MARITIME CENTRE of EXCELLENCE for WOMEN'S HEALTH

Nova Scotia
Advisory
Council on the
Status of
Women

A Healthy Balance

A community alliance for health research on women's unpaid caregiving

---

Thinking It Through:

Women, Work and Caring in the New Millennium

Pat Armstong, PHD
Department of Sociology
York University
Toronto, ON

Hugh Armstong, PhD
School of Social Work
Carleton University
Ottawa, ON

PO Box 745
Halifax, Nova Scotia
B3J 2T3 Canada

Telephone 902-424-7392
Fax: 902-424-0573
healthy.balance@dal.ca
www.medicine.dal.ca/mcewh

The Healthy Balance Research Program is Funded by the Canadian Institutes of Health Research, and is supported by Dalhousie University and the IWK Health Centre.

DALHOUSIE University

IWK Health Centre

This paper was funded by the Healthy Balance Research Program, through the Canadian Institutes of Health Research, Maritime Centre of Excellence for Women's Health (MCEWH) and the Nova Scotia Advisory Council on the Status of Women (NSACSW). It expresses the views and opinions of the authors and does not necessarily reflect the official policy of the MCEWH or NSACSW, or any of its sponsors.

TABLE OF CONTENTS

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

EXECUTIVE SUMMARY

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.

"Thinking It Through" draws on both Canadian and international literatures to help understand the forces, structures and relationships that construct women as carers and undervalue care work. The purpose of this analysis is to develop guidelines for thinking about caring. It is designed as a companion piece to "One Hundred Years of Caregiving in Canada."[1] Based on the Canadian research on care giving among adults, that paper outlines what kinds of care are provided and who provides different kinds of care, leading to a framework for assessing policy. The guidelines set out here should be combined with that framework in order to understand and assess women's caring.

What, then, do guidelines for understanding women's caring look like?

First, **they 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.

At the same time, there are fundamental differences among women linked to their time and their economic, social, political, racial, cultural and physical locations. Understanding these differences requires us to take a range of approaches or slices. Slicing not only adds a recognition of differences among women, it also adds the possibility of developing different views of the same issues, circumstances and evidence.

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.

Second, **analyses of women's work should locate women within both their general and their specific environments**. Globalization, changes in the nation state, the increasing emphasis on markets, communities and families all establish contexts for women's work. Contexts also include notions about these, as well as 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, although the role they play is frequently contradictory and shaped by human hands, including those of women.

In spite of notions about inevitability, globalization and changes in the Canadian state are about processes that result from actual decisions and practices rather than from forces beyond human control. Canadians 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 and 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 and what is private in the sense of being outside the formal economy. The benefits and negative consequences 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 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.

The market mechanisms that have become so popular with governments 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 while increasing inequality and sending more care to communities.

Like globalization, communities have a variety of meanings, including not-for-profit and for-profit organizations as well as friends and neighbours. When we talk about sending care to communities, we most often mean to families and, within families, to women. But sending care to the community may mean undermining those communities and does not necessarily mean more local participation or control**.** And it 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.

Third, **it is necessary to examine the ways globalization, states, markets, communities and households penetrate and structure each other, each influencing how the others operate.** While the period following World War II 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, 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 at the same time as more rigid lines are drawn in some areas in order to reduce public support. Therefore, it is important not only to see how these sectors influence each other but also to see how the ways they influence each other are changing over time and with regard to place.

Fourth, **critical questions need to be asked about who pays for care, and at what cost to which women**. Funding and payment are about much more than the money, and costs are about much more than payment. How payment is made, under what criteria and for what care are issues that have significant consequences not only for access to care but also for caregiver costs.

Fifth, **it is important to explore questions about the time and locations of care**. Where, when and for how long is care provided? Social, cultural, racial, physical, age, sexual and psychological locations all have an impact on the nature of the work needed and provided. Although this paper raises only some of the issues related to space and care, they should be sufficient to show that physical location must be taken into account in understanding care. Time interacts with space, and like space, it is about social relations. But when time is money, care as a relationship may be sacrificed. 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.

Sixth, **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 decision-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 and social support. The more resources are distributed by market mechanisms, the greater the disparities in resources, and thus, in power.

Finally, **care needs to be understood as the objective, not the problem**. It 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 care.

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

The American feminist Deborah Stone, an eloquent analyst of women's caring, talks about being a "'lumper' rather than a 'splitter.'"[2] For "lumpers," the emphasis is on what is common about women's work, on what women share. At the same time, there remains in her publications a clear recognition of tensions and differences. Miriam Glucksmann's revealing analyses of British women's work speaks of "slicing" data, theory and concepts to create multiple and complex pictures of particular peoples in particular places.[3] Her purpose is to look at the various ways work is divided up within what she calls the "total social organization of labour."

This paper is about both lumping and slicing. It attempts to explore what is common, not only among women but also across time and space. At the same time, it seeks to examine different slices of the same questions. Such slices are meant to help expose the complex and contradictory nature of the concepts we use in considering women's work and of the current state of women's work. It assumes that contexts and locations matter, and that while women face considerable pressures from forces outside their immediate control, they also are active participants in shaping their own lives.

Why Lump?

Everywhere throughout recorded time, there has been a division of labour by gender. Every society we know about has defined some work as men's and some as women's. And every society we know about has made distinctions between what women can and should do. Women have primary daily responsibilities for children and for the sick or disabled, as well as for much of the other work in domestic domains. They do most of the cooking, washing, cleaning, toileting, bathing, feeding, comforting, training for daily living, shopping and planning for domestic consumption and care. And it is women who bear the children.

This division of labour is combined with a gap between average male and female wages. Jobs mainly done by men pay more than those mainly done by women. Women are much more likely than men to work part-time or part-year and to have interrupted career patterns or casual, temporary jobs. When self-employed, they are much less likely than men to employ others. And much of the work women do pays no wage at all.

Feminists have long been struggling to make the full range of women's work both visible and valued. Lumping has allowed them to do this. They began in the early 1960s by focussing on domestic labour, understood as the unpaid work women do in households, and by revealing the institutional and social arrangements that combine to produce systemic discrimination in the paid workforce. Initially, the emphasis was on what was termed the reproduction of labour power on a daily and generational basis. This meant having babies and providing for their needs, along with those of their breadwinning fathers. As the research on women's work expanded, the picture of this work became both more refined and more complex. More categories of work, such as care for the elderly, the sick and the disabled, appeared in the literature. Then this care category, too, was further refined to include care management, assistance with daily living and personal as well as medical care, and it came to be seen as a relationship rather than simply as a work category. Similarly, the picture of women's work in the labour force was further developed to encompass the detailed division of labour found within occupations and industries and the nature of workplace relationships. Within the formal economy outside the home, working in the public sector was distinguished from the private sector, and then this private sector itself divided between the for-profit and the not-for-profit, or what came to be called the third sector. Within this not-for-profit sector, women's work as volunteers was distinguished from their paid employment. Locations in the underground economy, where women worked for pay as cleaners, prostitutes, babysitters and secretaries, and in formal economy jobs that they did in their own homes, also have been exposed.

Lumping also allows us to explore the social, economic and institutional arrangements as well as the policies and practices that contribute to these patterns in women's work. But lumping is not only about processes remote from the individual lives of most women, about abstract concepts or far-away decision-makers. It is also about how women's work is shaped at the level of the hospital, day-care, community centre, clinic, home and office; about the fine divisions of labour; the ways policies are played out in daily lives and the ways women act to create spaces in their own lives or to limit those spaces. So, for example, lumping allows us to ask what kinds of caring work women and men do, and what kinds of government funding support or undermine this work.

