Hierarchies of care work in South Africa: Nurses, social workers and home-based care workers

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Abstract. *This article examines care-worker hierarchies in South Africa, notably since the HIV/AIDS pandemic and the structural changes it has brought. The nurses, social workers, home-based care workers and volunteers are mostly women, of varying racial, socio-economic, demographic and educational backgrounds; they work in the public, private, and not-for-profit sectors. Recent changes in care provision have brought improved earnings for some, but the "care penalty" remains, and task-shifting because of the epidemic has been mostly downwards, increasing the burden on the lowest paid – or even unpaid – in the worst working conditions, thus increasing inequality between women.*

An overarching concern in the welfare regime analysis pioneered by Esping-Andersen (1990) is the extent to which social provision moulds class formation in society as a whole. Subsequent analysis by others has tended to focus on the recipients of welfare benefits and services, especially in health, education and the social services, all of which influence care. Esping-Andersen (ibid.) further held that welfare regimes also mould class formation through policy decisions about, and fiscal allocations to, the providers of benefits and services.

To take a simple example, if a policy reform results in the growth of tertiary-level health care, that has consequences for the types and levels of nursing and other staff who will need to be trained. Since nurses are typically female, the policy decision will in turn have an impact on the potential for women's career mobility. Similarly, differences in the working conditions in the public, the private, and the private not-for-profit sectors will lead to consequences for

inequality of treatment between different groups of women in paid work, and also between those in paid care work and those in unpaid care work.

Korpi argued in favour of focusing on the impact of care provision on the labour force: "behind the distinctions between paid and unpaid care work, between the public and the private spheres, looms the fact that the labor force is the arena for the major socioeconomic stratification processes in modern societies, processes where agency is crucial" (2000, p. 139). He also stressed the importance of a combined gender and class analysis. Pascall and Lewis (2004) analysed gendered trends and differences within countries in the newly expanded European Union, looking at household composition and at which household members are earners, i.e. the change from the "male breadwinner" to the "dual earner" model and other models. Ungerson (2003) pursued a different theme with her "routed wages" concept, exploring how policy reforms in different European countries have involved a shift from a model where the State directly provides services, to one where money is given directly to the person cared for, who can then buy support from carers. In these important feminist critiques of welfare regime analysis, little attention is given to the social stratification dynamics between female care providers, and between occupational groups. Pascall and Lewis (2004) examine class (and age) differences in the ability of households to buy in care (wealthier households can buy private care, for example), but their overall analysis considers women as a whole, and men as a whole.

This article focuses on relationships between different groups of care providers – or care workers – most of whom are women from a variety of social classes. It uses the lens of HIV/AIDS to explore the changing dynamics of care work. The context is South Africa, 15 years after the country's transition to democracy in 1994.

The following section provides a brief background to the racially and spatially discriminatory patterns of settlement and access to land, and to social services in South Africa. The third section then presents a profile of the selected groups of care providers: nurses, social workers and home-based care workers (HBCs – non-professional, non-family members who visit a person who needs care, mostly in his/her own home, but sometimes in a community-based facility or clinic). Then each group, its tasks, earnings, racial and gender characteristics are described, as well as the regulation of the work of the different groups, and whether the carers' access to formal social security is secured or denied. The fourth section explores the dynamics between and within different provider groups. It shows nurses moving from the public to the private sector; social workers in not-for-profit organizations (NPOs) being subsidized by the State (but on disadvantageous terms) to do statutory work, train new cadres of workers, and mobilize and manage volunteers; HBCs and volunteers gaining a point of entry into the labour market through the new HIV/AIDS-related programmes, while working under exploitative conditions; and task-shifting in nursing, which may simultaneously present HBCs with opportunities for work and a threat to work safety. The conclusion draws out some of the implications

of these trends, in terms of secure and improved employment conditions for some care professions, by contrast with the lower-paid, insecure and sometimes "quasi-commodified work" done in the guise of "community care" or policies and programmes reliant on "volunteers".

The South African context

With the Nationalists' victory in the general election in 1948, Dutch and then British colonialism in South Africa was replaced by a formal system of apartheid, whereby every aspect of economic, political, spatial and social life was segregated and racialized. White privilege was protected at the expense of black (African, Indian and coloured) people, the great majority of whom had already been structurally impoverished and dispossessed of land and other assets under colonial rule.

