

# **Women's Paid/Unpaid Work and Health: Exploring the Social Context of Everyday Life**

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On a étudié la documentation de différentes disciplines pour obtenir une description de la vie active des Canadiennes. L'analyse allait dans le sens des recherches de Smith (1987, 1990), de féministes et d'autres théoriciens critiques qui soutenaient que la majeure partie du travail des femmes était invisible et sous-estimée. Les schémas de pensée normative ou l'idéologie peuvent masquer l'étendue et la valeur de la contribution des femmes. L'étude semble indiquer qu'une «idéologie des sphères séparées» opère dans la manière de désigner l'activité rémunérée dans la sphère publique (à savoir, le travail), tandis que les activités qui ont lieu dans la sphère privée (à savoir, chez soi) sont négligées. On indique également que l'immense participation des femmes dans des activités non rémunérées qui soutiennent autrui et renouvellent sa force de travail, en fait des citoyennes de seconde zone et les conditions préalables à leur propre santé sont souvent compromises. Souvent, le travail des femmes a lieu en dehors de l'économie formelle, dans une économie de l'ombre qui est celle de la subsistance (Illich, 1981) et qui est fondamentale au maintien de la bonne santé d'autrui.

Literature from various disciplines was reviewed to obtain a description of the working lives of Canadian women. This analysis drew on the work of Smith (1987, 1990) and other feminist and critical theorist authors who have argued that much of women's work remains invisible and undervalued. Patterns of normative thought or social ideology may obscure the extent and value of women's contributions. It is suggested here that an "ideology of separate spheres" operates in the designation of paid activity in the public sphere as work, whereas activities pursued in the private sphere of the home are overlooked. It is further argued that women's heavy involvement in unpaid activities that support and sustain others results in a state of lesser citizenship, and women's own prerequisites of health are often compromised. Women's work often takes place outside the formal economy, within a "shadow" or subsistence economy (Illich, 1981) which is essential for the continued health of others.

The activities individuals engage in that affect their health are by no means a simple matter of personal choice. They are facilitated and constrained by social and material conditions that form the context of human action and exert an impact on the prerequisites of health (Poland, 1992). Indeed, the Ottawa Charter for Health Promotion (1986) implicitly defines health as a product of social relations in the statement that health "is created and lived by people in the settings of their everyday life, where they learn, work, play, and love" (p. 427). Furthermore, the Charter acknowledges that "changing patterns of life, work, and leisure have a significant impact on health" (p. 427). Thus, any analysis of women's health must include some consideration of their work, as well as the social and material conditions under which it is performed. By definition, women's activities affect their own health and that

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of others by exerting an impact on prerequisites of health such, as time for personal growth and leisure, adequate income, and equity (Doyal & Gough, 1991; Ottawa Charter for Health Promotion, 1986; Pascall, 1993). This approach to women's work and health directs attention to the general coordination of activity in our society and the resultant effects on the prerequisites of health. Rather than focusing on outcomes such as stress, fatigue, or the presence or absence of disease, I will therefore analyze the organization of work according to gender in Canada.

West (1993) explains that gender is the product of social interactions that involve "the local management of conduct in relation to normative conceptions of attitudes and activities that are appropriate for particular sex categories" (1993, p. 59). The gendered division of labour in the home and the work place is part of a negotiated order that is accomplished within the social context of a prevailing set of normative conceptions, or ideologies, about what activities are appropriate for men and women. According to Drover and Kerans, "the contemporary family is still largely constituted by a gender division which defines certain kinds of work as domestic, female and unpaid, while other kinds of work are public, male and paid" (1993, p.18). Nurses can better understand the working lives of female clients, and indeed, the work of the nursing profession, if that work is reframed within a macro-analysis of the social ordering of women's activities. Concern is shifted from the problems of individual women clients to the common challenges shared by larger groups of women.

Entire aspects of women's everyday paid and unpaid work remained invisible until the concept of work was expanded by several authors to include women's activities in the privacy of the home (Pascall, 1986; Smith, 1987, 1993). The physical and ideological separation of home and place of employment as settings of everyday activity has had far-reaching consequences for women's health and well-being. Women's activities in the two settings have been considered separately, but their similar purposes and outcomes, as well as their combined impact on the prerequisites of women's health have only recently been recognized. Beginning with the work of selected critical and feminist theorists as an analytic framework, I will examine aspects of women's work to find the connections between the conditions that shape women's health and the "ideology of separate spheres" of work as defined by Drover and Kerans (1993). Next, I explore the extent of women's paid and unpaid work, drawing on literature from a variety of disciplines. Finally, I consider the value of women's work on a broader social scale, citing examples of how social policy affects women's working lives.

