and physical health, and access to health care. Participants were recruited through partnerships with community-based organizations, schools, and Filipinx serving institutions across the United States. Additionally, the survey has been complemented with *kuwentuhan* with over 70 respondents led by interns and staff members at the Bulosan Center.

The CARE Project and Filipinx Count! were vetted by university review boards as we were collecting data on Filipino home care workers who are vulnerable because of their immigration statuses and the experience of job insecurity as care workers. Research staff for both studies made resources and contact information for organizations in support of migrant workers for those who needed assistance after their participation with the studies.

In what follows, we will juxtapose the experiences of Filipino caregivers from the CARE Project, before the COVID-19 pandemic, and after its onset in the United States through the Filipinx Count! Project. We make this methodological choice to support our argument about the worsening of an existing crisis for workers in the long-term care industry in the United States.
**Findings**

*We Find That RCFES Have Notoriously Failed to Comply With Wage and Labor Standards Long Before the COVID-19 Pandemic*

Based on the study from San Francisco State that collected data between 2017 and 2019, before the pandemic, there is ample evidence showing that employers in RCFEs were not following mandated laws for rest and meal and sleep breaks. The state of California requires uninterrupted 30-minute breaks for every 5 hours worked. Yet the study demonstrates that 49% of workers had their meal breaks cut short due to responsibilities with their patients. Additionally, 50% of workers keep working while on break, which is in direct contradiction with what the state mandates for caregivers. Elaine, one of two caregivers during one shift in a five-bed facility, explains how her breaks are cut short.

> Well, there’s, there’s not really, like, formal break. Of course, sometimes you sit down! But there’s no really, like, formal, “Oh, on this time you can take a break.” It’s just, maybe they’re [patients] still. Or they’re all, all of them are, like, taking their nap. So you have quiet time but all the while you know, you’re doing the cooking or you have the laundry running. So no breaks, just go go.

Elaine provides context on the issue that breaks only occur as happenstance when downtime in patients’ schedules allow. She qualifies that breaks are not scheduled into a work day, especially when staffing for a particular shift is minimum. With two caregivers and five patients, alongside their responsibilities for daily living activities such as meals and cleaning, the mandate for breaks are not enforced.

To this end, the Filipinx Count! kwentuhans reveal a similar trend continuing in and through the COVID-19 pandemic. A caregiver, Angelica, recounts her experiences of receiving breaks.

> Yeah, but our break time is twelve to three pm. But, it is not being followed cause it’s like some patients will call us and then they will tell us, “why do you have . . . both of you will have a break?” Because we don’t have a rest in the morning, [we] will wake up at like 8:30 and then the work will continue until 12 and then we don’t really [ . . . ] have a break . . . we do have [a break], we eat but the break like one [to] three hours. It doesn’t get followed.

In this quote, Angelica demonstrates that even if there is a scheduled time for breaks in a facility, daily living activities still pull caregivers into the work of taking care of patients and the facility. This leads to their inability to avail of the state mandated uninterrupted time to take a break from their work responsibilities.

Yet across our studies, caregivers found ways to exchange resources regarding available low-cost health care options. Richelle from the CARE Project said,

> I learned, way back from one of the caregivers, that there’s a program from the Valley Center, they call it a “pay-what-you-can” like your ability to pay. This helps especially
us overstaying people, who will always be here and they would always be possibly
going hurt.

Richelle has benefitted from the network of caregivers who have worked in the same
care homes under similar conditions.

Caregivers find information that can support their health in their occupation in their
social immigrant networks. For Gabi, who is a member of a local immigrant workers
organization, shares how she was able to find services and empowerment through
being a part of a support network of caregivers like herself.

Hinahanap ako sa sino ay pwedeng mag tulong ako tapos takot na takot ako sa lahat ng
parang walang pwede na sabihan, yung status mo, at doon nakikilala ko ng [organization].
Pag nakita ako ng [organization], parang meron akong medyo lakas ng loob, nalaman ako
yung akin rights, na pwede namin na ganito, hindi pwede naman yung ganito. So ang
dami ako na inituro. Pag sa-salamat ako sa [organization]. So least may tulong ko.

I keep looking for who can help me out, and I’m always afraid of everything because it’s
like you can’t say anything, like your status, and that’s how I got familiar with
[organization]. When I saw [organization], I started feeling more courageous—I learned
about my rights, what we can do, what we can’t do. I learned a lot. I give my thanks to
[organization]. So at least I have help.

In what Francisco-Menchavez (2018) calls, “communities of care,” we find that
when caregiver health is disavowed by the state and their employers, they turn to one
another to find solutions to find care for themselves.