Under apartheid, there was a mixed system of public and private provision in most social sectors. In health, welfare and education, high-quality private services were available for those who could afford them (predominantly white people), as well as racially separate government facilities for white people and, to a lesser extent, for wealthier black people living in urban areas. The latter services were far superior to those available to poorer people, especially those living in rural areas. At the same time, the "helping professions" – teaching, nursing and, later, social work – were among the few avenues enabling black women to obtain secure employment with the possibility of career advancement.

At the heart of the apartheid project was the creation of separate residential spaces for different "race groups". As far as possible, African people were to be moved out into peripheral "homeland" areas; those living in cities were to be there under strict regulation, mostly in order to work in industry as migrant labourers or as domestic workers or, in rural areas, on white-owned farms. It was assumed that the reproduction of labour in the homelands would be taken care of by the women left behind; few women qualified to go to the cities. So long as the migrant labour system effectively perpetuated the disruption of family life (Budlender and Lund, 2009), social services in the rural homelands and non-homeland rural areas were slow to develop. The few mission schools and hospitals were closed by the Nationalist Government, and replaced by newly extended state education and health services – though these were generally of poorer quality. The health services coped with diseases that were readily preventable and largely associated with poverty. School curricula taught that black children were fit only for work in the service of the white minority. In extended families, women provided much of the care. As state pensions for elderly people increased in value and spread to rural areas, their role in enabling and supporting within-household care grew (Lund, 2002).

In 1994, the ANC Government was democratically elected and introduced a number of social policy reforms that had a direct impact on care work. Free primary health care focused especially on women and young children, access to abortion became legally available, and there are now more affordable generic

drugs and, more recently, a rapid implementation of the programme of anti-retroviral therapy (ART) for those with HIV/AIDS. Free education was promised initially, then reduced to free education only for the very poor, through a school-fee exemption policy for individual children, followed by an exemption policy for all children whose parents' income levels were low, provided the children attended specific schools. Nevertheless school enrolment rates are high, including those of girls. The school nutrition programme is patchy, but provides some food in thousands of schools, especially to younger children. For the first time, many poor households, as well as women in their own right, have access to a housing subsidy as home-owners.

There has been an expansion of social assistance in the form of pensions and grants to poorer people in specified categories, in particular to elderly people and those with disabilities. These forms of social assistance, which predated the ANC Government, were made racially uniform in 1993 and, since 1994, have been made more accessible. By 2010, the Child Support Grant, introduced in 1998, reached some ten million poor young children through their (mostly female) primary care-givers. Within the social welfare services, a policy shift towards "developmental social welfare" has led to a reduction in institutional care for elderly people, people with disabilities and children, which increases the care responsibilities of their household members. Two social components of the expanded public works programme (EPWP) directly affect care provision – one on early childhood education, the other on home-based care.

The recent social programmes are a partial response to the crisis in the care of children and adults associated with the HIV/AIDS pandemic. In 2007, the HIV/AIDS prevalence rate among people aged 15 to 49 years was estimated at 11.4 per cent, and higher for women (21.6 per cent) than men (15.4 per cent). With the HIV/AIDS pandemic, there are many more sick people to be cared for. The pandemic also fundamentally changes the balance between those who need care and those who provide it: there are more orphaned children and, with the death of women during their reproductive years, more elderly people (especially elderly women) have seen their care responsibilities increase (although Chazan (2008) points out that South Africa's specific history meant that older women were caring for grandchildren before HIV/AIDS). The epidemic is not a narrow "health problem": it changes who works and how, and what people and households spend their money on, with far more going on health services and funerals. It places an immense strain on paid health providers, and contributes to (but did not alone cause) the shortage of health personnel: in 2008, 36 per cent of professional posts in the public health sector were vacant.

The providers: Nurses, social workers, and home-based care workers

Here the focus is on three groups of care worker: nurses, social workers, and home-based care workers (HBCs). This selection allows insight into a number of labour market trends. First, it shows the horizontal linkages and the move-

ment of care workers between the private and the public paid care sectors, and the linkages with unpaid care work. Second, it sheds light on the vertical movement between workers having different employment statuses, and between formal, higher-status and better-paid jobs and precarious and lower-paid jobs. Finally, it shows how paid home-based care overlaps with the "voluntary" work done by non-household members (the HBCs) and with care provided inside the home by other household members.