Lumping, then, is appropriate because there are so many common patterns in women's work. Lumping allows us to see what women, as women, share, in terms of the nature of both the work and the work relationships. It also helps us to expose the forces that keep these patterns in place and change them.

Why Slice?

Although there is a division of labour by gender everywhere, there is also no common division of labour across time and space and often not even within countries during a particular period. What is defined and practised as men's work or women's work varies enormously, and most cultures have at least some women who do men's work. Moreover, the actual division of labour can contradict the prescriptions or accepted practices. Equally important, there are significant differences among women related to class, race, culture, age, marital status, sexual orientation and spatial locations, as well as for the same women over time.

Once, those paid to do secretarial and teaching work were mainly men; now, most are women. Those paid as chefs are mainly men, while women do most of the unpaid cooking. However, in Canada at least, if the unpaid cooking is done outside on the barbeque, it is men who do the work, but the unpaid kitchen jobs are still primarily left to women. In the USSR, most doctors were women at the same time as North American medicine was dominated by men. The care provided by women in an Bosnian refugee camp differs fundamentally from that provided in a household in Ottawa's exclusive Rockcliffe neighbourhood. While care work is women's work, there are multiple forms of women's paid and unpaid caring. There are also considerable variations in what is defined as women's caring work. Our grandmothers, for example, did not clean catheters, insert needles or adjust oxygen masks as part of the care work they did at home.

There may also be large gaps in both places between what women and men think they should do and what they are able to do. There is, other words, often a gap between practices and ideas about appropriate practices. For example, while most Canadian and British men think they should equally share the domestic labour, there is little evidence that such sharing actually happens in practice. Yet many men who think care is women's work find themselves providing care for ill and aging partners. Many women who provide care do not necessarily think that it is their job, nor do they necessarily have the skills to do the work. At the same time, many women who think they should provide care cannot do so because they have too many other demands on their time, because they do not have the skills, because they do not have the other necessary resources or because they do not have the physical capacity. Many who do provide care, providing services such as meal preparation, comforting and cleaning, may not even see this as care because it is so much a part of their daily lives.

Not only within countries at particular times, but also within workplaces, there may be significant differences among women. A hospital, for example, may have women working as managers and women working as housekeepers. The managers are more likely to be white, Canadian-born, with English or French as a first language and relatively young, while the housekeepers are more likely to have migrated to this country, to have neither English or French as their mother tongue and to be older than the female managers. And, of course, there are significant differences between these groups in terms of power, pay and ideas about work, and in their political, material and symbolic resources related not only to their positions in the paid work force, but also to their positions in their households and neighbourhoods.

But slicing is not only necessary to draw out the differences related to women's various spatial, physical, social, psychological, economic, work and age locations, it is also necessary in order to see the different ways of understanding the evidence, different ways of developing evidence and different views on the same processes. It is, for example, possible to look at care from the perspective of the care provider or from that of those with care needs, or to examine care as a relationship. Furthermore, the family as a group may see care issues one way, and the government, the agencies and the paid providers in other ways. Indeed, each household member may have a specific way of slicing the situation. Equally important, the tensions among these may not be possible to resolve but possible only to recognize and handle. By beginning with a recognition of contradiction, by taking this slice, it is possible to base and develop policies and practices that seek to accommodate such tensions rather than setting out single solutions based on notions of harmony.

Analysis can begin from a number of different questions: asking, for example, what does this mean in the short term and what does it mean in the long term? What does it mean for those immediately involved, and what does it mean for the country or the world? It can also begin by acknowledging that some practices, conditions and situations are contradictory. Women, for example, may at one and the same time want to provide care and find it impossible to do so. They may love the person for whom they provide care but, precisely because of this love, hate to provide care.

Slicing can expose the different kinds of care work involved in providing for children with and without disabilities: for teenagers who join gangs and for those unable to attend university because there is no money, for adult neighbours with chronic illness and for those with marital problems, for healthy elderly and severely ill old people. It can also reveal what it means to provide this care at home or in an institution and what different kinds of institutions and homes there are.

It is also possible to begin with quite different purposes. For example, most policies are about helping households and families adapt to the demands of paid work and services. It is also possible, as some Norwegian policy analysts make clear, to start by figuring out how paid work can adapt to family lives.[4] Instead of asking what resources the growing number of elderly require, the questions could be about the resources they bring and the services they provide. Rather than asking how care can be made an individual responsibility, we can ask what conditions make it possible to care without conscripting women into caregiving. Rather than assuming, as we do in Canada, that public care is what supplements family care done mainly by women, we could assume that families supplement public care.

Slicing adds both a recognition of difference and the possibility of developing different views of the same issues, circumstances and evidence.

Why Women?

On the one hand, we have a universal pattern in terms of a division of labour by sex and women embracing caring work. One the other hand, we have an incredible range of labour done by women and defined as women's work. We also have women resisting caring work. Indeed, American historian Emily Abel argues that some nineteenth century women "complained bitterly that caregiving confined them to the home, caused serious physical and emotional health problems, and added to domestic labour, which was gruelling even in the best of times".[5] What factors, ideas, structures and processes contribute to this universality and difference, this embracing and resistance? More specifically, why do women provide the care but in so many different ways? There are no simple answers to these questions. Rather there are a number of answers that help contribute to a better understanding of care as women's responsibility.

We do know that only women have babies. But we also know that the meaning, experience and consequences of having babies varies enormously, not only across time and with location and culture, but also for individual women from one baby to another. Having a baby is fundamentally different for Céline Dion than it is for an Aboriginal woman who must leave her northern Quebec community if she is to receive medical assistance. Moreover, there is no necessary connection between having babies and rearing them; that is, to providing care.

Bodies, then, are a factor in all of women's lives, but these bodies themselves are embedded in social, economic and political structures that are continually influencing how bodies work, as well as how they are defined and valued. They cannot provide much of the explanation for why women provide most of the care, not only for the babies they bear, but for other people as well.

Although there is plenty of evidence to suggest that women are more likely than men to identify with the emotional aspects of caring, there is very little evidence to suggest that this is connected to the way women's bodies or minds are physiologically constructed or that men are physiologically incapable of such caring emotions. There is also evidence to suggest that girls are taught and expected to exhibit such caring, and they are also more likely than their brothers to be assigned the caring jobs in the home. What sociologists call early socialization obviously contributes to women's skills in and attitudes about care, as well as to their brothers' notions of who is responsible for care and knows how to care. However, the pressures on women to provide care do not end and perhaps are not primarily created by early learning. Just as children are born and formed within a social context, so too are women carers daily created and shaped within social relationships, processes and structures. At the same time, women are active in creating these same relationships, processes and structures, albeit often from a weaker position than that of men.

These relationships, processes and structures are about power, not only in the sense that governments, employers, community organizations and husbands have specific powers and protect specific rights, but also in the more general sense of whose preferences, ways of acting and ideas prevail in daily practices. And they are about resources and the principles, as well as the mechanisms for their distribution. Power and resources in the formal and underground economies, in community organizations and households are often mutually reinforcing and are definitely linked. They are also unequally distributed, not only between women and men, but also among women. Women do have resources and are active participants in creating caring work. However, most women have fewer resources than most men, and the resources, as well as the means of participating they have, are frequently different from those of men.

There is, then, very little that is "natural" about women's work in general or their caring work in particular. Contexts matter much more than bodies in creating and maintaining women's caring work. Caring can be understood only as women's work within unequal relationships, structures and processes that help create women as carers and undervalue this caring work.

THINKING GLOBALLY: THE LARGEST CONTEXT

Globalization has become a familiar term in recent years. While familiar, though, teasing out its meanings and its implications for women in different locations is a complicated task.

