

# *Bringing it Home: Women's Health Work*

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*The current paper addresses the past and present issues in Canadian health care, paying particular attention to the gendered implications of that care. Starting from an analysis of the theories and practices of health care in 1960s and 1970s, the paper summarizes the debates in the division of labour, women's changing role in the paid labour market/their segregated work and the unfolding interest in violence in the household. In the second section, in addition to the continuing debates, the critique of what the second wave feminist movement has missed is identified. Most particularly, the debates about the diversity amongst women themselves as representing different classes, races and abilities and how their role as receivers and providers of care is configured by their various locations and relations are highlighted. The beginning of the 2000s has brought some new issues such as increased privatization of health care as well as insecurities and precariousness of paid work. Moreover, there remains the continuation of older issues such as gendered inequities in non-paid work, violence and increasing disparities amongst women themselves. Looking for the future, the authors suggest the need for an 'active state' which is democratic, responsive, equity seeking and service providing, as well as one that assures meaningful employment. Otherwise, the cost of care will be unbearable in social/economic terms, as well as in relational terms for women who deliver/are expected to deliver a major chunk of health work.*

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The discussion in this paper will be divided into four parts and sets out some issues and ideas for further discussion and debate. It is based on our research and activism that has been primarily focused in English Canada. We also hope that what we discuss will have some resonance for those from elsewhere in the industrialized North. We will not make the assumption that the Canadian experiences are automatically applicable elsewhere. Indeed, we begin with the assumption that 'context' always matters.

The first part of the paper is about the central theory and research that shaped not only most collective academic approaches to women, health, homes and households, but also some practices in the 1960s and 1970s. The second part is about changes in women's work and health during the last part of the twentieth century as well as about critiques of academic approaches developed earlier in the postwar period. The third part is about current conditions and the need for a revival of earlier ideas. The fourth and the final section looks into the future and provides suggestions for what needs to be done.

All of the discussion is framed by a feminist political economy perspective, which assumes that the political and economic are intertwined in ways that establish the conditions for, but do not determine

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people's actions. The paper is also framed in a way which allows for only a brief outline rather than a layered exploration, to stimulate further discussion and explorations.

### CENTRAL THEORIES & PARCTICES: 1960s – 1970s

A central theme in early second wave feminist writing was the public/private divide. This was understood as a division between household and formal economy, one which left women and their work *Hidden in the Household*, to use the title of Bonnie Fox's book (1980). Hidden in the household were both work and violence, factors seen as contributing to and reflecting women's subordinate position throughout society.

During the 1960s and the 1970s, there were great debates about whether this unpaid work of women was productive in the Marxist sense or not. While the debates were never settled, it became clear that women made central contributions through their unpaid labour and that this unpaid labour reinforced their low pay and status in the paid work force, which in turn limited their power at home. Our examination of *The Double Ghetto* (Armstrong & Armstrong, 1978) was just one example of efforts to establish empirically and theoretically the nature and conditions of women's segregated work. The time-use studies of household labour that helped make this work visible focused primarily on domestic work and childcare, with some analysis of sex/sexuality. More than one feminist recalled Engels' (1963[1884]) line about a prostitute selling herself by the hour and a married woman doing so for life.

The women's health movement also grew during this period. *The McGill Birth Control Handbook* (1968) gave birth to a series of pamphlets on women's health intended not only to empower women, but also to change the practices of others. The Montreal Health Press that followed, along with women's health organizations across the country, worked to bring women's health out of doctors' and legislators' control and into women's hands. They promoted health and critiqued the medical model in health care. Along with more theoretical explorations such as those by Canadians Roberta Hamilton (1978), Mary O'Brien (1981) and Charnie Guettel (1974), they made women's bodies central to debates. As we argued then, although women's bodies unite them in many ways, class plays out through those bodies in ways that are evident in differences in the experience and consequence of giving birth.

One strand in the earlier debates was about making women equal to men and about establishing similarities with men. Another strand emphasized differences and the need for special treatment. Class differences among women became a question for exploration, with some arguing that women formed a class *qua* women and others emphasizing significant differences among women. One strand advocated more private

choices for women, as reflected in the pro-choice position on the private issue of women's self-determination concerning abortion. Another strand sought to use public means to restrict choice, such as in the efforts to develop and enforce laws against domestic violence, although here too the related shelter movement was and is a device for temporarily expanding choice for abused women and their children.