Profile of the care providers

Nursing involves attending to all the physical, mental and emotional needs of the patient, including curative, preventive and "promotive" care. In reality, the work of the average nurse involves attending to the curative needs of ill people, including some basic care tasks such as feeding and cleaning. Specialized fields of care (such as midwifery and geriatric nursing) require further training and, in general, the higher a nurse is in the professional hierarchy, the less bodily contact with patients is required.

Of all health professionals in South Africa, nurses are the most numerous. Professional nurses (PNs) and assistant professional nurses (APNs) together comprise just over 160,000 people, compared with the next largest category, the 45,000 medical practitioners.

Social workers engage in three main work methods: one-to-one case work or counselling, group work, and community work. One particular aspect of their work is mobilizing volunteers and other carers and support networks. There are specialist fields of care (such as childcare, disability care, rehabilitation of offenders). In South Africa social workers are a much smaller group than nurses, standing at slightly more than 11,000 registered in 2005 (Earle, 2008).

The term HBC covers the many new types of community-based worker who have emerged in response to the growing need for care associated with HIV/AIDS (see Patel, 2009, pp. 38–45 for a rich description of the variety of organizations involved). Tasks vary between programmes, but typically they include training household members in health-related tasks, such as preventing bed sores and administering medication; relational tasks such as offering emotional and spiritual counselling and support; as well as ordinary household chores such as cleaning and cooking (Lund and Budlender, 2009). Many HBCs are themselves not properly trained (Hunter, 2005; Parenzee and Budlender, 2007). It is not possible accurately to estimate the numbers of HBCs (ibid., 2007), though it is clear that they are a significant new cadre of carers.

Women predominate in all three occupational groups. The majority of nurses are African, though there are substantial numbers of white and coloured nurses, and a few Indian ones, too. More than half (54 per cent) of the PNs (the most skilled group) are African; whites, however, who constitute just under 10 per cent of the general population, constitute 23 per cent of all PNs. Social workers have a different racial profile, with only half of those registered being African, whereas 35.6 per cent are white (Earle, 2008, p. 47). Though there has

been no large survey of HBCs, a number of sources consistently show them to be mostly female, African, and with far less education than the nurses and social workers.

Both nursing and social work are highly formalized professions, and closely regulated by professional councils. Both require a four-year university degree for entry into and registration of professional status. For HBCs, the boundary between "worker" and "volunteer" is fuzzy and, among "volunteers", it is unclear whether and, if so, how much they are paid. Though their work is promoted by the Government as a central plank in the new community care policy, the volunteer's employment status is ambiguous and precarious. As Samson found, the rights of HBCs doing the same work vary considerably, and the laws, regulations and codes applying to these workers vary, too. Often, officials responsible for engaging HBCs on the programmes were unaware of the regulations governing their work (Samson, 2008).

The three groups of worker have differential access to work-related support and protection against risk. As citizens, in principle they all have access to free health care, including reproductive health services, though the low quality of public services means that many better-off people opt for access to the private health system. Nurses are well covered as regards health insurance, with two-thirds of PNs and three-quarters of APNs belonging to contributory schemes. Many social workers are likely to have health insurance coverage as well. Nurses and social workers employed in both the public and the private sector have access to contributory retirement schemes. Self-employed nurses and social workers in private practice would have to pay to belong to private schemes (and some are covered by their spouse's formal employment benefits). Nurses and social workers in the private sector are covered by the formal contributory Unemployment Insurance Fund; those in the civil service have separate unemployment coverage.

It is unlikely that many HBCs have access to the private health insurance or pension schemes. They do have access to free health care and, for those eligible, to the pension for elderly people, a non-contributory, means-tested benefit. In any case, they are likely to have to rely heavily on their families for support. At the same time, and as with social workers and nurses, the very fact that they are care workers means they are likely to shoulder additional care responsibilities, outside their work-related activities, in the families and communities in which they live.

Earnings and the care penalty

Until recently, salary levels for professional nurses, social workers and teachers were low compared with those of other professions. After a protracted civil service strike in 2007, both nursing and social work were recognized as occupations of which there is a country-wide skill shortage, and in which measures were needed to "recruit, train and retain", with improved salaries, recognition of prior service in the private nursing sector, and improved career paths. The entry-level

salary in the public sector for a nurse, requiring four years of university training and one of community service, increased from an annual R86,000 to R106,000.