Globalization implies a process that is drawing the world and its occupants closer together on what is often seen as an inevitable and undirected path. At the core of this process are giant corporations centred in one, usually Northern, country but operating throughout the globe. These transnational corporations (TNCs) helped create the technologies that have themselves contributed both to the corporation's multinational form and their power. Such technologies make it possible to move money rapidly around the globe, thus allowing these corporations to avoid or at least threaten to avoid any particular government's taxes and regulations by moving their investments. The technologies also make it possible to move work around the world, thus allowing the corporations to avoid or threaten to avoid demands from workers or restrictions on the use of labour imposed by governments. In order to facilitate this movement of goods, money and work, the giant corporations have been central in promoting what is often called free trade. Free trade is far from new, and traders have always enjoyed considerable freedoms as well as considerable power. It may well be, however, that the speed of transactions has altered along with the size of the corporations directing them. As a result, their power may be greater than ever before.

Instead of combining to resist this pressure, many governments have come together to support the process of achieving greater and easier movement of goods, services and money. At the international level, the First World countries (also called northern, developed or industrial countries) in particular, have worked through the International Monetary Fund, the World Bank and the World Trade Organization to promote the removal of restrictions on trade, a process which entails both de-regulation and re-regulation. Countries owing enormous debts have been required to introduce structural adjustment programmes that involve the removal of many restrictions on foreign investment and labour practices, as well as the sale of public corporations to private ones, cutbacks in public services and the adoption of market strategies within the public sector that remains. The impact on women has been mixed and contradictory, both within and across nations.

Some women have been able to get new jobs on the "global assembly line," producing goods and even services previously produced mainly by women in the highly industrialized countries. Precisely because firms have relocated in these countries in order to avoid high wages and restrictions on working conditions, these jobs for women have rarely been good jobs. But they have offered some new possibilities for work, income, shared locations and minimal protections. More common has been the expansion of paid work for women outside the factory walls within the underground or informal economy where few, if any, rules apply. Women have been drawn into small-scale retail and service work, into domestic and homework, or simply into semi-clandestine enterprises.[6] Here the boundaries between household and formal economy, between public and private space, and between employment time and non-employment time are blurred and protection along with visibility absent. At the same time, the withdrawal of public services has meant that women have had to do more of this work without pay or support within the confines of their private worlds, where the work is less visible and less available. For many women within these countries, there is no paid work at all. The poverty and unemployment that follow in the wake of structural adjustment policies push many to search for jobs in those First World countries that have created these policies. Women, in particular, have sought work as what Grace Chang calls "disposable domestics."[7] Separated in time and space from their children, these women often do the domestic and caring work for First World women under conditions supported in the First World by the combination of government regulations, women's working conditions and the failure to provide care services. Like free trade, the movement of women to do such work is not new, but the scale has altered. The result is a growing gap among women within and between countries, a gap that is frequently linked to racialized categories, as well.

In addition to imposing structural adjustment programmes on Third World countries (or what are often called southern or developing countries), First World countries have entered into trade agreements that promise to support the movement of goods, services, money and, to a lesser extent, people across borders. This has not necessarily meant less government, but it has meant more measures to allow corporations to operate with less regard to national practices and preferences and fewer taxes or other contributions to national economies. It has also meant less local and democratic control as more decisions are being made by these international trading groups. Facing debt pressures themselves, these countries have adopted strategies similar to those imposed on the Third World. First World countries have acted more like entrepreneurs at the same time as they have handed over more of the services previously provided by governments to private, for-profit firms.

These shifts have had critical consequences for women. The expansion of the public sector had provided many, and often quite good, jobs for women. Indeed, "in 1981, between 65 and 75 per cent of college-educated women in Germany, Sweden and the USA were employed in the 'social welfare industries.'"[8] Many of these jobs disappeared or their character changed in the wake of the global reforms. Trade agreements did allow some women to move to other countries in search of work. Registered nurses, for example, left Canada in large numbers when hospitals closed, acquiring jobs in the United States. But those women from Third World countries seeking work in Canada found it more difficult to gain full citizenship status, providing just one example of how free trade has not worked in the same way for everyone.

As public services have declined, more of the services have been provided for sale in the market. This process, often described as commodification, determines access primarily on the ability to pay rather than on need. More of the women in First World countries, as compared to those in the Third World, have had the means to pay for commodified services. However, women in both Worlds have continued to earn less than men, and women have continued to bear primary responsibility for care and domestic work. Faced with fewer public services and relatively low pay, but still in need of income to purchase these services, women in the First World have sought the cheapest means of paying for care or other supports. These means have often involved the even poorer women from the Third World. This is not to suggest that most First World women have completely escaped unpaid work or that the majority of women could afford to pay for services. Indeed, the reduction in public services has meant that a considerable amount of this work, formerly done by women for pay in the market, is now done by women without pay in the home. In other words, it has been de-commodified but not eliminated. Rather, it is to stress the linkages among women created by globalization and the growing gaps among women that these linkages often entailed.

Globalization does not simply refer to economics, however. It also refers to the ways people, ideas and cultures are brought closer together around the world. This has, in many ways, meant the spread of First World, and especially US, practices. Along with music, movies, fashions and food have come ideas about all aspects of social life, including women's work. This dissemination of ideas is also linked in many ways to the corporations, both through their ownership of companies that produce these goods and through their influence over the media. In these global sources, the emphasis is increasingly on the individual as a consumer with choices based on the capacity to purchase. Like the relocation of jobs, the spread of ideas is a mixed blessing. On the one hand, feminist ideas have spread rapidly around the world. On the other hand, the First World version of feminism was what has spread most rapidly, and this version too often fails to take context and difference into account.

This notion of shared international perspectives is not particularly new. Indeed, after the Second World War there was much talk of a postwar consensus. This consensus was based on a commitment to expanded government-provided services to a mixed economy that combined public and private enterprise, and to policies of full-employment along with sustained economic growth.[9] Redistribution of goods and services was part of the package, as were collective responsibility and shared risk. Now, this consensus seems to have fallen apart, only to be replaced by a new, and quite different, one. Public rights are replaced by private ones, with markets rather than states as the preferred means of allocating jobs, goods and services. But markets are unable to respond to many human needs and are especially ill-equipped to promote equity and full employment or to avoid long-term problems like pollution or other health consequences. Instead, they result in greater inequality, especially for women. As British theorist Ian Gough puts it, "Markets paradoxically require altruistic, collective behaviour on the part of women in the household in order to enable men to act individualistically in the market."[10]

Globalization has allowed much more than money, people, goods and services to move quickly around the world. Diseases, too, face more permeable borders. New epidemics, such as HIV/AIDS, are transported along with old ones, like tuberculosis and hepatitis, around the globe with relative ease, transported in and by airplanes, as well as by service workers. Increasing inequality, not only in the Third World but also in the First, encourages their development and prevents their treatment. Diabetes has become much more common, especially among marginalised groups in large urban centres and on reservations. At the same time, protections under free trade rules for pharmaceutical patents frequently leave treatments beyond the reach of many.

One way, then, to slice globalization is to reveal the increasing dominance of transnational corporations, the converging of governments around market strategies, the declining democratic controls and the growing gap for and among women. Another way to slice it is to expose the counter tendencies. The same technologies that support corporate power allow various kinds of social and labour movements to organize around their interests. We see evidence of this not only in the "battle of Seattle" and in the streets of Quebec, but also in the Beijing Conference on Women that reached a consensus around means of promoting women's equality and in the attempts to protect sweat shop workers encouraged by the success of Naomi Klein's book *No Logo*.[11] The movement of people around the globe has meant that many of us are more familiar with other cultures and practices.