### **The Invisibility of Women's Work**

As West's (1991) definition of gender suggests, one method of linking everyday experience with social context is through idiographic or cultural analysis, as first explicated by Denzin (1989). Working from the feminist perspective, Smith (1987, 1990) provides an analytic framework for this method. She argues that the everyday lives of women are situated within a network of social relations that extend outward to institutions such as the health care system, education, and the state. Women's activities, both in the home and in the labour force, are largely concerned with the concrete and particular details of the physical subsistence and well-being of others. As clerical workers, health care workers, and homemakers, for example, women perform the bulk of the mundane labour that facilitates more abstract, better-rewarded work. However, ideologies reflect the views and experiences of dominant groups in the social order and not necessarily those of women. Ultimately there exists a "line of fault" between popular discourse about women, and the actualities of women's experiences (Smith, 1990). If, for example, we think in terms of separate locations when considering women's work, we may fail to see the continuities in the purposes and outcomes of women's activities across all situations and misunderstand the total effects on prerequisites for women's health.

The recognition of women's contributions to societal well-being has been similarly impeded by the artificial splitting of the private sphere of the home from the public domain of productive, market-related activity; the result is the ideology of separate spheres (Armstrong & Armstrong, 1994; Drover & Kerans, 1993; Wilson, 1991). This rupture began during the Industrial Revolution, when wage labour became centralized in factories and other commercial sites. Existing gendered patterns of subsistence activity became exaggerated and solidified; the public sphere became the male dominated world of work, and the private home became a supportive environment created by women for the nurturance and socialization of children and for the restoration and relaxation of men as they returned from their daily labours (Johnson, 1974; Phillips & Phillips, 1993; Strong-Boag, 1988). Yet the ideology of separate spheres is based on the historical experiences of a more advantaged segment of society. It obscures the reality that women in some socioeconomic groups have always contributed to the economic circumstances of their families, either through paid employment or through informal means such as economizing on household expenditures (Phillips & Phillips, 1993). Finally, this distinction between sites of activity underlies the devaluation of women's health-oriented and caretaking work by locating them outside the cash nexus (Anderson, 1989).

Feminist and critical welfare theorists argue that social policy decisions are informed by these elements of the ideology of separate spheres, and reduce women to a state of lesser citizenship (Drover & Kerans, 1993; Eichler, 1988; Evans, 1991; Neysmith, 1991; Pascall, 1986, 1993). Doyal and Gough (1991) suggest that social arrangements ought to be judged according to their adequacy in meeting common human needs and observe that, in comparison to men, women's basic needs are poorly met in all societies. Pascall thus reasons that full citizenship for women would mean "the equal recognition of needs – for shelter and food, personal space and time, for social acceptance – and the construction of rights and obligations within such a framework of needs" (1993, p. 115). In Pascall's view, then, full citizenship would mean that the prerequisites for physical and mental health were satisfied. The following analysis of the current situation for Canadian women builds on this definition of citizenship by examining the structure of their everyday lives, as well as the social and material conditions that contribute to the creation of this structure.

### **The Working Lives of Canadian Women**

West (1993) argues that if the concept "gender" becomes individuated as the property of a person, it is prematurely treated in research as an explanation rather than the starting point for a critical analysis of social experience. Thus, while it is clearly useful to study such concepts as stress and fatigue in women as the result of specific work situations, West urges us to also consider the broader social arrangements that render women's work in specific locations stressful or fatiguing. The purpose of this section is to describe the working lives of Canadian women by examining their unpaid work in the home, and their paid work in the labour force. The adequacy of these working arrangements to meet the prerequisites of women's health is also considered.

### ***Women's Unpaid Work in the Home***

In 1990, 71% of all couples with children under age 19 in the household were dual earners, while only 30% of similar couples were dual earners prior to 1970 (Marshall, 1993). Although polls show that men are gradually taking on more household chores, women continue to bear the brunt of the gender-negotiated division of work. The work that women do in the home is marked by frequent interruptions, contingent upon the changing developmental and physical needs of others, conducted in isolation, and seemingly never completed (Armstrong & Armstrong, 1994). Within the ideology of separate spheres there is an androcentric notion of the home as a restful haven from the world of commerce, further obscuring the restorative work that is endlessly pursued in that setting. For women, the home is not necessarily a site of leisure, and the work they do there has no temporal boundaries. The unpaid activities they pursue at home are multifaceted, including housework, repro-



duction and childcare, care of the elderly and disabled, and tension management (Armstrong & Armstrong, 1994). Many authors acknowledge an element of emotional labour that is embedded in most of the physical activities of homemaking (Hochschild, 1983; Hochschild & Machung, 1989; James, 1989; Wilson, 1991). All of these aspects of homemaking are essential to the health and well-being of family members, as well as to the continuity of production outside the home, yet the conditions under which they are enacted have an impact on the prerequisites of women's health.