In many countries, care workers earn less than workers with comparable levels of skill and education in occupations that are not care-related – a phenomenon known as the "care penalty" (England, Budig and Folbre, 2002). Budlender investigated whether this care penalty pertained to South Africa, comparing professional and associated nurses with professional and associated engineers (Lund and Budlender, 2009). In each case the professionals had the same requirement for years of university study; in each case the associated category was pegged at the same skills level in the official categorization of occupational status. Ninety-one per cent of the professional nurses were female, while 92 per cent of the professional engineers were male. Of the associate professional nurses, 89 per cent were female, while 68 per cent of the associate engineers were male.

Budlender's comparison of earnings suggested there is a care penalty. More than a third of the engineering professionals and 8 per cent of the associate engineers earned more than R16,000 a month, whereas only 1 per cent of professional and associate nurses did so. Nearly two-thirds (65 per cent) of the professional engineers earned more than R6,000 a month, compared with 54 per cent of the professional nurses (Lund and Budlender, 2009).

At the other end of the continuum of paid care,[1] there is great variation in the pay of HBCs or other categories of "volunteer" care workers, depending on the programmes for which they work, the norms applicable in different departments, and the levels of funding set by donors (Patel, 2009, p. 35). For HBCs, Samson (2008) reported incomes ranging between R500 and R1,500 a month; Mitchell (cited by Budlender, 2009) found that those in care-related HBC programmes within the public works initiatives received between R9 and R80 a day – far less than the low wages of those in the more "male-dominated" infrastructure programmes (R30–R120). It would appear that the care penalty applies even in these public works programmes.

Public- and private-sector dynamics, and movement within occupational sectors

The flows of staff within and between different care providers are complex and fluid. Here we look first at the movement of nurses from the public to the private sector. Second, we show how social workers move in the opposite direction, from the private to the public sector, and how the subsidized non-profit sector

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[1] The concept of the "care continuum" was originally introduced in the mid-1990s as part of the WHO's health-policy framework for addressing the care needs of people living with HIV/AIDS. Generally viewed as an important advance towards a more holistic policy approach, the basic idea was to strengthen linkages between the various (formal) health-care levels and actors that follow up after voluntary counselling and testing (i.e. the entry point to the continuum). However, this framework has been criticized for neglecting the crucial role of "unlinked" (and often unpaid) forms of care, such as "peer support", home-based care and community care (for a discussion, see Ogden, Esim and Grown, 2006).

carries out the work of the State. A third trend is the movement of HBCs from informal to formal work, and between the public and the private sector, as exemplified in a small informal hospice run by "volunteers". Finally, we examine the phenomenon of task-shifting, the process whereby within the health sector specific care tasks are re-assigned from one set of care workers to another, and ultimately to the HBCs and "the community".

Choices in nursing: From the public to the private sector, and to other countries

Most nurses – 66 per cent of PNs and 71 per cent of APNs – work in the public sector. A quarter of both categories work for units called "private business or household". It is not possible to distinguish between those employed in private health facilities, such as clinics and hospitals, and those employed by a private individual, such as an elderly person in need of care. However, it is likely that most work in private health facilities.

Various factors determine the movement of nurses from the public to the private sector. Pay has increased appreciably in the private sector and, following the civil service pay increases after the 2007 strike, a major private health provider (Netcare) announced its intention to increase salaries to keep ahead of the public sector. Facilities and standards of care are also generally better in the private sector. In both sectors, the HIV/AIDS epidemic has brought high levels of emotional stress for those caring for the very ill and dying, and a constant exposure to disease, especially to tuberculosis and viral infections. Much is written about the vulnerability of health personnel to needle-stick injuries as a contributory factor in stress and burnout. However, Schneider, Oyedele and Dlamini (2005, p. 16) hold that: "[…] HIV is by no means the only factor linked to burnout. Workloads in general, resource shortages, perceived self-efficacy, and quality of team work and management all combine with HIV to produce burnout."

Other studies (Zelnick and O'Donnell, 2005; Henwood, 2005) confirm that HIV/AIDS work is just one among many causes of stress in an overall stressed work situation. The nurses' experience of managing in difficult conditions is ignored. The working environment could be improved by including nursing staff in policy and resource discussions.