Carol Bacchi's insightful book *Same/Difference* (1990), helped persuade us that women could demand both equal and different treatment, while remaining consistent in our understanding of women's rights and interests. We would add that this is also the case with simultaneously promoting private choice in the case of contraception—what former Canadian Prime Minister Pierre Trudeau called 'keeping the state out of the bedrooms of the nation'—and public intervention in the case of violence in the home. At the time, women's health movement tried appropriately to demand it both ways.

Missing from much of early second wave feminist theory and research was women's unpaid care for the elderly and the disabled and the health hazards that women faced in female-dominated paid and unpaid work in particular. Later, there were glimmerings from prescient people like Harriet Rosenberg (1990), Jeanne Stellman (1978) and Karen Messing (1991), but their research was central neither to academic debates nor to action. At work was *One-Eyed Science*, as Messing (1998) on put it. Also missing from the research was much exploration of the oppression related to racialization, age, sexuality and physical location.

To summarize the efforts in this important era, feminists in the Canada of the 60s and 70s made women's work and health in and outside family relations and the location and relations involved in both, central to debates and research. They did so during a period of unparalleled growth both in women's labour force participation and in public services. These services provided women with jobs and support while women's collective and individual efforts helped improve their conditions of work in and out of the paid workforce. It was far from a perfect time for all, but there were many improvements for many women.

### CHANGES IN WOMEN'S WORK & HEALTH: 1980s – 1990s

The focus of the earlier efforts began to change in the 1980s. The state came under attack from the increasingly dominant neo-liberal forces operating at all scales. 'Steering, not rowing' became the mantra for the ship of state, with states withdrawing from social supports while enforcing paid work to ensure markets operated in everything.

The growth in labour force participation rates for women nonetheless slowed appreciably, as did their rates of unionization. While women's participation in higher education continued to grow, state finan-

cial support for that participation shrunk, in relative terms. This forced more and more female students into debt. Although male students also became more indebted, this was a less serious problem for males, given the higher pay they typically received while at college and could anticipate upon graduation. Young couples often had to wait to start their families until their debts were paid.

New technologies helped alter old patterns of segregation in the paid workforce, without eliminating segregation itself. Likewise, the old divisions between the public and private spheres shifted and blurred, again without being eliminated.

Publicly-funded health care became increasingly defined as a problem rather than a solution, especially in terms of hospital care. Ideas promoted by the women's health movement were paradoxically used to justify sending women home almost immediately after giving birth and critiques of the public system were used to justify the withdrawal of psychiatric care. Canadians were warned that public care is both abusive and abused, especially for and by women and is too expensive. We were exhorted to take responsibility for our own health and, if one happened to be a woman, for the health of her family and friends as well.

The women's movement also experienced a slow decline, at least in terms of its most public face. Some of the most visible forms of what was usually called discrimination seemed to be addressed with women's increasing participation in education and the labour force and with laws supporting equal pay and prohibiting harassment. Women's studies became an established part of academe and equity officers sprouted in corporations and university settings.

As suggested above, the women's movement was criticized from within for failing to make racialization, disability, sexuality and physical location central to its concerns. It was denounced for being essentialist, sometimes for even speaking about the category woman and for thinking in terms of dualisms and universals.

Indeed, it was forcefully and properly made clear to second wave feminism, which was at first largely located within middle class and educated circles, that in its failing fully to embrace diversity, the women's movement itself was part of the problem, not part of the solution. As was more clearly conceptualized later, drawing respectively on Deborah Stone in the US and Miriam Glucksmann in the UK, a gender-based analysis must involve both lumping and slicing. It must analyze and act upon both the commonalities and the differences women face and do so in full recognition of the oppressions that pervade both these commonalities and these differences.