We also see counter tendencies in the escalation and power of terrorism. Although many governments have adopted strategies taken from the for-profit sector, there is still an incredible variety in the ways these governments operate. Important public programmes that reflect a continuing commitment to social rights and collective responsibility remain in many countries. Others have taken a route that emphasizes family values while still others have turned to religion and ethnicity. Moreover, the trade alliance among members of the European Union has served to improve working conditions for many women and help improve services for others. Instead of de-regulation, we see on occasion the extension of regulation. Britain, for example, has been required to provide protections for part-time workers and to introduce both minimum wage and equal pay legislation, all of which improve women's market jobs. Several countries are resisting the high drug prices that prevent them from treating mothers with HIV/AIDS, a sign that not all countries are willing to put property rights above people's right to life. And perhaps most importantly, there is ample evidence to demonstrate that spending on social programmes can enhance rather than prevent trade, and that gender-based analysis linked to effective programmes is essential to economic development.

Contradictions within global developments, as well as those among particular kinds of developments, are important in understanding where and how change may occur or is occurring. It is equally important to examine the details of how global agreements and patterns are played out within specific locations, because practices may well defy or transform intentions.

In short, globalization is about processes that result from actual decisions and practices rather than about forces beyond human control. **While there is strong evidence to demonstrate that corporations are powerful players that are often supported by governments, there is also evidence to suggest that there are both limits on this power and contradictory patterns. 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.**

THINKING NATIONALLY: THE CANADIAN STATE

The debates around globalization have led to questions about the power of the nation state, while the emphasis on markets has led to talk about the end of the welfare state. The state in these debates refers to much more than government in the narrow sense of elected officials, the legal system and the bureaucracy that supports them. It also refers to more than the right to rule over a specific territory. While it involves these well-known aspects, it also includes the broad range of institutions, policies, practices and relations that together constitute governance.

Those who talk about the end of the nation state base their claims on the rise of global corporations and the development of both international agreements and international institutions. Globalization, from this perspective, means the demise of national sovereignty. Some fear this decline, arguing that it means nations can no longer make their own choices and that democratic control is undermined. Health care is a case in point. Although the current Canadian government argues that national, public health care is protected under a special clause in the North American Free Trade Agreement (NAFTA), legal opinions sought by union and other groups warn that the public system is quite vulnerable to foreign investment and, thus, foreign control under this agreement. Clearly, nations have surrendered some rights in signing these agreements and give away even more perhaps in negotiating separately with corporations and in creating the conditions for foreign investment. However, as Dexter Whitfield puts it in his book on this issue, "the nation state continues to play a crucial role in creating and maintaining the conditions for capital accumulation, ensuring the health, education and safety of citizens, providing a framework for social relations, and maintaining civil society."[12] Undoubtedly, **Canadians still have important powers in terms of establishing the conditions for work and in deciding how, when and where care is provided, even though both federal and provincial governments have surrendered some powers to corporations and global decision-making organizations.**

Those who talk about the end of the welfare state point to the "shrinking" of the public sector,[13] as well as to a shift away from a notion of collective rights and responsibilities along with the adoption of market strategies. Welfare is, of course, not new. States were involved in welfare programmes long before the Second World War. Canadian governments supported hospitals and schools, charitable organizations and widowed mothers through allowances, to name only some of the welfare aspects of the Canadian state. But the Second World War marked a qualitative change in the guiding philosophy and in the extent, as well as the nature of state intervention. The period from that war's end until the mid-1970s has become known as the "Golden Years" of the welfare state because they were not only the years of the most comprehensive and universal social programmes, but also because they were marked by a notion of shared risk and collective rights that meant the state bore overall responsibility for the welfare of citizens and for limiting the negative impact of markets. States played a more active and visible role in the redistribution of income, power and other resources, and in the delivery of services. And any redistribution from those with these resources to those without is likely to benefit women more than men because women have fewer resources than men. These developments both reflected and contributed to postwar prosperity and were linked directly to the demands from unions, citizen organizations and women's groups for a better world.

During this postwar period, Canada introduced universal family allowances and pensions, paid to everyone in the maternal and old age categories as a right of citizenship. Pensions meant that many women, in particular, escaped poverty and could live independently in their old age. Universal health coverage for necessary doctor and hospital care also proved to help poor women significantly and to do so without the stigma of a means tests. This not only meant all Canadians had the right to health care as a right of citizenship, it also meant they had more choices about publicly provided care and that there was no need to sort the deserving from the undeserving. Education was also provided on a universal basis, allowing many more women to go beyond elementary school. However, tuition fees remained at the post-secondary level and, thus, still constituted a barrier for many seeking to become experts in care. Additional barriers linked to race, culture and other locations also remained because the main focus was on ensuring the same access, rather than on recognizing and accommodating differences. Universal treatment can mean treatment based on a standard that assumes everyone has the same needs, and too often that standard is a white, relatively healthy and wealthy male. Welfare, childcare, homecare and long-term care received significantly more resources, but they remained as means-tested services directed at those who could prove they were deserving. Although women's positions at home and in the labour force meant they were more likely than men to fit these criteria, the construction of these programmes often served to reinforce, rather than alleviate, women's dependency.

Immigration rules were also changed in an attempt to make Canada more open to people from a broader range of countries with a wider range of backgrounds. As a result, Canada became a much more racially and culturally mixed society. Supports were still lacking, especially for the women who came as dependents. And there were still important barriers, such as those that applied to the recognition of foreign credentials for nurses or other professionals and those that applied to women entering as domestics. Racism remained embedded in most social and economic structures and relationships. But many more immigrants were able to enter and thrive. Aboriginal peoples may have fared less well than immigrants, and Aboriginal women fared less well than all other women in terms of jobs, pay and protections. Perhaps the best that can be said of this period is that there was a movement away from a policy of assimilation towards one of recognition, after hard struggles by Aboriginal peoples against state initiatives.

Canada also intervened directly in the market to introduce employment protections that influenced the distribution of power. Labour standards legislation provided for a minimum wage and improvements in some health and safety regulations, along with other rights such as statutory holidays and overtime regulations. These changes were much more likely to protect the women who fill the majority of the lowest paid and least unionized labour force jobs, many of which involve providing care. The same was true of human rights legislation. Meanwhile, unemployment insurance and workers' compensation were intended to provide income for workers whose jobs disappeared or who were injured at work. Both programmes recognized that job loss was often the fault of employers or the economy rather than individual workers, but the way they were structured and implemented meant they applied mainly to men. The same was true for the workplace-linked Canada/Quebec pension scheme. Moreover, the regulations and benefits seldom applied to part-time, short-term or casual work, where women were found in far greater numbers than men and where work often involved care. Full employment policies were more frequently preached than practised, but to the extent that they contributed to higher employment levels they helped redistribute income.

State investment in these health, education and welfare programmes meant enormous job expansion in the public sector. Many of these jobs went to women because women were available, they needed the income, they had the training and it was clearly defined as women's work. By the end of the Golden Years, almost one in three employed women worked in the broader public sector. Brought together in large work places, women formed unions and demanded the state live up to its international commitments to equality. As a result, the state not only provided benefits, services and protections, it also provided jobs; and many of these were quite good jobs in terms of pay, benefits and security. And a majority of these jobs were about providing care in one form or another. With pay came some recognition that care is work and that care requires some support and training. Women's pay and better access to higher education also helped increase their power within households and so did new rules on property rights, violence and abuse.

The impact of the welfare state in these years was contradictory and far from perfect for women or for particular groups of women. Feminists have rightly criticized the welfare state for failing to substantially reduce inequality between women and men or among women. They have argued that in many ways the rise of the welfare state meant that rule by the father or husband was replaced with rule by the state, and that many programmes and policies have served to reinforce women's segregation in the labour force and responsibility for care inside and outside the formal economy. Feminists have also objected to the bureaucratic rules and institutional practices that standardized care in ways that eliminated the personal, the dominance of professionals who failed to take women's needs into account and the failure to support women's independence from families or the state.