The constant drain of skilled nurses from the public health system weakens the sector that serves the majority of the population. This, in turn, has a negative impact on the health of those relying on public-sector care. Nurses have some degree of choice in being able first to move from the public to the private sector, and second to go to work in other countries. In turn, South Africa benefits from the immigration of health professionals from the rest of Africa and from other parts of the world. For example, a recruiting manager in one of the largest private hospital groups described the recruitment from India of highly skilled nurses who were fluent in English and eager to earn South African Rands (*Health Link Bulletin*, 11 July 2008).

Doing the Government's work: Social workers in the not-for-profit sector

Social workers are employed in government agencies, the non-profit sector or industry; a few are in private practice. Unlike nursing pay, the full remuneration package for a government-employed social worker is much larger than for those working in the private and non-profit sectors.

Many formal non-profit organizations (NPOs) receive a state subsidy to support the work they do. In some fields (especially childcare, mental health, substance abuse and the rehabilitation of offenders) the subsidy is subject to the NPO carrying out statutory services on behalf of the State – services that in terms of the law have to be provided in order for a critical stage in a welfare service to be reached. This work concerns people who are in the care of the State, but on whose cases a social worker's intervention is legally required. Good examples are assessment visits to the home of a couple applying to foster a child, or court reports on the home circumstances of a person in a psychiatric institution ready to be discharged back to their family.

In these situations, social workers in NPOs operate precisely at the interface between government support and unpaid care by family members. Official reports acknowledge that, compared with social workers in government service, social workers in NPOs carry out a disproportionately large share of the statutory work required. However, the subsidies from the State do not fully cover the costs of the NPOs, whose skilled senior professional staff therefore spend time on public fund-raising. These same NPOs are also responsible for training new social work auxiliaries, in an attempt to augment their own staff. However, many of these trainees rapidly move on into government employment. The same NPOs also recruit and train volunteers, such as HBCs.

Opportunities and traps for HBCs: Between voluntary work and employment, between the private and the public sectors

The HIV/AIDS epidemic has placed a great strain on health services, and precipitated a move towards "home-based and community care", including calls for more volunteer workers (Hunter, 2005). As noted earlier, in this charged context the terminology has changed, and the new terms are used differently: "volunteers" are often paid "stipends" or "honoraria", although they are expected to work fairly regular hours, with specific tasks to perform, such that their work has the characteristics of a real job that should be properly paid; more formally engaged grassroots community-based and home-based workers are recruited on widely varying pay and working conditions, even within the same programme. Samson (2008) describes the case of an NGO which had been contracted by the health department to employ Community-Based Workers (the term the health department uses for the more generic term HBCs used in this article). The health department paid the NGO the stipulated wage,

plus an amount for contributions to the Unemployment Insurance Fund (UIF), a condition usually granted only to formally employed workers. Thus the State was paying the UIF contribution on behalf of the NGO, while insisting that the beneficiary was not "employed"!

The related growing care crisis has led to informal facilities developing to meet the need, and existing formal hospices have extended their work into communities. In provinces such as KwaZulu-Natal, where the epidemic is especially severe, it has become accepted hospital practice for terminally ill patients to be sent home to die. The widespread and rapid implementation of the anti-retroviral therapy (ART) programme means that the care needed and given is itself changing; however, thousands who need ART cannot yet receive it, and there are high rates of patient non-compliance with this complicated intervention, necessitating skilled support and attention from caregivers.

A small eight-bed hospice facility in Durban provides an interesting set of care work flows, with volunteers becoming formalized, and patients being moved between formal public and informal private facilities (Lund and Budlender, 2009). The suburban cottage which housed the facility was donated by a local businessperson to the Catholic Church, and the care initially provided by nuns. Management was gradually taken over by someone who had volunteered her services in gratitude for the high standard of care her own daughter had received there while dying of AIDS. She became "house mother" (essentially, the matron/manager), supporting the women working there who were called volunteers but who worked regular hours at exceedingly low pay. Volunteers used the networks available to this facility to access locum work in more formal health facilities in the private health sector. All of them hoped that this occasional work would lead to more permanent employment, and in some cases it did.

This informal facility was not registered with the provincial health department, but it was known to provide a high standard of care. From about 2005 onwards, from a true hospice for the dying, it had turned into a place of hope for extended life because of the ART rollout. Public health patients routinely die while waiting for ART because of the time-consuming process of application, proof of compliance and counselling required. In this small private health facility, informal relationships operate in which the house mother uses her local networks to gain access to ART in three days, rather than the three months it can often take through the public sector. Once the patients' condition has stabilized, they are transferred back to the public hospital, where they can obtain free ART on a longer-term basis.

