THINKING IT THROUGH:
WOMEN, WORK AND CARING IN THE NEW MILLENNIUM

Women's Unremunerated Labour

Pan American Health Organization

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Care work is women's work. Paid and unpaid, located at home, in voluntary organizations or in the labour force, the overwhelming majority of care is provided by women. It is often invisible, usually accorded little value and only sometimes recognized as skilled. It can risk the health of the women providing care and, when provided without pay, severely limit women's economic position both now and in the future. Unpaid care constitutes a huge underground economy. Canadian estimates based on the low pay of domestic workers calculate that unpaid informal caregiving was worth nearly 51 billion dollars in 1998, an amount significantly greater than the 42 billion dollar total labour income of those employed in health and social service sectors.[i] Estimates also indicate that between 80 and 90 percent of care work is unpaid.

Given that the previous speakers have talked about both the invisible nature of that work and the economic consequences of unpaid care, I want to focus on developing guidelines for thinking about care that are linked to policy and practices. I will set these eight guidelines out briefly to offer a basis for discussion here.

First, **such guidelines should be simultaneously concerned with similarities and differences**. Because there are so many common patterns in women's work, it is useful to talk and think about women; that is to lump them together as a group and to look at general patterns in their work, their

conditions and their relationships. Lumping allows us to see what women, as women, share. It also helps us to expose both the forces that keep these patterns in place and those that change them.
Taking this approach has allowed us to learn a great deal about women's unpaid care work.

We know that it has increased significantly. Better food, clothing, shelter and health care mean more people live into old age, often with chronic conditions. New technologies mean more people survive with disabilities and more complex care can be provided at home.
We know women provide more demanding unpaid care compared to men. They also work longer hours and have more daily responsibility as well as more responsibility for the most intimate personal care.
We know their lives are more disrupted by unpaid care and women are more likely to face low wages and worse paid working conditions partly as a result.
We know as well that women are often subject to violence and other risks. Women who provide unpaid care frequently end up with poor health, health status directly linked to their caregiving work.
And we know that care work can be rewarding for women, whether it is paid or unpaid.
Lumping has allowed us to see these patterns that can be found throughout the world.

At the same time, there are fundamental differences among women linked to their time and their economic, social, political, racial, cultural, and physical locations as well as to their health and their abilities. We know there are significant differences among women in terms of both their care responsibilities and in their access to resources. The care required for someone sent home early from the hospital to recover from surgery is not the same as that required for a child born with severe disabilities and there are real differences between providing personal care and financial support or help with shopping.

Understanding these differences requires us to take a range of approaches or slices. Slicing not only adds a recognition of differences among women and among those for whom they provide care. It also adds the possibility of developing different views of the same issues, circumstances and evidence, views that allow us to take complexity into account. The interests and needs of the care providers, the care recipients and the other household members, for example, may all be different, creating tensions and stress.

Slicing also allows us to see that there is very little that is ‘natural’ about women’s work in general or their caring work in particular. Bodies, and women’s caring, can be understood only within unequal relationships, structures and processes that help create women as carers and undervalue this caring work.

Which brings me to my **second** guideline. **Analyses of women’s work should locate women within both their general and their specific environments as well as the intersectins among these environments**. Globalization, changes in nation states, new technologies, the increasing emphasis on markets, communities and families all establish contexts for women’s work. Contexts also include ideas about all these, as well as ideas about women, race, culture, sexuality, equity and age. All play a role in the distribution of income, power, symbols, social supports and services. And all play a role in shaping women’s caring. It is equally important to recognize that the roles these factors play individually and collectively play are frequently contradictory, leading to tensions and conflicts. Perhaps most importantly, it must be remembered that all these factors are shaped by human hands, including those of women. Women can, and do, make a difference. There are choices to be made.

In spite of notions about inevitability, globalization is about processes that result from actual decisions and practices rather than from forces beyond human control. Nations still establish many of the conditions for work and for deciding how, when and where care is provided. In providing supports, benefits, services and regulations, or in not providing these, state practices establish the conditions for care in and outside the formal economy. The state plays a fundamental role in determining how political, material and symbolic resources are distributed. Equally important, states play a critical part in mediating the distribution of these among markets, communities, households and individuals. Indeed, states are central in determining what is public and what is private in the formal economy. States are central as well in determining what is private in the sense of being outside the formal economy, what is an individual or family responsibility.