For Filipinos Who Work as Home Care Workers, Such as Caregivers,
Health and Safety Protections Are Rarely Enforced, if at All

The CARE Project found that 64% of respondents felt persistent pain in various parts
of their bodies. This overwhelming number of caregivers, who reported a range of pain
as a result of their work, incur negative physical health outcomes with supporting their
patients with assistance with daily living activities such as toileting, getting up or lay-
ing down in bed, walking, sitting and standing, and so on. Movements in support of
patients are repetitive and caregivers exert energy and strength to do these essential
activities of caring for the elderly, chronically ill, and differently abled. Linda, a
54-year old caregiver of 20 years states, “You do these things every day, and its not
like you are always 100% paying attention to your own movement. You’re bound to
get hurt. You’re bound to mess up with yourself.” In this quote, Linda’s comment rep-
resents the mind-set of caregivers who focus in on their work

Still when aches and pains occur, roughly a third of caregivers responded that they
did not receive the care they needed because of cost and a lack of insurance. Since
caregivers, and domestic workers of the like, do not have entitlements to sick leave or
paid time off, their health and safety become the last of their priorities over earning a
wage at their work. Ana, a caregiver in a four-bed facility stated,
If I do get sick and I don’t go in for work, I don’t get paid. So even if I am sick, even if the employer sees me as sick, they don’t tell me to go home. I still have to work. I still need money for my family.

In this quote, Ana’s use of the word “sick” pertains to having an illness or having aches and pains from the daily work conditions of a caregiver. More important, Ana demonstrates that without basic labor rights to medical sick leave and health benefits, caregivers are willing to risk their own health to earn a wage and care for their patients.

Because many caregiver employers seldom provide health care insurance for employees, caregivers feel discouraged about seeking preventative care for their health or urgent care when they are in need. Martin, a caregiver in a six-bed facility, reported that he believed he has hypertension because it runs in his family but he could not be sure. He said,

> If you go to the hospital, it’s so expensive with no insurance. You cannot pay. Then you’re afraid to know what your diseases are. And they’re gonna prescribe you a lot of things and oh my god, now you know your sickness. I’d rather not know and just work, work, work.

In Martin’s logic, he avoids medical care because of the cost and his inability to access employer-sponsored medical insurance. In the United States, where there is a lack of socialized health care. Caregivers like Martin whose employer is not mandated by the government to provide health care must pay for individual private health insurance which can total up to a thousand dollars a month. This becomes a deterrent for caregivers like Martin to pay monthly for health insurance and consequently, it disallows him from understanding the kinds of health issues he might have. Because his work as a caregiver does not entitle him to basic access to health care, he surrenders the opportunity to care for himself.

During the COVID-19 pandemic, workers’ health and safety are even more susceptible to diseases and poor health outcomes because of the lack of protections enforced in the workplace. Lisa, a caregiver, who works in a private home, remarks the following.

> When this COVID came, we were just told to use the . . . well, they provided us with PPE, but only very minimal. Like four pieces only and then we have to reuse it. So it’s not good to be reusing those masks. And then they just told us to spray them with disinfectant and reuse it again.

Lisa was told by her employer that she had to reuse the four pieces of personal protective equipment and spray disinfectant on them, even though PPEs are not reusable due to the potential spread of the virus. Lisa’s situation shows how her workplace fails to protect her and her colleagues by giving them limited PPEs, putting her and her patients at risk for faulty health protections.
Workers’ Health Is Compromised and Preexisting Conditions Are Worsened With Very Little Access to Health Care, Employment, and Legal Protection/Governmental Assistance. Governmental Protections and Welfare, and the Lack Thereof, Are a Determinant of Health

In California, workplace safety and health regulations are mandated by the Division of Occupational Safety and Health (otherwise known as Cal/OSHA). Often workplaces are required to set and enforce standards of safety and educate workers about how to stay safe in their workplace. Yet the sector of domestic workers, which include caregivers, are excluded from these regulations because the site of work is often in private homes and in nonhospital settings. These governmental protections not only skip over caregivers but create a culture where employers of caregivers do not seek to set safety standards, enforce protections and ensure their workers are educated about workplace safety. In turn, caregivers accept these conditions as normal parts of their work. Hester, a caregiver at a six-bed facility, says,

Because I have a very active patient. Well we get hurt every time, you really can’t stay away from it. Especially when you have a client who’s really active. When he grabs you, scratch [you]. It’s included in the job.

Hester’s quote demonstrates that the risks of incurring injuries on the job as caregivers is “included” in her, regardless of the fact that there should be employer and industry standards to help mediate caregiver susceptibility to injury.