No register of health services will pick up this virtually invisible help and the complexity of movement between private informal and public formal service. Very little is yet known or understood of the manner and extent to which such care work opens up somewhat improved career opportunities for the "volunteers" at the facility, rather than simply trapping them in low-paid voluntary work. Given the high unemployment rates in South Africa, it might well be a point of entry to the labour market for women, rather than men, albeit in the traditional and low-paid care sector.

Task-shifting: Tasks cascade from nurses to "the community"

In its health and welfare sectors, South Africa has adopted a policy of community care. Under the auspices of the World Health Organization (WHO), South Africa is also participating in the global initiative on task-shifting. Task-shifting is the process whereby tasks defined as the preserve of those possessing a certain level of skill are delegated to those with another level of skill. In the context of scarce resources and a health sector under pressure, this delegation is usually to a lower level, allowing those less formally skilled to undertake a broader range of activities. The WHO explicitly states that this is to provide more room for "community workers [who] can potentially deliver a wider range of HIV services, thus freeing the time of qualified nurses", as well as "creat[ing] local jobs and new opportunities for people living with HIV" (WHO, 2007, p. 3) – through the inclusion of people living with HIV and with AIDS as community workers.

Task-shifting is not new, though the term is. A hallmark of primary health care was allowing nurses to take on doctors' tasks, and nursing assistants to take on those formerly exclusively done by formal nurses. Within South Africa, the greater access to legal abortion in the 1990s gave rise to what became international best practice in task-shifting (Marion Stevens, personal communication). Previous legislation had allowed abortion in the narrowest of circumstances (for example, when the pregnancy resulted from rape) and only by medical doctors. The new legislation allowed access to abortion on demand, and its performance by nurses.

Training of and funding for thousands of nurses and facilities were key to the successful implementation of the new policy (Stevens, Frayn and Nombulelo, 2008). In the HIV/AIDS crisis, task-shifting is being introduced precisely to *solve* a resource problem, though the policy states that it also seeks to provide a more appropriate form of quality care. Without training, funding, and ongoing supervision and support, task-shifting will place new responsibilities on poorer-paid workers, and on volunteers in temporary placements in public works programmes. This is best described as "quasi-commodified" work. If under-funded over a period, the care tasks will finally fall on household members who will effectively provide unpaid care.

Some of the South Africans involved within the country and in the global initiative include experienced health activists who played leadership roles in the struggle for health rights for all South Africans. There is no public evidence that the (largely female) professionals promoting the practice have seriously considered the gendered implications of the new policy for other female care workers. Likewise the WHO's widely disseminated official booklet on task-shifting in response to HIV/AIDS makes no mention whatsoever of the potential gendered impact of task-shifting (http://www.who.int/healthsystems/task_shifting/en/).

Conclusion

The HIV/AIDS crisis has resulted in new care needs and a crisis in the health services. This crisis arose from the legacy of disrupted family life left by the HIV/AIDS crisis, combined with very high rates of unemployment. Lund and Budlender (2009) noted the absence of demands by unpaid carers for more public support for care. They suggested that a possible reason was the presence of unemployed adult women in the households of those needing AIDS-related care. This article has explored other dynamics that may be shaping the lives and work of paid and volunteer care providers.

The care providers examined here work in a range of jobs. Some are formal-sector, secure, strictly regulated and highly unionized jobs (77 per cent of PNs and 74 per cent of APNs are unionized) and collective labour action has led to better salaries and career mobility for nurses and social workers, with the private health sector subsequently committing itself to increase its own salaries for nurses (ibid., 2009). Nurses move from the public to the private sector in search of better conditions of work, whereas social workers move from the private sector (where conditions are worse) to the better-paid public sector. Some of the most skilled women in the nursing profession emigrate from South Africa and (some of) their places are taken by women immigrating from poorer African and Asian countries.

The HBCs are a new cadre of workers but their employment status is very ambiguous. Their work inside private homes, usually in poor communities, means that they are largely invisible, and they are paid very badly, if at all. Some of them accept to do their work in exploitative conditions because they perceive this work as a potential avenue to a better job; they are not likely to complain loudly or to organize assertively. However, Samson (2008) points out that though they are not in a position to bargain for better wages, other things could be done in the immediate term. The organizations in which they work and the nurses and social workers under whom they work could put pressure on the Government to ensure that all who are entitled to stipends do actually receive them, for more timely payment of the stipends, and for better work-related equipment (Samson, 2008). Samson also suggests that the NPOs supervising the HBCs have a role to play in actually applying the labour laws, and building up the capacity of the HBCs.