These critiques, along with developments in women's material lives, promoted more sophisticated theory, research and action. In theorizing, differences and inequities among women themselves became more

central. We began to explore, for example, differences within the formal economy between jobs in the public and private sectors. Caring work was increasingly examined as a complex issue for women, one that went well beyond care for children to, for example, persons with disabilities and frail seniors. It was also increasingly understood as a relationship, one that varies over time and usually involves contributions from both the care provider and the person with care needs.

### CURRENT CONDITIONS & NEED FOR REVIVAL: 2000 ON

One consequence of the developments discussed above was a blurring of the public and the private, both in terms of the distinction between the public and private sectors within the formal economy and in terms of the distinction between the private household and the formal economy.

The private sector in the formal economy developed ways of avoiding many of the regulations that had been introduced to promote equity and protect women. Work became more precarious, both in the sense of more jobs being part-time and casual, or classified as own-account self-employment and in the sense of protections against discrimination. Many of these precarious jobs had no such protections, as Leah Vosko (2006) so clearly shows. Lack of childcare and other supports, as well as good old-fashioned discrimination, meant that women are more likely than men to be in precarious work relations.

Capitalistic models were generalized and efforts were mounted to operate states as if they were businesses. In a shift to what is often termed New Public Management, managerial practices were altered. This shift resulted in significant changes in the conditions of work for the primarily female, public sector labour force. The public sector, although far from perfect as a site for employment, had provided women with most of their best jobs in terms of pay, benefits, security, equity with men and protection against arbitrary employer action. This partly reflected the high rates of unionization and it partly reflected ideas about the public sector as model employer, as well as the greater visibility of workplace arrangements in the public sphere.

At the ideological level, Canada had for years prided itself with its public health care. Nevertheless, the increasing adoption of private sector practices in health care meant that some entire parts of the workforce, like the housekeeper and dietary workers in British Columbia, saw their work contracted out to private sector employers. In the process, as Marjorie Cohen and Marcy Cohen have shown, these workers lost most of their union and public protections, along with half their pay and all their benefits. This form of privatization disproportionately affected immigrant women and those from racialized groups, especially in urban

areas.

For those who remained with public sector employers, the work became more precarious as more were hired on a part-time and casual basis. For those with more permanent employment, more of the work became more intensive. Women struggled longer and harder to make up for the care deficit, often doing so on unpaid overtime and through compulsory volunteerism (Baines, 2004). As Kate Laxer and Pat Armstrong (2006) have shown, divisions among women working in health care increased. This was especially the case between those defined as professional and those defined as ancillary. Under such conditions, it is not surprising that violence towards health care workers has increased, that they have the highest rates of work-related illness and injury of any industry and that immigrants see their health deteriorate in the decade after they come to Canada.

The love affair with markets and for-profit practices in health care has also contributed to a shift of care work to the home. So have the new technologies that make it possible to send people home from hospital quicker and sicker. The assessment that institutional care is bad for everyone, as many feminists have been vocal in expressing, has also contributed a different layer of complexity for the overburdened women carry as care-givers. The following points reflect some of the dimensions in this complexity, as they have materialized in the Canadian health provision scene:

1. More work for women, who provide the overwhelming majority of unpaid personal care and often greater stress on household relations. The additional work and stress are mounting, on them and on their households, despite the fact that men are taking on more unpaid work at home.
2. More violence hidden in the household, violence against both those who need care and those who provide care, whether paid or unpaid.
3. Increasing disparities among women and households, because some can afford to pay for substitute care and can create homes that are havens in heartless worlds while many have no homes or homes that are poor places for care.
4. More precarious employment for women who provide unpaid care and, often, an undermining of efforts to make the skills of caregiving visible, since it is assumed that any woman can do the care work. The shift to the home is not a matter of sending care back home. Our grandmothers did not insert catheters and IVs. But now that such care is being taught to unpaid providers in brief sessions, the skills of both teachers and providers are devalued.

5. The private home is no longer private in the sense of the state increasingly entering the bedroom to determine if care is required and, literally, in the form of some paid care providers.
6. Within the hospital and long-term care facilities, there is an even greater emphasis on the medical model, with care defined exclusively in terms of cuts and chemicals there.