The lack of governmental assistance and protections for care workers is exacerbated with the COVID-19 crisis. For many migrant care workers, they seek to adjust their status in order to receive increased benefits. For Gina, a caregiver who resigned due to health issues, she explains difficulties in getting government assistance as a noncitizen.

For example, in our green card application, we’re getting hit really hard. There are lots of emails that are sending us about housing assistance but I cannot apply for a housing assistance because right now, if you are going to apply for any government aid or government assistance, you will not be granted a green card because of that.

Gina describes the risk of being a “public charge,” or as the U.S. Citizenship and Immigration Services defines it, an individual who may be dependent on government assistance, “as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.” An individual who is likely to become a public charge is admissible to the United States and is ineligible to becoming a lawful permanent resident. The public charge rule has been hotly debated during the Donald Trump administration, and has been marked as an attack toward poor and working class immigrants who rely on public assistance to put food on the table while desiring to adjust their status. For Gina, the COVID-19 crisis and the lack of government protections for noncitizens has made it difficult to
apply for housing assistance without being at risk for being deemed a public charge, and thus unable to receive a green card.

These issues have been further exposed through the CARES Act, a major stimulus package passed in March of 2020 that provided a $1200 stimulus check to families across the United States to alleviate the economic burden of the COVID-19 crisis. Yet, Rosa, a migrant care worker, shares,

I got the $1200 like but I gave it back to the IRS because our sponsor said that we were not eligible to get those money because we’re not citizens of America. So I gave it back to the IRS.

Rosa shares how the CARES Act has denied many undocumented citizens a stimulus check, which could have greatly assisted migrant workers, including care workers. The production of caregiver invisibility is facilitated through informal relationships with employers and sponsors, but also the structural devaluation of care work and immigration status (Kaur-Gill, 2020). Rosa and Gina’s stories show the limited protections and support migrant care workers have received during the pandemic, even though they themselves are essential workers most at risk of contracting COVID-19 in their workplace.

Discussion

*Understanding Migrant Care Labor Within a Critical Immigration Studies Framework*

Critical Immigration Studies helps us understand the historical and social contexts contributing to the paradox that immigrant care workers, under an unprecedented health crisis, are both devalued and essential. This framework allows us to include the reality that racial capitalism in the United States requires immigrant labor for precarious, gendered occupations such as caregiving to the elderly, yet rejects the possibility to sustain their own health and life under this pandemic.

It is clear that Filipino caregivers contend with the various pressures as migrant workers: financial obligations to their families in the Philippines, their own debts toward their migration costs, and their daily living costs. And under the current pandemic, these costs only worsen as their families in the Philippines lose the ability to work in the country and abroad (Ortigas & Liao, 2020). Filipino migrants, working as caregivers, are often the only lifeline to their family’s livelihood and survival. These circumstances constrain their choices in working safely with COVID-19 patients and vulnerable populations in “hot spot” transmission sites. The caregiving industry has long been a labor niche for immigrant women of color which has and continues to lack any governmental oversight and labor protections. This leads us to conclude that this essential industry’s workers are a sector of workers in the American society that is expected to be burdened with deaths, loss, and dispossession under COVID-19.
Inheriting a Racialized and Gendered History of Care Work

Currently, households across the United States are experiencing a crisis of care under shelter in place orders and the ebbs and flow of the COVID-19 pandemic. Families are contending with having to take care of elderly family members and children while working full-time jobs. According to a study by Oxfam International, COVID-19 has led to an increase in unpaid care and domestic work demands for Americans, especially for Black, Latinx, and Asian communities (Lawson et al., 2020). These effects are disproportionate when race and gender are factored in. In a more alarming sense, there is evidence that racism increases risk factors and negative health outcomes for COVID-19 in communities of color (Pirtle, 2020). Furthermore, we find that the care workers in these very communities of color bear the brunt of this paradox: they are caring for those most vulnerable to COVID-19 while putting themselves under great risk.

These studies demonstrate how essential care work is to sustain human life, yet, as Müller (2019) states, “patriarchal capitalism relies and builds on care work, but requires that specific elements of care to be structured as abject, unpaid and invisible.” With the case study of Filipino caregivers in California, we find evidence of the abjection and devaluation of care, both paid and unpaid, as a condition of capitalism (Müller, 2019). As the COVID-19 crisis worsens, it is the case that the crisis of capitalism relies on the devaluation and invisibilizations of particular care workers and care sectors. In the nonhospitalized settings of elder care in the United States, care work is not seen as “real work” as it occurs in private homes that are ascribed to feminized labor and thus, accepted as invisible labor. The dearth of labor protections for care workers in RCFEs and private homes are a direct inheritance from an American history of racialized and gendered devaluation of care and care workers (Glenn, 1992). In addition, the denial of government assistance toward migrant workers under the CARES Act and the risk of public charge further exacerbates this paradox: although migrant care workers are essential, they are still ineligible to receive economic support from the state in which they care for. Migrant care workers are seen as exploitable while being posed as a foreign threat that takes jobs and resources from their destination state. These multiple tropes demonstrate the ways in which racial and patriarchal capitalism has used devaluation to deny sources of relief and protection to Filipino care workers, a population highly vulnerable during this mass public health crisis.