It has long been known that state support to the social services underpins and thus enables provision by other public and private agencies. In South Africa, the Government subsidizes NPOs, which in turn employ social work auxiliaries and volunteers. However, compared with social workers in government services, the social workers in NPOs do a disproportionately large amount of work and are paid less. The same NPOs provide the training ground for new social workers who obtain their first round of training and supervision while working there, and then leave for better-paid and more secure civil service jobs.

This investigation of care providers yields some pointers for further analysis of care work. First, some comparative analyses of welfare regimes select a

sector (such as health or education) from which to draw up the characteristics of welfare regimes, and hence to establish appropriate classifications. This study suggests the need to look closely at how both the health and the welfare sectors differentiate between women and men, between women, and between different groups of care providers. Much is missed by choosing one group as representative; at the same time much would be missed by simply aggregating all the different groups.

Second, alongside the health and welfare sectors exist a range of complementary programmes that influence and support care work. In the South African context, these include nutrition programmes for children, housing subsidies, and infrastructure provision such as domestic electricity, water and sanitation, all of which make a significant material difference to the lives of those doing the care work, including provision in the homes of carers and of those cared for. Greater understanding is needed of how separate care provision by the Government and the private sector drives access by poorer people to such services.

Third, though many people aspire to a sense of community, there is danger in the abstract notion of "community" (Hunter, 2005; Lund, 2006). The WHO publication on task-shifting cited earlier goes so far as to advocate "community-led care" as a response to care needs in the context of HIV/AIDS. In the context of already scarce resources for coping with the pandemic, what can this possibly mean except further responsibilities for the women doing unpaid and low-paid care work, many of whom are already poor and overburdened? The first South African Time Use Study was undertaken in 2001, a little too early to capture the effects of HIV/AIDS on care work. A new Time Use Study, planned for 2011, will go some way to filling this gap.

Fourth, in the South African context, greater understanding is needed about the future impact of ART on care needs and on what carers will need to do. There is early evidence that ART may improve the morale of formal and informal carers, though current regulations governing access to ART (a CD4 count below 200), mean that an applicant has to be very sick indeed before becoming eligible – with negative consequences for the health services and for carers. As is now widely accepted, the availability of ART means that HIV/AIDS must be managed as a longer-term chronic condition, rather than as a terminal illness. Some carers will have to learn to cope with the difficulties faced by their patients in sustaining the management of long-term ART use; other carers will have to continue coping with the harrowing terminal stages of this illness.

Fifth, it would be interesting to examine whether the tasks of domestic workers are increasing in response to the care work deficit. South Africa's million domestic workers are largely African women who work mostly in better-off households, but also in many poor households. In practice, are they taking on more care tasks as the HIV/AIDS epidemic spreads? If so, do they receive any training and support, let alone increased compensation, for this increase in their tasks? Or is this another realm in which women's care responsibilities expand in quiet and unacknowledged ways – in a sense, task-shifting upwards?

Finally, the professions under focus here are dominated by educated women, but neither the social workers nor the nurses appear to publicly articulate a gendered analysis of their occupations and their places in society, the links between their own paid care work and the unpaid care work of other women, or the tension between their own paid work and the unpaid care work they carry out in their personal lives. This coincides with a complete absence of awareness in the new community- and home-based care policies of the impact these policies may have on women's overall well-being, including their access to the labour market.

Some of the new programmes clearly create points of entry to the labour market through voluntary or quasi-voluntary work; one could say, through an interim stage of "quasi-commodified" care work. However, if HBCs are to represent a central plank in the overall HIV/AIDS strategy or if grassroots community workers are to represent a plank in other non-AIDS-related social programmes then, as Samson (2008) rightly holds, the Government must develop a clear policy on the employment status of these new care workers. At present, new forms of de facto employment are being disguised through the process of contracting to NPOs. If their employment status is not clarified, the responsibility for care will continue to be displaced on to female HBCs, unpaid or partly-paid volunteers, and unpaid female workers in poor households – all of whom suffer from an ambiguous employment status.

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