### *The Division of Work in the Home*

The population-based survey findings on the division of household labour reveal the differences in time spent on housework by men and women, but reveal little about the social processes behind these differences. The results of the 1992 General Social Survey show that Canadian women spent an average of 4.5 hours/day doing unpaid housework, in contrast to 2.6 hours/day spent by men (Devereaux, 1993). Several conditions appeared to contribute to this inequity. The presence of young children in a household expands the amount of work to be done (Chandler, 1994; Devereaux, 1993). Women who were employed full time and had children under age 6 did an average of 5.4 hours of unpaid work daily, while their partners did 3.4 hours (Devereaux, 1993). Of the hours allotted to unpaid work, these women devoted 2.2 hours solely to childcare, while men spent 1.2 hours in childcare.

In the dual income families where both spouses were employed full time, women were solely responsible for housework in 52% of the families, and mostly responsible in 28%, responsibility was equally shared in 10%, and the men were solely or mostly responsible in 10% (Marshall, 1993). The age of the couple appeared to be linked with the division of household work: 47% of women were solely responsible for housework in the under-35 age group, 53% between ages 35-44, and 69% between ages 45-64 (Marshall, 1993). The division of household tasks was also linked to income: sole responsibility for housework was held by 67% of women whose incomes were under \$20,000, 53% of those with incomes over \$40,000, 39% of those whose husbands' incomes were under \$20,000, and 45% of those whose husbands had incomes over \$40,000. However, Brayfield (1992) found that unemployed men did no more than 40% of the housework regardless of their spouses' employment status. Hessing (1993) found that female clerical workers frequently altered their own employment routines to attend to sick children or household errands in order to protect the schedules of their spouses, who had more lucrative jobs.

When housework is shared, women are often responsible for such daily routines as meal preparation and laundry, while men take on chores of a

more episodic nature, such as home and car maintenance (Armstrong & Armstrong, 1994; Devereaux, 1993; Hochschild & Machung, 1989; McKeever, 1994). Marshall (1993) observes that:

because of the differences in the nature of the responsibilities, it is usually more difficult to manage the daily household chores in conjunction with full-time employment than to manage the more infrequent repairs, yard work and maintenance. Without a more equal division of responsibility for housework, women will have to continue to juggle employment, household chores, and family time. This, in turn, will leave them more limited time for professional or personal development (p. 14)

Thus, time is a critical resource for employed women as they seek a position of health for themselves amid the demands of home and career, but time studies and population surveys do not fully reveal the challenges women face while attempting this balance (Hernes, 1987; Hessing, 1993). Hochschild and Machung (1989) used findings from their qualitative study of dual career couples to illustrate a state of transition from a more traditional ideology about the gender division of household work to an ideology that emphasises equality and fairness. Where the traditional view prevailed, women retained primary responsibility for household work. The costs of this arrangement were seen in career sacrifices and diminished leisure time for the women, as well as in increased marital conflict and family discord. Only 20% of the couples equally shared household tasks, and, although both husbands and wives in these less traditional families grappled with resultant limitations to their leisure and career pursuits, they appeared more content with their marriages and family lives.

Neysmith (1991) observed that the notion of community based care that has become a prevalent feature of Ontario health policy in recent years merely transfers economic responsibility to the family. But historically, family responsibilities have been women's responsibilities, and this ethic is embedded within the ideology of separate spheres (Anderson & Elfert, 1989; Andrew, 1984; Neysmith, 1991; Ursel, 1992). Women's undervalued work as family caregivers bears a legacy of poverty as women limit their paid activities to attend to the needs of children, spouses, and ill family members (Evans, 1991). Anderson and Elfert (1989) found in a qualitative study that responsibility for managing the care of chronically ill children rested primarily with their mothers. McKeever (1994) found that in a sample of 62 biological and foster mothers of children with disabilities, 30% of the 48 married mothers reported that their spouses gave no assistance with child care, and another 25% that their spouses helped for less than an hour per day. The majority of the women were also solely responsible for household chores (85% for meal

preparation, 65% for meal clean-up, and 77% for cleaning and laundry). The incidence of some physical ailments, such as migraine headaches, was higher in this sample than that found in general population surveys.

