

Discourse

Between Women: Nurses and Family Caregivers

Patricia McKeever

Throughout Canada in recent years, contractionist policies have predominated in a labour market recession with high levels of unemployment. Government-funded healthcare has become overwhelmingly expensive, hence related policies and programmes have undergone rapid and profound transformations (Dominelli, 1991). Correspondingly, there have been major reallocations in healthcare work in both the public and private domains (Dowler, Jordan-Simpson, & Adams, 1992; Drover & Kerans, 1993). These changes have been especially dramatic in the burgeoning area of longterm care. "The family" is now held responsible for providing care to even the most severely disabled people, and the household has become the primary site for care delivery (Steel & Gezairy, 1994).

Although health care activities have always been within the realm of domestic responsibilities, the scope and extent of these activities have changed remarkably in the last two decades. These changes have been associated with widespread sentiment against institutional care, the closure of longterm care facilities (Switzky, Dudinski, Van Acker, & Gambro, 1988), and the increasing proportion of very old people in the population (Steel & Gezairy, 1994). In addition, advances in medicine, pharmacology and biotechnology have led to decreased mortality rates and increased rates of severe chronic illness and disability among people of all ages (DeJong & Lifchez, 1983). Consequently, more people now require care at home that is complex, labour-intensive, and very expensive (Plough, 1981).

My aim in this paper is not to discredit the indisputably humane goals of the homecare movement, but rather to identify some negative consequences that deserve serious consideration. First and foremost, I believe that women currently are bearing a disproportionate share of the costs that are associated with chronic illness and disability. Because the traditional division of domestic labour undergirds government policies as essentially as do class relations,

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redistributive health care practices have perpetuated gender inequalities (Fraser, 1987; Mayall, 1993; Wilson, 1982). Secondly, nurses and family caregivers are in ambiguous social positions and they have been pitted against one another in some untenable ways. Finally, nurses are losing wages and jobs, and family caregivers are forfeiting wages. Hence, both are losing employment benefits, pension entitlements and will have diminished lifetime earnings.

The current form of longterm care represents a "mixed economy" (Beecham, Knapp, & Fenyo, 1994). Families bear the major associated costs, unpaid women do most caregiving work, and nurses and cheaper health workers provide some relief and support. A chain of relationships links government and corporate interests to paid healthcare workers, unpaid family caregivers and people who have longterm care needs. At the bottom are family caregivers whose work has been appropriated from the domestic sphere and substituted for formerly paid nursing work. This transfer of work from paid to unpaid is a very unusual reversal of a longterm trend in capitalism (Glazer, 1988). It has been supported by the ideology of the market that proclaims competition and efficiency to be the major criteria by which to justify government expenditure and the ideologies of individualism, neoconservatism, and personal responsibility which justify the retrenchment of public services (Anderson, 1990; Simms, 1989; Sorochnan & Beattie, 1994). In addition, because caregiving work is viewed as a low status activity (Rosenberg, 1987), the fact that many nursing skills can be performed competently by lay women in household settings may have diminished further the societal value of nursing work.

Estes and Alford (1990) argue that homecare can be seen as part of a larger process in which economic, sociocultural, and political problems are displaced into nonprofit services and the family in order to avert major fiscal crises. Without question, the deconstruction of the boundary between care given by nurses and that given by family caregivers in the home has led to fewer nursing positions and considerable public savings (Premier's Council on Health, Well-being and Social Justice, 1994). The fact that there also have been associated costs and some negative consequences now needs to be addressed.

The Relationship Between Nurses and Family Caregivers

Points of tension and conflict are inevitable between nurses and family caregivers because contemporary homecare occurs amidst ambiguity, very limited resources, and competing agendas. Both groups of women have few sources or past experiences to draw on as they try to meet ambiguous and conflicting expectations. The household as the site of caregiving is problematic and awkward because it is the setting that traditionally has been considered a

refuge from work and public interference (Graham, 1985; Rosenberg, 1987). In contrast to the institutional care milieu, family care is embedded in intimate, affective relationships that have histories and futures. Hence home care is delivered in a complex interactional context which is characterized by tension as well as solicitude and warmth (Atkin, 1994).

Nurses are urged to form "partnerships" with family caregivers (Jutras, 1988), to teach and supervise them, and to provide "family-centered care". Hence, they are required to view family caregivers simultaneously as colleagues, subordinates and people who themselves are in need of nursing care. Although the relationship between nurses and family caregivers has not been studied to date, it would appear that conflict and confusion are inevitable because these conceptualizations lead to mutually exclusive approaches. For example, there are usually clear disparities between the needs of family caregivers and those of care recipients that put at odds nurses' efforts to simultaneously maintain optimal patient care and ensure caregiver wellbeing (Twigg, 1992a).