At the same time, the welfare state did improve the lot of many women. Some income was redistributed from the rich to the poor and from men to women. Services funded by the state were even more successful at improving access for women and so were many of the protections against employers and spouses provided by the state. Professional autonomy also meant practitioners could base decisions on individual cases, and the existence of government benefits, along with programmes and services, did allow some women to make choices about their private lives. Moreover, it was much easier for women to influence the state than it was to influence employers, given access to some democratic means of participation in the state sector. Consequently, women still looked first to the state for an expansion of rights and care.

Since the mid-1970s, there has been a fundamental transformation in guiding philosophies and actual state practices. There has been a slow but steady shift away from the notion of shared risk to one of individual risk and responsibility, from social rights to individual consumer rights. Instead of a commitment to full employment through state intervention, there has been a growing commitment to reliance on market mechanisms in and outside the state, as well as an emphasis on individual responsibility for getting and keeping paid work. State initiatives are designed more to support the market than to limit its impact. Markets, rather than states, are to be the main mechanism for redistribution. On the basis of arguments about both debt loads and poor public sector practices, public programmes and protections have been reduced. Fees have been added and services cut back. New regulations have been introduced to sort the deserving from the undeserving and to limit the power of unions. Services have been privatized or had private sector techniques applied. In the process, many of women's good jobs in the public sector have been eliminated or transformed while less of the caring work is provided with little or no charge in the public sector. Care still needs to be done, but less is done for pay in the public sector or provided without direct financial cost to citizens. While the number of public employees has shrunk, the power of the state within Canada has not.

Although the elimination of the deficit and the reduction of the debt have made it harder to use these as the basis for reform, the state continues to pursue market-oriented ideas and practices. However, now they tend to be justified on the basis of the growing number of the elderly and the rising expectations of "consumers," most of whom are women. Yet there is increasing evidence to show that there is no inevitable increase in dependency with aging. As the British authors in a recent book on aging put it, "the association of aging with disease and inevitable decline is better re-framed so that aging is seen as a *social* rather than *biological process.*"[14] There is also evidence to show that the very market mechanisms designed to save public investment in care promote the same rising expectations that are defined as the problem.

Governments at the federal and provincial levels have simultaneously decentralized some responsibilities while centralizing other powers. Decentralization has been promoted as a means of enhancing local decision-making, but this decentralization has been combined with a reduction in resources and often increased regulations about what local authorities can do and how they should do it. As a result, local decision-makers may be left with the responsibility for cuts but not the choices about whether or how to cut. This may mean they are pushed to privatization, both in keeping with government regulations and in an effort to deal with costs in the short term. Moreover, groups such as lesbians and Aboriginals may find it difficult to have their voices heard at the local level because their numbers are small.

One obvious result of these developments, established by various research projects, is the existence of growing gaps among people. Income gaps are growing between women and men and among women in ways linked to race and other locations. While the Golden Years of the welfare state did not create equality, they did reduce inequality, and their end is marked by new patterns of inequality and the reinforcement of old ones. There are increasing gaps in power as well as in income, and there are increasing symbolic gaps, as well. For example, women on welfare and women who use emergency rooms are increasingly defined as abusers of the system, and women's groups are described as protecting "special interests."

Nevertheless, some important services, benefits and protections remain. Hospital and doctor care provide the best examples. The continued existence of a universal health care scheme, albeit one in the process of reforms that may transform it, is testimony to both the power of citizen support and the effectiveness of the programme in providing care. Some commitment to collective rights and responsibility clearly remains. Moreover, some supports like shelters for battered women have been restored or expanded, also in response to citizen claims. Some pensions are still universal. Important rights, like those protected by the *Charter of Rights and Freedoms* and the *Canadian Human Rights Act*, have been maintained. There are also significant differences among jurisdictions in Canada, demonstrating both that there are still choices to be made and that citizens' protests can still make a difference.

These state practices set the context for context for care. **In providing supports, benefits, services and regulations, or in not providing these, states 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 and 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, and what is private in the sense of being outside the formal economy. The benefits and negative consequences are unevenly distributed between women and men and among women. It is, thus, necessary not only to find out what the state does, but also to determine who benefits and how they benefit if we are to figure out how to create good conditions for care.**

THINKING MARKETS: INVISIBLE AND VISIBLE HANDS

While the welfare state has not disappeared, the role it plays in relation to the market has changed in terms of both policy statements and policy practices. This is not to suggest that the market was not strongly supported by the state even in the Golden Years, but rather to indicate the new and public emphasis on markets as the best means of both delivering and distributing services. Once defined as public goods largely produced and distributed outside the market, care services are increasingly defined as markets goods to be produced by for-profit means and distributed according to consumer preferences.

Market mechanisms are assumed to be more efficient at producing services because producers want both to create the best services possible in order to attract customers and to spend less in order to ensure profits. Thus, the search for profit, combined with competition in an open market where everyone has equal opportunity, leads an "invisible hand" to develop the best services at the best price through the best means.

There are several problems with these assumptions, especially as they apply to care. First, markets have never been free in the sense implied by the notions of an open market with equal opportunities and no directing hands. States actively protect property rights; for example, in ways that directly contradict this notion and in the process favour some market participants over others. So pharmaceutical companies can patent products for 20 or more years to protect them from competition and can deduct from their taxable income expenditures on research and development. In the process, the public assumes much of the risk that is invoked by these companies as justification for their patent protections and their huge profits.

Second, there is a tendency towards monopoly as companies seek to buy out the competition, in the process eliminating much of the very competition that is supposed to be the essence of the market. Again, this process is abetted by the state. To return to the pharmaceutical sector, many of the research and development expenditures that its firms deduct from taxable income are in reality marketing initiatives that have the effect of reducing and eliminating competition. Third, the market is riddled with "irrational" processes that prevent the kind of allocation that the notion of an invisible hand implies. Systemic discrimination in job allocation, for example, contradicts the equal opportunities claim.

Fourth, consumers have fundamentally unequal power when they come to the market as purchasers. The inequalities are not simply about money; they are also about information, access and time. These inequalities then get perpetuated and magnified by market mechanisms that mean that certain choices prevail. Fifth, there is little firm evidence to show that the companies producing the best products in the best way survive. States cannot afford to let many giant companies disappear, even if they are inefficient producers which fail to produce desired goods in the market.

In care services, there are even more problems with the assumptions about market efficacy. First, services are often required on an urgent or emergency basis, leaving no time for comparative shopping. People cannot easily know what illnesses they will get or what services they will require even on a non-urgent basis, with similar implications for comparative shopping. Second, the consequences may be literally fatal or last throughout life. While purchasing the wrong cereal may put off your whole day, failing to buy cancer care could mean death, and the wrong day-care can risk your child's current safety or future possibilities. Third, those using the services typically lack the kind of knowledge necessary to make informed choices on complex matters. This is one reason why many who work in care are termed professionals and are accorded the right and responsibility to make choices on our behalf. We do not want these choices made primarily on the basis of cost or profit as they are in the for-profit system. Fourth, it is difficult to provide continuity in care across services if they are each competing with the others and are owned by for-profit firms that treat information as trade secrets essential to competition. Care services require significant coordination and long-term planning, neither of which is consistent with the market distribution of services. Moreover, competition means some firms disappear, leaving people without their services or with different services. Or it means states step in to support them or take them over, contradicting the very notions that are the basis for market claims.