Inheriting a History of Resistance

Although COVID-19 has exacerbated ongoing labor exploitation, the pandemic also poses as a portal toward futures and worlds rooted in justice, as writer Arundhati Roy shares. Filipino care workers have greatly taken up this call to create new worlds through building immigrant worker power in multiple arenas. For instance, the California Domestic Workers Coalition has led a campaign to pass Senate Bill 1257, a bill that would have ended the historic exclusion of domestic workers and day workers in Cal/OSHA’s workers protections. Although the bill was ultimately
vetoed, SB 1257 brought together Filipino care workers and domestic workers, in organizational coordination with Black, Asian, and Latino communities, across the state to push for increased legal protections in their workplace. Additionally, immigrant worker organizations in Los Angeles County, as well as San Francisco and Santa Clara County, are garnering support to implement Health and Safety Worker Councils with County Health Departments. These Worker Councils will allow for workers to pose anonymous grievances if their employer fails to protect the health and safety of their workers, and provides workers the ability to implement key accountability measures in their workplace.

While racial and patriarchal capitalism continues to devalue care in a time when we need it most, Filipino care workers, in tandem with other essential workers, are building interracial coalitions through grassroots organizing through local statewide movements, these political “communities of care” (Francisco-Menchavez, 2018). As scholar-activists in solidarity with immigrant workers, we call on government officials to follow the lead of care workers through this portal and to pass policies that ensure Filipino care workers obtain the care and protection they provide for families across the United States. Care workers are more than the “essential worker heroes” that are often described in pandemic media campaigns, nor are they merely workers insibilized and exploited in their workplace. Rather they are care workers who ensure the folks who are in most need of care are looked after, thus allowing the rest of society to function. They are workers who are tirelessly working to recognize their own humanity through political organizing and coalition building. They are workers who are risking their health and safety, even under structural neglect, to provide care to those who are the most vulnerable to COVID-19. Especially during the unprecedented crises, we are living under today, we argue that the labor of home care workers must be seen and recognized so that they can do their jobs with dignity and safety.

Conclusion

In this article, we have traced how Filipino care workers have become invisibilized as key essential workers before and during the COVID-19 pandemic. Using a Critical Immigration Studies framework, we demonstrated the requisite link between the contemporary brokering of Filipino care workers to the United States rooted in histories of U.S. colonization. Furthermore, through a racial capitalism analysis, we provided evidence on the devaluation of care and care work of Filipino caregivers logic and practice inherited by a legacy of racialized and gendered history in the United States, that thus translates to a dearth of legal protections for the care workers in our study, in particular, and care workers across racial and ethnic backgrounds, more broadly. We use these theories to emphasize that the paradox of Filipino care workers’ invisibility under this pandemic does not emerge because of the current conditions, rather the lack of visibility and protections for Filipino caregivers are a product of ongoing neoliberal and racialized processes in the United States. We use these theories to connect historical systems of racialized, gendered and neoliberal trends to devalue care and care workers in the United States to draw a through line to the current conditions
of exploitation for Filipino caregivers. Our aim is to connect these structural problems to possibly illuminate commonalities among care workers that might lead to solidarity and political organizing.

Through analyzing our two studies from San Francisco State and the Bulosan Center for Filipinx Studies, we found that both before and during the COVID-19 pandemic, RCFEs have notoriously failed to keep their care workers safe and that legal protections and government assistance has been egregiously limited. Our study demonstrates how legal protections and public assistance, or the lack thereof, is a major social determinant of care workers’ health. The experiences of Filipino home care workers during the COVID-19 pandemic broadly expose the elder care industry’s exploitation of racialized migrant workers and the government’s neglect in protecting them, endangering key essential workers during a historical public health crisis. And yet, we have found that Filipino care workers are crafting “communities of care” that circulate different forms and ethics of care among themselves. Rather than surrendering to the throes of institutional failures, Filipino care workers are finding essential information about health care and COVID-19 in their networks. Although these informal networks are not a sustainable replacement for state-sponsored health care and health resources, we uplift the innovative strategies of Filipino care workers to demonstrate their ingenuity and commitment to caring for themselves and one another.

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Notes
1. See Verrett (2020).
2. See Penton (2020).

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