It is difficult to calculate the value of women's unpaid work in terms of outcomes such as family health, but attempts have been made to attach monetary values to the work itself. Chandler (1994) estimated from 1992 General Social Survey data that the replacement value of household labour done by women, based solely on the cost of paying other individuals to do domestic work, care of household members, and shopping, ranged from \$26,310/year for women with children under age 5 to \$8,260 for those with no children. However, this estimate does not factor in the value of intangible activities such as emotional support, nor does it deal satisfactorily with the overlaps in tasks that mothers deal with in caring for young children while doing housework (Wilson, 1991). These figures are also based on the wages of workers whose activities in the marketplace are considered less skilled and low in status; those familiar with the issues of Pay Equity will recognize that these figures are based on undervalued wages (Armstrong & Armstrong, 1994; Cuneo, 1990; McDermott, 1992). Indeed, Chandler assigns a higher hourly rate to men's activities in the home than to women's because men tend to do heavier maintenance and repair work that requires more skill to perform, therefore the replacement cost of their contribution is higher. Whatever the estimated value of the work, it still remains that women who labour to sustain the health and well-being of family members do not receive any financial reward.

### *Emotional Work*

Within the ideology of separate spheres, rationality is the province of the public world whereas emotionality is relegated to the private domain (James, 1989). The suppression of emotion during the hours of paid employment may be compatible with productivity, but its expression is merely postponed. Armstrong and Armstrong (1994) classify some aspects of women's household work as tension management whereby women "sustain and orchestrate the private implosion of public tension" (p. 125). Some authors argue that this activity can only be understood subjectively and does not lend itself to empirical study (Graham, 1983). However, a small number of researchers have provided qualitative evidence that women consider tension management an important responsibility, and develop strategies for relaxing and soothing their spouses (Gaskell, 1991; Livingston & Luxton, 1991; Luxton, 1980). The theoretical and empirical literature in the areas of social support and caregiving provides additional clues about the emotional activities that sustain the well-being of families.

Although the ideological association of emotional work with women and the private sphere has enabled its dismissal as instinctive or natural, on closer examination emotional work is complex and demanding (James, 1989; Wilson, 1991). The needs of the other must be comprehended and interpreted in order to provide an appropriate and effective response. Within families, it is necessary to consider how the needs of each member will affect the functioning of the group. Finally, emotional labour is often intertwined with other activities and responsibilities, requiring some capacity to pace, organize, and prioritize tasks (James, 1989). Women's own emotional needs may be subordinated to those of other family members.

In recent times, much attention has been focused on social support as a determinant of health. Some authors have recognized the need to study the conditions that foster supportive relationships (Gottlieb, 1990; House, Umberson, & Landis, 1988; Pilisuk & Minkler, 1985), but there has been little recognition of the possibility that a socially structured and gendered division of labour may be one such determinant. House, Umberson, and Landis (1988) implicate recent upheavals around the structure of the family in the waning of supportive interactions, but argue that it is more than simply the end product of the double burden of paid and unpaid work. Pilisuk and Minkler (1985) reason that "if social support is essential to health, then our economic arrangements, our individualistic values, and our dispersed families place large numbers at risk, especially when local communities are unable to provide supplementary assistance" (p. 99).

House and Kahn (1985) note there is some evidence that "relationships with women may be more supportive and health promoting than relationships with men" (p. 83). They also review evidence that marriage is more beneficial to the mental health of men than of women; women more commonly turn to same-sex relationships with friends and relatives for support and companionship. The working mother has less respite from demands for attention and nurturance than her partner does, and the time consuming nature of housework leaves little time for leisure and self-renewal (Belle, 1982; Wilson, 1991). However, some authors have found that the relationships women form during employment hours also serve to bolster and sustain them. Indeed, the satisfaction of successfully providing support to others is a powerful intrinsic reward for women (Wharton, 1993; White, 1993; Wilson, 1991).