It is surprising, if not alarming, that there have been few feminist voices raised recently to question, much less to resist, the massive movement of care into the home. This silence occurs despite the complaint of many women, reported by the National Forum on Health (1997) a decade ago, that they were being 'conscripted' into providing home care. This silence is despite the earlier feminist concerns about women's subordination, about sex segregation at work, especially women's hidden work in the household, about violence against women, about choices, about women's health, about the medical model and about the same/difference tension. Indeed, as Nancy Guberman (2004) explains, many characterize facility care as always bad and homes as always good, suggesting clear dichotomies. We would add that this polarized characterization stands in direct contradiction to old feminist claims about homes not being havens in a heartless world for many women.

While feminist voices in and out of the labour movement are being raised about issues related to precarious paid employment, few gains have been made in terms of protecting the paid and unpaid workers in home care, or in terms of reducing inequities among women, inequities that have a critical impact on their health. We argue that it is time to revisit some of those old feminist concerns and apply them to the new contexts in order to create strategies for change within the emergent Canadian realities.

### **WHAT NEEDS TO BE DONE: LOOKING TO THE FUTURE**

We contend that such developments set the stage for exploration of new ideas about what needs to be done in research, policy and practices.

1. We must begin with the recognition that context matters and context is important at the international, national and local levels. We must explore the ways these contexts structure the possibilities and limits for families, for women and for care.
2. The notion of public and private still needs to be central to our analysis. More than ever, we need to understand both their interpenetration and the ways the lines between them blur in the current times and in particular places. And we need to expose the

consequences of this blurring for families, for women and for care.

3. We need to make complexity and contradiction a mainstay in our analysis, recognizing tensions in order to balance them and avoid the dichotomous thinking of the past. Within the health context, this means constantly asking for whom, where, when, at what cost for whom. There needs to be analytical vigilance in defining costs broadly to include such aspects as stress, time, relations, lost paid employment, discrimination and oppression, opportunities that emerge or get lost now and in the future. This also requires due recognition of factors such as class, race, sexual and other inequities and the need to address such inequities in structural as well as legal and educational terms. We need standards rather than standardization that balance professional skills with individual choices. We also need to balance responsibility and risk, rather than simply shifting them to individuals and mostly to women. This balance does not simply mean shifting more responsibility to men but also balancing individual and family responsibilities with those of employers and the state.
4. We must examine health hazards in paid and unpaid work, as well as the consequences they have not only for each other and for the individuals who do the work, but also for their household and relations. We can do so effectively only if we bring to bear a gender lens, as well as one that recognizes other social locations and power relations as well as connections between households and formal economies. When we asked, in our interviews with long-term care workers, what was the impact of all this intensification on their life at home, one said: 'No sex'. As a society and as individuals, we must make sure to recognize violence as a health hazard.
5. We need to interrogate notions of choice, making sure we understand the structures of inequality and the relations of ruling that often challenge any possibility of choice. We also have to examine the extent to which options are available and examine the nature of those options with a view to making them better, as is the case with hospital and long-term care. If we understand care as a relationship, we must focus on the conditions both for care providers and for those needing care. Creating the conditions that respect the fact that care work, whether paid or unpaid, is a relationship, means taking into account the needs of both care providers and those to whom they provide care. We need to provide adequate care at home for all who need it under terms of their choosing. As Canadians who do regard health care as a social right that defines us, we need to make care affordable to all who need it and ask: Can we afford not to care?



## CONCLUSION

The discussions so far point to a need for a new vision, to deal with the changes and the realities in the 21<sup>st</sup> century. However, we must not overlook the insights that have been accumulated since the 1960s, since some of the earlier debates are increasingly becoming meaningful again, albeit in slightly modified ways. To conclude, we will borrow a term from Jane Aronson and Sheila Neysmith (1997, p. 37-66) and call for an "active state". More precisely, we have in mind a particular kind of active state: One that is thoroughly democratic; that actively seeks gender and other forms of equity; that serves as a model employer providing good pay, benefits, conditions and employment security; that actively promotes health, healthy households and healthy communities; that renders more visible, indeed that celebrates, the vital and skilled care work that we need both in public facilities and in private households. The gender sensitive research agendas of social scientists can contribute to the realization of these worthy goals. In our view they should!

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