Nurses and family caregivers must encroach on each other because their roles and relative status overlap and shift. For example, nurses give care based on their professional expertise whereas family caregivers rely on a skill repertoire that is specifically related to particular relatives' needs. Over time, most family caregivers develop a care regimen and a knowledge base so attuned to the care recipient's needs that their skill rarely can be matched by nurses (McKeever, 1992). On the other hand, nurses have more formal education, are invested with more authority and enjoy a higher social status than most family caregivers because only 35% of Canadian women have attained post secondary school education (Statistics Canada, 1990). In summary, unusually complex negotiations related to authority, accountability, values, and the use of household space must prevail between these two groups of women.

The Economic Consequences of Homecare

Many of the economic consequences of home care are related to the fact that nurses and family caregivers are in competition for scarce public resources. Nurses are vying for jobs and wages and family caregivers desperately need more support services. In addition, most of the ongoing costs associated with homecare are borne by families with a single wage earner. Consequently, most nurses and family caregivers work with few resources in contexts of financial distress (Glazer, 1988; McKeever, 1992; Scott, 1984). Although the occupational health conditions of homecare have not been documented, it seems fair to suggest that they are far from satisfactory.

Finally, most family caregivers make significant economic sacrifices by quitting their jobs, working part-time, or not seeking employment at all. The

majority do not have retirement or pension benefits and few participate in dental or medication prescription insurance plans (McKeever, 1992; Phillips & Phillips, 1993; Stone, 1994). Similarly, as more and more nursing work is performed by family caregivers and health aides, many nursing jobs have been lost or reduced to part-time positions. Currently there are many unemployed or underemployed nurses in Canada whose expected career paths, lifetime earning profiles, benefits and pension savings have been seriously affected (Premier's Council on Health, Well-being and Social Justice, 1994). Hence, it is beyond dispute that, when longterm care is delivered in the home, women suffer serious immediate and long term financial consequences.

Suggestions and Conclusions

The combined effects of the economic recession, technological innovations and unbalanced economic growth will increase the need for homecare for the foreseeable future. The structural position of nurses and family caregivers remains subordinate to that of those who control household resources and determine policies and practices (Mayall, 1993). The challenge therefore, is to alter the current arrangement so that responsibility and costs are distributed more equitably. I believe that nurses and family caregivers could contribute to meeting this challenge by working together to reconceptualize and repoliticize longterm care.

This task will not be easy because the medical model still dominates the healthcare system and absorbs most available resources. However, the enormous social value of female domestic work is finally being acknowledged (Theilheimer, 1994) and the concept of a clear division between the private and public domains is being discredited. Stacey and Davies (1983, In Mayall, 1993) argue that paid health work such as homecare nursing, actually occurs in an "intermediate domain". Situated between the private and the public domains, it complements, parallels, competes with, or replaces unpaid work in the private domain.

The concept of the intermediate domain can be used to facilitate recognition of the fact that the family and the state are indivisibly interconnected and that activities in one have significant implications for those taking place in the other. It also provides a framework that could be used to first understand and then ameliorate the tensions and adversarial relationships that develop between nurses and family caregivers. If nurses and family caregivers differentiated and clarified their respective roles, their mutual plight would become obvious. Together, they could lobby for their collective well-being. They could highlight the fact that they are performing an essential social service by supporting extraordinarily dependent people in the community. However, they are doing so with inadequate societal support and at great cost.

Davies (1983, pp. 39-41) argues that power, in its widest sense, is the ability to alter or influence the course of events, and to create possibilities where none existed before. As social individuals, caregiving women hold simultaneous memberships in various *systems* of power within the private, intermediate and public domains. By using these positions as a source of control, it is possible that gender could be upturned to provide a powerful avenue for bargaining and exchange. Although it is not considered "feminine" for women to act together in public political protest and women usually underestimate the value of the work that they do (Bielby & Bielby, 1988), there are few other options. Without positive public sentiment and acknowledgement, nurses and family caregivers will not fare well in the current policy environment.

Canadians espouse egalitarian values, therefore both groups of caregiving women should expose inequitable practices and structures which support gender disparities. The nonprofit service sector could be shown to legitimate the economically driven system by removing and treating "social problems" through policies that are consistent with the ideology of individualism (Estes & Alford, 1990). If women are to bear the major responsibility for homecare of the chronically ill, they must be able to discharge this responsibility in a context of societal support in which they have political power (Ruddick, 1989, p. 46).

Finally, most homecare research essentially continues to be driven by the *anti-institution* themes generated during the 1960s. The relationship between research findings and the rationalization of care suggests that investigators also have contributed to retrenchment practices (Simms, 1989). By reconceptualizing homecare and recognizing the price it is exacting in its present form, nurse researchers would no longer contribute to this process. As I write, governments are seeking ways to divest themselves of more and more health and welfare expenditures. In that this means enlarging the invisible welfare system of family caregivers and eliminating nursing jobs, this matter should command the immediate attention of researchers, clinicians and family caregivers.

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