Unlike the activities of social support which take place within relationships of mutuality, those of caregiving imply a greater immediacy of need or dependency in the case of one participant with less likelihood of reciprocation in kind (Baines, Evans, & Neysmith, 1991). In either case, there is a dimension of affective attachment, or *caring about*, that encompasses the emotional,



informational, and appraisal support functions; and one of *caring for* that includes the instrumental or tangible aspects of support. This entanglement of emotion and labour, together with normative expectations of women, may lead to feelings of guilt on the part of those who are unable to perform caring work for family or who find the work unpleasant and frustrating (Aronson, 1991; Wilson, 1991). Women who care for children with disabilities deal with a contradictory complex of worry, frustration, attachment, and emotional rewards (McKeever, 1994). Mothers with chronic illness struggle to find a balance between their own health needs as "good patients" and their obligations as "good mothers" (Thorne, 1990).

Turner and Avison (1989) found that in a sample of 947 married adults with physically disabling chronic illnesses, the women recalled significantly more negative events than did men. When asked to enumerate stressful events transpiring within the previous 12 months, the women reported far more negative events that involved significant others instead of simply reporting incidents more central to themselves. The authors speculated that:

the role of married women includes the experience of responsibility for the well-being of family members. Because control over the happiness of others or over events that impinge on such happiness is clearly limited, the adequacy of personal coping skill may be irrelevant to the impact of such events on mental health (p. 453).

Marshall, Barnett, Baruch, and Pleck (1990) describe *contagion stress* as a product of exposure to the problems of others and explain that it is manifested as "worrying about other people's problems, feeling unable to help important others, or blaming oneself for others' difficulties" (p. 269). They found that in a sample of 367 American women who were employed as nurses or social workers, those with higher levels of contagion stress, burden from social network caring, or costs of caregiving at work had significantly poorer mental and physical health than did the other women. Women who had high scores in more than one of the three dimensions of emotional involvement exhibited the poorest mental and physical health.

Thus, although the physical and emotional work of women may sustain the health of others, the conditions under which they labour may exert an influence on their own well-being. Although the domestic workload of women is undervalued, time consuming, and tediously cyclic in nature, a powerful emotional dimension simultaneously obligates and rewards them. The nature of the work that women perform in employment reveals some continuities in the gendered division of labour in the home and in the labour force.

### *Women's Waged Work in the Labour Force*

In 1991, 45% of all members of the labour force were women and 60% of women over 15 years of age were employed or actively seeking employment (Armstrong & Armstrong, 1994). Over 60% of all married women participate in the workforce (Phillips & Phillips, 1993). Although the dramatic increase in women's employment has been attributed to the influence of the women's movement since the early 1960s, some authors are quick to point out that most women work out of economic necessity rather than choice (Connelly & MacDonald, 1990; National Council of Welfare, 1990). The Keynesian model of full employment featured the notion that *men's* wages ought to be adequate to meet the living requirements of their families. Since the end of the post-war economic boom in the early 1970s, there has been a continuing erosion of the "family wage" for men, as well as marked increases in unemployment; during this period, the contribution of women to family well-being has been extended to include wage earning (Armstrong & Armstrong, 1994; Pascall, 1986, 1993). Other authors have noted that eligibility for social benefits such as the Canada Pension Plan and employer sponsored dental and drug plans serve as an additional incentive for women to participate in the labour force, accepting the extra burden of work as the short-term payment for long-term financial security (Phillips & Phillips, 1993; Wilson, 1991).

Some critics of the feminist perspective blame men's unemployment on women's increased labour force participation, but the Canadian labour force is characterized by marked horizontal (occupational) and vertical (hierarchical) gender divisions. Horizontally, women entering the workforce have predominantly concentrated in a narrow range of service industries where the demand for inexpensive, flexible labour power has increased dramatically (Armstrong & Armstrong, 1994; Phillips & Phillips, 1993). Approximately 80% of female workers are employed in labour-intensive service occupations, and are particularly concentrated in the public sector where the "fiscal crisis of the state" has recently generated cutbacks in services, wage freezes, and loss of jobs (Marchak, 1987; Phillips & Phillips, 1993). Work intensification is another solution to fiscal shortfalls that further erodes the prerequisites of women's occupational health. Finally the clerical, service, sales, teaching, and health care positions that women occupy in the labour force emphasize the needs of others and have been gender-typed as women's occupations (Armstrong & Armstrong, 1994; Belle, 1982; Hochschild, 1983; Wilson, 1991). Physical and emotional care are as predominant in women's paid employment as they are in the home. Smith (1990) explains that, in the labour force and in the home, women deal with the concrete and particular details that form the foundations for the more highly rewarded and abstract work of others. For example, nurses do the vital work of physical and emotional care that enables physicians to pursue their own better paid activities.