Governments, for example, set the conditions for health care in the formal economy and for care in the home through their support for a wide range of programs and services, as well as through the messages they send out about responsibility, women and families. The benefits and negative consequences of these state actions, or failure to act, are unevenly distributed between women and men and among women. It is thus necessary not only to find out what the state and global forces do, but also to determine who benefits and how they benefit, if we are to figure out how to create good conditions for both paid and unpaid care.

While there are powerful forces limiting our options, there are choices to be made. These choices can have important consequences for women and their work, and have to be considered in developing strategies for care. **We cannot develop policies for recognizing unpaid care without recognizing these contexts for care.**

The market mechanisms that have become so popular with governments also have to be carefully scrutinized for their impact on the nature and distribution of both care and care work. We have to ask where, when, and under what conditions markets are appropriate and what their impact is on care. In spite of the popularity of market mechanisms, there is every reason to believe these mechanisms will change for the worse who gets what kind of care through paid services and the conditions under which providers work. At the same time, they tend to increase inequality while sending more care to communities and households where the time, the skills and the stress involved in the care work become invisible.

Like globalization, communities have a variety of meanings. It is important to define these communities as governments throughout the western world at least talk about moving care into the community. Communities include not-for-profit and for-profit organizations that provide care with or without pay. Churches, for example, are usually considered part of the community. And churches often define care as women's duty. Communities also include friends and neighbours. However, when policy makers talk about sending care to communities, they most often mean to families. And, within families, they usually mean to women. Such families are most often assumed to be heterosexual unions based on loving relations and mutual support. Yet we not only have a great deal of research showing that fewer and fewer families fit this mold. We also have research showing that many families do not have a bread winning father or a father at all. Many lack children who can afford to stay near home to provide care. Too many are characterized by violence.

Sending care to the community does not necessarily mean more local participation or control. Nor does it necessarily mean more family togetherness**. Indeed, the increased burden of care** may mean undermining those communities and families. Families and communities are centred on reciprocal relationships which can suffer when the load becomes too heavy as stress and tensions increase. As Stacey Oliker says on the basis of her research on welfare,

> [W]e might find damage to personal networks and personal relationships, which could threaten families' capacities to care. The damage might take the form of constriction and greater fragility in networks, the replacement of caregiving support with support for subsistence, and a decline in communal commitments to care.[ii]

And sending care to communities may mean little care**.** Without time, space, economic resources and other supports, all communities may be at risk, and innovation as well as participation stifled. Families, we know, often fall apart under the strain, most frequently leaving women alone to provide the unpaid care. One final point needs to be made here. The care being sent home has never been done there. My grandmother and yours never filled IV tubes or inserted catheters.

Which brings me to my third guideline. **It is necessary to examine the ways globalization, states, markets, communities and households intersect and structure each other, each influencing how the others operate.** The period following World War Two was marked by increasingly clear distinctions between public and private sectors in the formal economy, between paid and unpaid work, between families and labour market employment, and between states and households. However, these distinctions have become increasingly blurred as we move into the new millennium. The blurring of the lines among these sectors makes it more difficult to see the links and more difficult for women to draw boundaries. Pubic private partnerships are one example of the former while more complex medical care provided at home is an example of the latter. At the same time, more rigid lines are drawn in some areas in order to reduce public support. So some care for new mothers, for example, no longer qualifies for public support.

In thinking about these contexts, it is important not only to see how they influence each other but also to see how the ways they influence each other are changing over time and with place.

This leads directly to my fourth guideline. **Critical questions need to be asked about who pays for care and at what cost to which women, even when our focus is unpaid care**. Funding and payment are about much more than the money and costs are about much more than payment. How payment is made or not made, under what criteria for what care are issues that have significant consequences not only for access to formal care but also for costs to caregivers, both paid and unpaid. Payment for women providing care for relatives in the home, for example, as proposed in some countries, may serve to reinforce women's responsibility for such work without providing them with adequate supports.