Fifth, the tendency or even the requirement for monopolies in highly technological services reduces the possibilities for competition. The complexity of health care and the interdependency of its many components, involving skills among a wide range of providers and expensive facilities, means that integrated care can be delivered only by a few organizations, reducing the possibilities for the very competition that is to produce the most efficient and effective care. In rural communities, the populations are too small to support competition among services and, in services such as child care, the profit possibilities are too small in most areas to attract for-profit providers. Sixth, consumer purchasing means unequal purchasing, because market power is based on resources and, thus, necessarily perpetuates inequality between women and men, as well as among women.

Seventh, the search for profit leads to making providers work as hard as possible and to providing as little care as possible while encouraging people to use as many services as possible, because profits are made by selling more and spending less. It also leads to an emphasis on the care that brings the most economic return, to the neglect of those people or services that cannot bring much or any profit. What is not profitable or not defined as part of care work will be left to individuals or charitable organizations to provide, meaning this care is often left to unpaid providers. Finally, the trust that not only makes the entire system work together but also is necessary between care recipient and care provider takes years to produce. This trust cannot be easily captured or replaced by contractual, market language. And for-profit techniques often undermine the trust among providers within the system as their work is more carefully monitored and controlled.

All these problems apply to market mechanisms inside and outside the public sector. Governments have recognized at least some of these problems and have addressed the ones they recognize by introducing "managed competition." This simply means that governments more carefully regulate the way markets in care operate, but it fails to address most of the problems of market mechanisms. And managed competition does nothing to address the problem of applying for-profit techniques within care services.

In short, **the market mechanisms that have become so popular with governments have to be carefully scrutinized for their impact on the nature and distribution of both care and care work. There is every reason to believe they will change, for the worse, who gets what kind of care through paid services and the conditions under which providers work, while increasing inequality and sending more care to communities.**

COMMUNITIES

Much of the reform in public care has been justified in terms of both cost-cutting and efficiency. But it has also been done in the name of sending care closer to home, to communities that are assumed to provide more of the kinds of social and emotional support that research tells us is so central to care. Communities are portrayed as warm, friendly, welcoming places, where everybody knows your name. In the 1960s, these communities were presented as alternatives to impersonal institutions, but in the new millennium they are understood as substitutes for public services. Yet, it remains unclear exactly what is meant by “communities.” There are at least four possible aspects of what constitutes a community.

First, there are the voluntary, religious and charitable communities operating as non-profit entities. Often organized at the national or international level and called Non-Governmental Organizations (or NGOs), these usually have a local presence. Their care services cover a wide range, although they frequently target particular populations based on the care required, such as those with HIV/AIDS, those suffering from abuse and those needing palliative care, or based on affiliations such as membership in a church or seniors’ group. There were once many local, community hospitals operated by NGOs, but a lot of them have been eliminated or transformed through restructuring. NGOs are not necessarily small, locally controlled or oriented to collective values, however. The Catholic Church, for example, may operate a local long-term care facility based on decisions made far away. Similarly, its refusal to offer birth control or other reproductive health services in its hospitals reflects a policy determined centrally, not locally.

Many of these organizations have long provided services, while others have served as incubators and demonstration projects for new services later taken up by the state. Also, many have performed an advocacy role. Most have received government funding of some sort. With the downloading of services, these community organizations are expected to take on much larger, and often different loads, and any hope of governments adopting demonstrably good services have all but disappeared. So has the time to advocate, as service demands take all the resources. Moreover, the conversion within the state to for-profit practices has meant these organizations now have to follow similar practices in order to be eligible for funding. Some have to enter competitive bidding processes that also absorb time and money while making jobs even less secure. Women tend to provide the majority of care in these organizations, although they are much less often the majority of the decision-makers. Much of the care is unpaid, and when there is pay, it tends to be low, with job insecurity high and benefits non-existent. With the majority of women in the labour force, and there because they need the income, there are few women available to provide the care as volunteers. And a growing number of women are not available as volunteers because they are providing the care for others at home. They may also be reluctant to take the paid jobs available in these community organizations, given the wages and benefit structures.

Second, there are for-profit concerns operating at the community level. Extendicare, for example, has the contract for many long-term facilities. Other, foreign-owned corporations have entered the long-term care facility and home care “market,” created by new managed competition strategies introduced by governments or left open by the government's failure to provide public care. Such organizations are not small, or locally controlled. And their emphasis is at least as much on the search for profit as it is on responding to local needs. In the for-profit sector, pay is usually significantly lower than the pay in public hospitals. Indeed, one of the justifications for the movement of care out of hospitals is the lower cost of long-term care. The costs are lower in large measure because people are paid low or no wages. Yet, restructuring of hospitals has meant that many of the same patients with the same needs who used to be cared for in the hospitals are now provided for through these community services.

Third, there are neighbours, friends and extended family members. These communities are based on reciprocal relationships that require time to nurture and support. In order to help each other, they need time. And while they may provide help without intent of gaining any return, the community cannot be sustained over time if there are only those who need care and few who can return the favour. As care demands increase and fewer women are around to provide care, these reciprocal relationships may well be undermined.

Alongside these various kinds of community, there are families. The concept of family is often more fuzzy than that of community, but it is clear that we often mean family when we refer to community care. Indeed, this fourth kind of community is where most care ends up when care is sent to the "community." Including families under the concept of community may hide their multiple and varied responsibilities. Considering them as part of communities may also hide the quite different logics at work within families, where love, blood and interdependency are assumed to be the glue that keeps this form of community together and that drives people to care. So it, perhaps, makes more sense to consider families as a separate category. However, they are included here as part of community precisely because they provide the bulk of what is meant by community care.

Like the term community in general, families are pictured as warm, supportive environments that can and want to care. Or if they do not, they should. Families are also usually pictured as being based on a happily married, heterosexual couple with several healthy children and loving grandparents hovering around the edges, sharing and caring for each other.

Some families do fit this vision, but a number of important features are missing from this picture. Most families have only a few members, many with only a mother and her children. These households have no men to share in care, few others to provide support and very limited economic or symbolic resources. And a significant number are reconstructed from families of previously married spouses who may bring with them multiple caring responsibilities but few resources. Some are based on homosexual relationships in couples that face barriers in accessing care based on notions of heterosexual relationships. Families often live far from their relatives and even from their cultural communities. They may even be isolated from their neighbours by physical distance, culture, resources or time. Most women are in the labour force, primarily because they and their families need the income. Most teenagers, too, have paid work, often because this work is critical to their needs or to those of their families. Many families live below the poverty line and often juggle several jobs even to stay close to it, leaving them with few resources in terms of time, power, social relationships or income. As more members have paid jobs, and paid work not only takes more time but also takes up more time at home, the stress on families increases and there is less time or emotional space to care. Families, then, are characterized by significant differences among and within them, differences often not taken into account in providing public care.

Families are likely to be characterized by inequality among members and by a sexual division of labour that leaves women doing most of the domestic work. Women without paid work are dependent on the economic earnings of others or on the state, with all the dependency relations that are entailed. Those with incomes seldom earn as much as men, given the gap between male and female earnings. Children, and increasingly young adults, are also economically dependent, leaving them, too, with less status than those who bring in the bulk of the income. Some families are characterized by violence and abuse, most of which is directed against women and children. Few have the kind of skills necessary to use oxygen masks and catheters, change wound dressings or provide support to someone with cancer. Many do not have appropriate physical space for the kinds of care required. While the nature of the human relationship is one of interdependency, the interdependency in households often means the dependency is unequal in ways that create significant differences in security, autonomy and rights.