In many industries, work is vertically divided according to gender: Male dominated occupational groups within job hierarchies are better rewarded than female dominated ones, and technical skill is better recognized than interpersonal skill (Armstrong, Choiniere, & Day, 1993; Butter, 1985; Cuneo, 1990). Furthermore, women who work within male dominated occupations and professions such as medicine earn less than their male counterparts (Armstrong & Armstrong, 1992). Although this is often partially attributed to the conflict between the burden of women's larger share of family responsibilities and the demanding nature of many areas of professional practice and education (Armstrong & Armstrong, 1992; Butter, 1985; Wilson, 1991), it is also suggested that women may be marginalized by an incomplete indoctrination into the political subtleties of an occupational subculture (Atkinson & Delamont, 1990). Furthermore, the time constraints introduced by the double burden of employment and family responsibilities make it difficult for women to participate in the activities of unions or professional organizations. Therefore their perspectives are often missing from negotiations with employers (Armstrong, 1984; Gannage, 1986).

The incompatibility between the structure of employment and the responsibility for family well-being is a pervasive issue for women. In 1991, Canadian women were no more likely than men to be absent from work due to illness, but lost an average of 17.5 days of work because of personal responsibilities in comparison to 3.9 days lost by men for similar reasons. Women were more likely than men to quit work to attend to personal responsibilities (Phillips & Phillips, 1993). Only 29% of the mothers of children with disabilities in McKeever's (1994) sample had some form of paid employment, and those who were not employed were reluctant to add a job to their already heavy family responsibilities. Not only is part-time work often preferred by women who seek to balance career and family demands, employers in many fields have found that the flexibility of part-time workers as well as their lower salary and benefit costs are an advantage in a climate of economic uncertainty. While part-time work may be a boon for the women who choose it, others are forced to accept it because nothing else is available (Phillips & Phillips, 1993).

In 1991, women's full-time earnings approached 70% of those of men (Canadian Social Trends, 1993). Pay Equity legislation has been introduced in recent years, but implementation has proven problematic in the Ontario experience and has been marked by expensive legal struggles between women and their employers (Cuneo, 1990; McDermott, 1992). Restraint programs in the public sector such as wage freezes, contract rollbacks, and unpaid leave have diluted progress towards fair remuneration. Anderson, Blue, Holbrook, and Ng (1993) showed that female immigrants who belong to ethnic or racial minorities must often settle for poorly paid, less flexible forms of employment

that conflict with their personal health needs. Women of colour, and those who are not fluent in English or French are among the lowest paid workers in Canada (National Council of Welfare, 1990). When these women belong to unions, they are often prevented from fully contributing their views by language barriers or culturally-embedded attitudes regarding femininity (Gannage, 1986).

Older women and female heads of lone-parent families are also at particular risk in this climate of wage inequity. Approximately one-third of all Canadian marriages are destined to end in divorce or separation, and including unmarried and widowed women, 84% of all women can expect to spend a significant portion of their lives without a partner (Phillips & Phillips, 1993). Although the wages and labour force participation of younger, better educated women have improved in recent years, older women who have returned to waged work after years of absence remain concentrated in less skilled and poorly paid occupations (Phillips & Phillips, 1993). Because the accumulation of pension entitlements is linked with years of labour force participation and the amount of wages earned, these older women are penalized for their years of unpaid work as homemakers and caregivers (Evans, 1991; Wilson, 1991). Single mothers, too, are at risk of poverty; in 1986, 44.1% of all single mothers had incomes below the poverty level in contrast to 9% for all couple families (Phillips & Phillips, 1993). For those single mothers who were employed on a full-time basis, the incidence of poverty was 25.7%, while poverty rates for those engaged in part-time employment and those dependent on welfare benefits were 75% and over 90%, respectively (Phillips & Phillips, 1993).

In summary, the above description of the everyday working lives of Canadian women leads us to question the adequacy of these arrangements in meeting the prerequisites for women's health. As Pascall (1993) points out, women are not as free as men to avoid unpaid labour, with the result that they have less time available for personal and career development. Women are bound to unpaid work by emotional and ideological obligation, and may seek to protect the financial welfare of the family by facilitating the more highly valued and better rewarded market activities of their spouses. Thus, the health prerequisite of time for personal growth and leisure is in short supply for women, particularly those who balance paid employment and family responsibilities. Because of their lower wages, most women are less able than men to afford the necessities of life, and many authors have observed that marriage remains an important economic boon to women in the current economic context (National Council of Welfare, 1990; Pascall, 1993). Women who belong to ethnic and racial minorities, single mothers, and retired or widowed women face financial hardship with the present structure of remuneration and social benefits. An adequate income is therefore another prerequisite of health that is less accessible to many women than it is to men.