My fifth guideline is also about relationships. **It is important to understand women's paid and**

unpaid care work as integrally linked. The movement of care into the public sphere as governments expanded public services simultaneously created paid jobs for women and reduced their unpaid care work. It also helped make both the work and the skills involved in care more visible and valued. However, as cutbacks in public care, combined with new technologies and new ideas about where care should be provided, move care into households, the skills and the labour time become much harder to see. Paid work thus also suffers because once again care seems to be about work any woman can do by virtue of being a woman.

My sixth guideline is somewhat different, although it is also about contexts and how they matter. **It is important to explore questions about the time for and locations of care**. Where, when and for how long must care be provided? Social, cultural, racial, physical, age, sexual and psychological locations all have an impact on the nature of the work needed and provided. Physical location must be taken into account in understanding care. Rural areas are different from urban ones; houses of the rich different than those of the homeless.

Time interacts with space, and like space, it is about social relations. But when time is money, care as a relationship may be sacrificed. There may be no time to care. With more and more women in paid jobs, fewer and fewer have time to provide unpaid care. While women with economic resources may be able to buy the time of others, most women have to speed up their work and sacrifice time for themselves in order to provide care. Time thus needs to be considered in order to understand the demands on providers, the control they have over their work and the alternatives available to them.

This is linked in turn to questions about assessing how much unpaid care is provided. The time required for care is difficult to measure, both because the work often remains invisible to the women doing it and because it overlaps so much with their other domestic work. So a measurement scheme which asks about primary tasks often make it look like women at home never look after their children, in large measure because such care is part of every task all day. Moreover, a man doing the job is more likely to see it and have an accurate assessment of the time consumed precisely because it is uncommon work for him and because he is more likely to take on that task as his primary one.

My seventh guideline once again shifts to new terrain. **The nature of power should be explored, along with the means of enhancing the control women have in providing and receiving care**. Power is primarily about access to resources. Some of these resources are material, like income and services, like drugs and diapers. Some are political, like the right to participate fully in decisions-making in ways that have an impact or like the right to equal pay and other employment protections or like the right to education and information. Some are social, like having time and space for friends and relaxation. Some are symbolic, like having care recognized as work that requires time, space, money, physical capacity, emotional involvement. skills and social support. The more resources are distributed by market mechanisms, the greater the disparities in resources and thus in power. Research has demonstrated that those with the least choice about providing unpaid care experience the most negative health consequences from this work.

All this leads me to my conclusions. We already know a great deal about women's unpaid work.

The question is, "How can we not only make care visible and valued but also how can we create the conditions that allow women and men to care?"

To do so, I would argue, **means understanding care as the objective, not the problem**. Care needs to be understood as a relationship, rather than simply as a task. All societies need to provide care. All of us need care at some periods in our lives. We need to identify the aspects of care that we want to keep and then figure out how to keep them. We need to recognize the conflicting, often contradictory demands on care providers, and how to handle these in ways that leave women with the right to provide and receive care.

Deborah Stone argues that **we need "to make the essence of caring visible, not so much in order to make it countable and rewardable, but rather, in order to render clear what it is that we want to provide in the public sphere".**[iii] It is, in other words, important to recognize what is valuable and critical to keep the care in care, wherever it is done. **But, I would add, it is necessary to do the same in the private sphere as well**. Recognizing the rewarding aspects of care is critical. However, placing too much emphasis on these may make caring impossible to achieve in either sphere, by paid or unpaid providers. There are dangers in the stress on relationships involved in care because this stress can be used to make paid workers contribute far more than the hours for which they are paid and unpaid ones work far beyond the point of exhaustion. In the case of both paid and unpaid care, defining it as women's work alone is detrimental to women's health and problematic in terms of measuring their contribution to health care.

Without both supports and alternatives, care for paid and unpaid care workers can become a burden without end. Without collective responsibility for care, those with the least resources are those most likely to have the greatest burden at the same time as they will find it difficult to provide care. By making care visible and beginning by making it the objective, we can then work towards solutions that give as many people as possible the right to care. **Care must be the objective, not the problem.**

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i.Nancy Zukewich, "Unpaid Informal Caregiving" *Canadian Social Trends* Autumn 2003, p.18.

ii. Stacey J. Oliker, "Examining Care at Welfare's End", in Meyer (ed.), *Care Work*, p. 178.

iii. Stone, "Caring by the Book", p. 91.