When care moves home, it usually means care by women because of assumptions made about who should care, the failure to provide alternative public care and men's higher wages, which means it makes sense for the women in the house to sacrifice their paid jobs or adjust them to the care work. Estimates indicate that such families have been providing between 80 and 90 per cent of all care, even before current moves to send care home. With most mothers in the labour force, and even mothers of small children now expected to work rather than remain home on welfare, few women have much time for additional care. Part-time employment is often so irregular that it cannot easily be accommodated to extra care work and so low-paid it may not be an alternative for many. The minority of women who have partners with full-time, relatively permanent and well-paid employment may also find it impossible to absorb this new care work, whether or not they want to provide it or think they should provide it, given the care responsibilities they already carry. The result may well be "compulsory altruism" for these women,[15] while other women may simply not be able to provide the care sent to the community or to support a caring community. The additional pressure on families can disrupt or even sunder those that do fit the rosy picture of family life.

In other words, **sending care to the community may mean undermining those communities and does not necessarily mean more local participation or control.** 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.[16]

This does not leave much space for even more care. Without time, space, economic resources and other supports, all communities may be at similar risk and innovation as well as participation stifled.

LINKING PRIVATE AND PUBLIC SPHERES

Rapid state and economic expansion were not the only significant features of the welfare state. The Golden Years were also characterized by the development of clearer boundaries between the private and public spheres.

Within the formal economy, large fields of activity came to be included in the broader public sector. Both those working directly for the government in the bureaucracy as “public servants” and those working indirectly in health, social services and education were part of this broader public sector. Funding for these industries came primarily from governments, and governments highly regulated them through detailed legislation and reporting rules. Governments carried out their commitments to human rights and welfare mainly though them. Pay and employment equity legislation, for example, applied primarily to the broader public sector. In Canada, almost all of the organizations in health, education, welfare and social services were non-profit. Their services, in other words, were not produced for exchange in the market; they were not commodified. Those working in these industries were paid a wage, and thus their labour was commodified, but the services, themselves, were not. There was a specific logic at work for these employees and employers, with public service defined and treated differently than other market work. It is easier to focus on care when profits and payments are not required. Unions flourished, in part because there was one main funder, and in part because governments had made commitments inside and outside the country regarding the kinds of rights unions demanded.

At the same time as the distinction between the public and private sectors in the market became clearer, so did the distinction between the formal economy and the household. Feminists increasingly talked about the separation of public and private spheres. Many more women worked for pay in the market, outside the home. Many services previously associated with households became available for purchase in the market. Frozen foods and McDonald’s hamburgers, machine knit sweaters and residential care for the disabled, all signalled this development. Although often described as moving women’s work out of the home, much of the caring work provided in the market either by the state or the for-profit sector was quite different from the work women had traditionally done in the home. More elderly, severely ill and disabled people are surviving, primarily as a result of public supports and access to highly technical medical care. The kind of care required by these people was never provided by women at home in the past, and the equipment and skills involved were most easily provided in institutional settings by people trained for the job. Medicalization drew further boundaries, identifying whole areas of not only bodies but also lives as appropriately treated by medical experts.

During this period, governments defined households as private domains, further supporting the separation. Prime Minister Trudeau talked about keeping the state out of the bedrooms of the nation. Divorce and abortion became easier, homosexuality and birth control were decriminalized, “spouse in the house” rules that involved state-supported inspection were relaxed. Households operated on the basis of a different logic: one based on relationships of blood, love and dependency rather than pay; although as many feminists pointed out, their very privacy also meant they often hid hate, violence, poverty, inequality and various forms of abuse.

There were, then, some advantages to this sharpening division. Work in the public and private sectors was understood to be based on different motives. Some of women's skills were more likely to be recognized and paid for. It became easier to distinguish work from non-work time, and to resist extra loads, as well as to fight for protections in each sphere. There were also, however, disadvantages. Boundaries often meant a greater focus on tasks, as jobs were broken down into clearly distinguishable and measurable parts. Medical intervention increased often in inappropriate ways, with medical experts dominating care. Paid care was also defined as superior and, in efforts to increase the emphasis on this work as professional, more of the care was defined out of the work.

The separation was always far from complete. Many publicly funded services continued to be delivered by independent organizations rather than directly by government, and some at least operated like for-profit ones. Some services associated with the home, like child care, never became widely available. Indeed, welfare legislation was built on the assumption that women should stay home to care for young children. Few human services ever become mainly the responsibility of the state, and many of the components in women's work remained the same, regardless of their location. Perhaps most importantly, as many feminists went on to make clear, households, private and public sector workplaces, were never separate in the sense of operating independently of each other. The segregation of women's work in the labour force reflected and reinforced women's work in the household, and the reverse was also the case. Welfare states only ever took over some of the caring, leaving women to provide the rest. And some women continued to do homework, taking paid employment within the home, while others took on only part-time or casual labour force work as a means of juggling their two linked workplaces. Others, unable to find permanent full-time employment or childcare, had little choice about taking on domestic work. As Gillian Pascal puts it, "a large part of state social policy consists in taking a small part of caring work into the public sphere."[17] Making only a small part of the care a public responsibility serves to perpetuate care as women's work, rendering much of the skill and labour invisible, and certainly making it undervalued. Indeed, states play a central role in what is done in private and public sectors in both sense of the terms, in determining what the boundaries are and in determining whether there are boundaries.

With the restructuring of the welfare state, has come a further blurring of these separations. Within the public sector, the adoption of for-profit strategies and the contracting out of services makes the logic of market relationships central to these concerns. Partnerships between public and for-profit companies have similar consequences. The cutbacks to services mean either that more care has to be purchased in the market or that more of it must be undertaken by unpaid providers, either at home or in institutions. Both of these consequences of cutbacks further reduce the separation between private and public, contributing to the way public processes reinforce and penetrate private household ones. Women who are paid carers find themselves teaching women in minutes how to do what took them years of training to learn, making it harder to distinguish both the work and the workers. At the same time, part-time, part-year, casual and self-employment are growing, supported by new technologies such as e-mail, cell phones and computer programmes, that make it possible to do paid work anywhere and to further mix paid and unpaid labour. These processes reflect, to some extent, women's increasing caring work, but they also serve to create women as carers in the private domain.

There is some blurring along gender lines, as well, with more men caring for their female or male partners as public care declines and fewer family members are available to care. These men are, however, more likely than their female counterparts to get help in their caring work from the state or from unpaid providers.

With more paid work now done at home, it is more difficult to separate the logics of households and market work or the skills required in each. With more paid and unpaid care provided in the home, the state moves more into the bedrooms of the nation. The conflicts among households, states and markets may be played out in these very rooms, among the women delivering care. Yet much of the abuse still remains hidden in the household, and indeed may even be growing as those with high care needs are added to what may be a volatile mix.

The restructuring of work in the for-profit sector has also blurred many of the old separations. More men have moved into traditional women's jobs as work in the factories and the fields, producing things or extracting resources, has rapidly disappeared. More men have also taken on casual, part-time and short-term employment, and many men's wages have stagnated or declined. Women, too, have made some shifts, with more of them doing traditional male work. As a result, men's employment patterns have become more similar to those of women. Within workplaces, some hierarchies have been flattened to make lines of authority less clear and to make the boundaries between union and non-union areas less clear. Multi-tasking breaks down old barriers among jobs and "generic workers" expected to do anything become more common. Employers are also extending work hours and, in the extreme case of Ontario, the province has altered employment standards to allow for a 60-hour week without overtime pay. Technologies make it possible to take more work home or to find workers more easily at home, making the distinction between home and work harder to make now for men, as it has long been for women.

With market logics more dominant and pervasive, so are differences related to economic resources. As more care work is done for low pay in the for-profit sector or for no pay at home, care work is less valued, and more women have to combine it with other forms of low-paid work. But this collapsing does not happen for all women, given that it is still possible to substitute paid services for much of women's work. The more money a woman has, the better able she may be to maintain the separation among household, community, state and market; the better able she may be to maintain boundaries.