Equity, or recognition of the value of women's contributions in the home and in the labour force, is another prerequisite of health that is not adequately met. Although some women's professions such as nursing and teaching have recently achieved greater recognition, largely through the efforts of their female dominated unions and professional organizations, others are afforded poor social status and acceptance because they are viewed as "unskilled" work. The complexity of skill and knowledge gained through experience and everyday activity remains largely unrecognized within the current discourse of science, therefore the paid and unpaid work that women pursue is poorly understood (Smith, 1990). Using Pascall's (1993) framework of citizenship requirements as a yardstick, many Canadian women are lesser citizens; their basic human needs or prerequisites of health are often poorly dealt with.

In the final section of this paper, I will examine examples of how Canadian social policy reinforces women's state of lesser citizenship, and consider the position held by women's activities within the economic structuring of our social order.

### Contextualizing Women's Work Within Canadian Social Policy

The continuity between women's paid and unpaid labour is intensified when this work is reframed within the context of the welfare state. Here, discussion of welfare policy goes beyond the notion of social benefits, to all aspects of state policy that affect social welfare, including such elements as health care, labour issues, education, and day care. Feminist and critical welfare theorists have argued that women are powerfully affected by policies in this area by virtue of their involvement as employees in the public sector areas of health care, education, and social work; as clients receiving social benefits; and as consumers of public services (Borchorst & Siim, 1987; Drover & Kerans, 1993; Eichler, 1988;). Historically, women have also been active in shaping Canadian public policy (Andrew, 1984; Ursel, 1992). This intricate set of relationships is summarized by Hernes:

To the extent that the welfare state's "crisis" is regarded as *financial*, women will be affected more than men by attempts to solve the crisis through budget cuts. To the extent that the "crisis" is regarded as a crisis of *legitimacy*, it is women who, through their demands and their support, can maintain belief in the state as opposed to the market as problem solver. If one regards the "crisis" as mainly a problem of governmental *overload*, women will be affected if one solves the problem by transferring services back to the family and to the market, a process which would affect women as employees and clients (1987, p. 80).

The state is caught between the contradictory tasks of maintaining its legitimacy as "the ultimate guarantor of societal promises" in the estimation of the electorate (Drover & Kerans, 1993, p. 20), and safeguarding the accumulation of capital in the market realm (Drover & Kerans, 1993; Ursel, 1992). For example, Pay Equity legislation served as a mechanism to legitimize the state in the view of women voters, yet the difficult wording of the legislation placed the onus on women to expend considerable time, money, and energy in the pursuit of its implementation (Cuneo, 1990; McDermott, 1992). As Drover and Kerans (1993) point out, the claims of dominant groups are rarely challenged because the basis of these claims are already aligned with prevalent attitudes and norms. On the other hand, the claims of subordinate groups challenge this established order by demanding a new system of social identity. In struggling for fair implementation of Pay Equity, groups such as the Ontario Nurses' Association were forced to deal with the embodiment in legislation of the socially embedded, androcentric definitions of such terms as *work*, *skill*, and *knowledge*. These biased definitions permeated the very measurement scales used to compare and assign value to the work done by men and by women (Butter, 1985).

Within the current discourse of scarcity, Evans (1990) notes that cost containment efforts within the Canadian health care system generate struggles between groups that seek to increase their profits and raise costs, and those that attempt to resist increases or transfer costs to others. The path of least resistance is an attractive one, he argues: "Transferring the burden of costs to some other individual or group is equivalent to reducing it...and may be a great deal less stressful managerially and politically" (p. 102). The deinstitutionalization of care for the chronically ill and elderly, as well as the transfer of some aspects of acute care from the hospital to the community has been accomplished in alignment with the ideology of separate spheres. Normative conceptions about the home as a site of restful relaxation and the family as the locus of mutual help and caring inform the notion of family care and encourage its acceptance (Anderson & Elfert, 1989; Drover & Kerans, 1993; Neysmith, 1991). Yet this same ideology subtly prompts women to accept the burden of family care, while the isolation and intensity of this work discourages the organization of similar women into interest groups to resist the transfer of care.

The women who shoulder the burden of cost containment in health care or who interrupt their careers to raise children face a legacy of poverty or lost income, as well as immediate restrictions to personal time and space (Evans, 1991; McKeever, 1994). Women are not paid for these services, and unemployment and retirement benefits are indexed only according to participation in the paid labour force under the implicit assumption that paid employment is the only valid form of "work". The adverse effects of poverty on health have

been documented (Black, Morris, Smith, & Townsend, 1980; Lundberg, 1993). Recently it has been found that there may be a positive relationship between economic status in adult life and health (Lynch, Kaplan, Cohen, Kauhanen, Wilson, Smith, & Salonen, 1994). That women experience an excess of physical morbidity and affective disorders in comparison to men has been documented, but a satisfying empirical explanation has not been found (Popay, Bartley, & Owen, 1993; Verbrugge, 1989). The ideology of separate spheres may mask the long-term costs in poverty and chronic poor health that women incur as they absorb the burden of costs transferred from social institutions that operate within the formal economy.

Smith's (1990) observation that the bulk of women's paid or unpaid activities enable others to pursue more highly valued and abstract work is particularly powerful when combined with Illich's (1981) analysis of "shadow work." Illich argues that an informal, parallel economy supports the formal, market-based economy; this shadow economy is based on activities and social relations that sustain and reproduce the labour force so that productivity is maintained. No estimate of Gross Domestic Product incorporates the value of shadow work, but the vitality of the shadow economy is crucial to the success of the formal market economy. Smith (1993) also argues that current ideas in welfare theory and policy fail to recognize the networks of social relations organized around human subsistence. From the earlier-mentioned analysis, it is clear that women are key actors in these networks of shadow work. Their work in the home sustains the health of the labour force and contributes to the socialization of a new generation of workers. Women actively ensure that men are free to participate fully in their better rewarded jobs. Women serve as an inexpensive pool of labour whose need for flexible employment arrangements often compliments fluctuations in market requirements. Current wage inequities for women favour capital accumulation, or at least cost containment. Finally, women buffer the formal economy from increasing health and social welfare costs by absorbing these costs into the shadow economy.

### **Conclusions**

The above analysis of women's working lives has many implications for nursing research and practice. First, several target groups of women have been identified as at risk for poor health because the prerequisites of health are compromised among them. Yet no reader will be surprised by the identities of these groups, not only because we have considered their needs frequently in our capacities as health care workers and researchers, but because the majority of nurses are women who have experienced similar conditions. Many nurses are, or can expect to be, members of dual income families, single mothers, retired women, women who belong to racial or ethnic minorities, women who are providing informal care for family members of all ages, or

women who are employed in labour intensive occupations where cost containment has produced additional burdens and frustrations. Indeed, many nurses hold more than one of these identities and can expect to hold others as their life circumstances change. Therefore, most will understand the need to consider in our research and practice the cumulative effect of multiple working identities on the prerequisites of women's health and well-being, as well as women's needs in relation to specific identities or situations.

Secondly, as implied by West's (1993) ethnomethodologic definition of gender, research is needed to examine how activities are coordinated around specific events or problems, such as care of a chronically ill family member. Consideration of the social conditions (normative conceptions about appropriate activities for either gender, for example) and material conditions (such as available financial resources) would be part of the analysis of how work is negotiated among members of social groups. Such studies would describe the actual work involved, as well as the way in which the division of labour is negotiated among those involved in the process. By describing the extent and nature of women's work in specific instances, a clearer understanding of the knowledge and skill that is embedded in everyday activities would be achieved. This description would also shed light on the many ways that women's work can affect their own prerequisites of health and those of others. An analysis of the division of labour around specific events or problems would necessarily include all of the actors involved in the process, from women and their families to others such as health care workers. Because everyday activities that affect health are often enacted in contact with the health care system and associated professionals (Smith, 1987, 1990), analysis of the influence of these contacts on women's activities and health will assist nurses in expanding and refining approaches to care.

Finally, as Borchorst and Siim (1987) point out, workers in female dominated occupations within the public sector are in a unique position to advocate for their female clients. As nurses, our understanding of the health implications of women's work, our strong professional organizations and unions, and our links with the research and policy communities situate us between the realities of women's experiences and the social institutions that exert a powerful influence on the prerequisites of women's health. The increasing politicization of nursing is a positive trend that has introduced a new perspective to health policy. Within a climate of cost containment through shifts to alternate models of health care, it is essential to the well-being of women that we urge attention not only to short-term cost containment, but to the long-term personal and health costs of reorganization. These efforts will be strengthened by research documenting the activities and circumstances of women as they attend to their own health needs and those of others.



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