There are, however, some contrary trends. The most obvious is the greater emphasis within the public sector on carefully defined boundaries for what qualifies as care under public services. In health care, for example, only the most acute, short-term interventions are now defined as necessary hospital care. The other aspects of care, those once combined in and provided by public sector institutions, are now defined outside the boundaries of high tech care and, thus, as both less necessary, less skilled and less valuable, at least in an economic sense. Less obvious perhaps are the more rigid definitions of who qualifies for supports from the public sector. With the emphasis on individual responsibility, it is harder and harder to meet the criteria that separate the deserving from the undeserving. As a result, more and more poor, old, immigrant, Aboriginal or sick women are defined as abusers of public care. And many of the boundaries between male and female jobs get reinforced by the increasing reliance on unpaid caregivers combined with continuing labour market segregation.

In sum, the components in the care work women do for pay in the public sector and in the private sector, and without pay in community organizations and households, are quite similar. It may be that the personal, hidden and unpaid nature of this work in households contributes to its low value in the labour force, but it may also be that the low wages paid for women's work in the labour force contributes to the low value of their caring work in the home and the assignment of this work to women. Government and employer practices influence the distributions of power, of work and resources between women and men, as well as among women, and the extent to which women must or can care. They also powerfully influence the boundaries among spheres. In recent years, the impact of the new emphasis on markets in everything has blurred lines between the private and public in both senses of the terms; that is, between households and formal economies and between public and private sectors within the formal economy

It is impossible to understand women's work and women's caring without examining the ways states, markets, communities and households penetrate and structure each other. The blurring of the lines among these sectors makes it more difficult to see the links and more difficult for women to draw boundaries, at the same time as more rigid lines are drawn in some areas in order to reduce public support.

PAYING FOR CARE

Care costs. Some of the costs are financial. Some are in time, some in emotional and social resources, and some in lost opportunities. These costs may be borne mainly by individuals, by families, by community organizations or by governments. Sometimes all share in the costs, although they seldom do so in equal portions or in similar ways. Whatever the distribution, the ways costs are borne and shared have significant consequences for women. But the issues go beyond what are the costs and who pays. They also include how payment is made and to whom, or through whom, it is made.

In Canada, the state provides most of the financial funding for paid care. But these payments take many forms. When the federal government decided to introduce public hospital care, it did so by funding services rather than individuals. These services are provided either directly by the government or, more commonly, by other non-profit organizations paid to provide the care. With the exceptions of the two provinces that also require premiums, these services are entirely funded out of general government revenues and are provided without fees. The federal government set out the principles requiring that admission be determined by doctors and hospitals on the basis of medical necessity and that comprehensive care be universally available. Initially, most jurisdictions funded hospitals on the basis of demonstrated need but later switched to global funding systems. More recently, some have moved to paying on the basis of Diagnostic Related Groups, which link payment to the illnesses treated rather than providing overall budgets.

These systems of funding expanded access to hospital services dramatically and helped the many women employed in these public hospitals to make important gains in terms of wages and working conditions. The location and nature of services provided did limit access for women in some areas of the country and prevent some women from receiving appropriate care, but there can be little doubt that services provided without financial costs increase access for women. This payment system meant care was not linked to insurance provided through employment or direct private payments, especially important for women given their lower employment rates and pay levels. Women could choose among hospitals and had some choice about when to leave. Hospitals had every reason to admit any patients with health care needs and to provide them with as much care as they thought they required for as long as they thought necessary. Hospitals took the lion’s share of health care spending and provided a wide range of services.

The principles of universality, accessibility and comprehensiveness remain, but a combination of factors has led to some dramatic changes. Costs rose enormously, government coffers were seen to be empty and there was a new set of values guiding state expenditures. Moreover, women’s groups, among others, criticized the bureaucratic and authoritarian nature of institutions, as well as the failure to respond to the needs of particular groups at the same time as they argued that much care could more appropriately be provided elsewhere. Funding was cut and new techniques introduced. There was a new emphasis on both market approaches and a narrower definition of hospital care. Hospitals were managed more like for-profit concerns. Some hospitals were amalgamated and others closed or converted. Day surgery, outpatient services and shorter patient stays became the norm. While people continued to be admitted, those admitted required much more care and had less choice about how long to stay.

For the women paid to work there, this has meant they have to work harder under conditions that make it more difficult for them to do their work, to feel secure or to get satisfaction from the work. It means they must rely more on relatives, especially female ones, and must cope with more frustrations. They have less time to teach, learn or care. They also have less autonomy, less control over both what they do and how they do it, as care procedures are increasingly standardized and monitored. With the highest recorded injury rates of any industry, they are clearly endangering their own health. And the strains of their work undoubtedly spill over into their households and communities, just as the work no longer done in hospitals does. For the women seeking care, less is provided in the fee-less sector, while restructuring often means that the available care is much farther from home, making it not only more difficult for patients to access, but also more difficult for friends or family to provide support.

The state also directly paid for medically necessary services provided and defined by doctors, but in this case, usually on the basis of each service rather than on the basis of salaries or global budgets. Patients could not be charged fees here either, and patients had the right to choose the services of any doctor. This method of payment also increased access and meant that many of the poorest and sickest could now get care. It also meant doctors could base their judgement more on care needs than costs. At the same time, however, it encouraged an emphasis on medical intervention and discouraged a focus on prevention, health promotion and care. That work was still left primarily to households and to public health units. Although some physician services have been identified as no longer covered by public coffers and some limits put on fees, in general, these have served to increase the emphasis on medical interventions, as have new approaches in hospitals. Meanwhile, public health, the other health service funded directly by the state and provided without fees, has been significantly reduced. This service not only helps keep people healthy, thus reducing care needs, but also helps women look after themselves and others in the home.

State funding for long-term care and home care, as well as other community services, is much more diverse. Most programmes have strict eligibility criteria and require fees. And rising fees have been combined with stricter criteria. The more fees and eligibility criteria play a role, the more difficult it is to ensure equal access and the more care is left to the household. The same is true of day care services, which for the most part are based on subsidies for the deserving poor rather than on funded centres open to all. As a result, there are growing gaps among those who receive and provide care. Moreover, more of the long-term home and day care paid for from the public purse is provided by for-profit firms. For-profit firms necessarily spend some of their money on profits rather than care, putting considerable pressure on those women who work in these organizations to work harder and for less money than in the hospital sector.

Governments also fund individuals directly or indirectly, allowing them to purchase or provide care. Tax deductions to cover the costs of providing or receiving care can provide some support, but they do little to help those with low incomes. Means-tested allowances to purchase or provide care services are another option. In addition to offering resources, these allowances may give care recipients more choices about what kinds of care they receive and who provides this care. They may also mean some pay for women who received no pay for providing care in the past. Care allowances can thus mean some power shift. And they may be the only option in areas without other services. Such allowances raise a number of critical issues, however. The allowances are usually quite low, reinforcing the low value attached to women's work while confirming this as women's work. These personal arrangements may be exploitative for either the provider or the recipient, especially if there are no other options. Finally, with the care hidden in the household, it is difficult to assess its nature and quality.

Insurance companies also fund care and are increasingly doing so as less care is provided through public services. Insurance companies have eligibility criteria both for joining insurance schemes, and for what care and how much of care will be covered. They also require premiums and most are made available through workplace plans. Women are less likely than men to be covered at work, but more likely than men to be covered as spouses. They are less likely to be able to pay the premiums and, given that they live longer and use more services, it seems likely that they would more often be denied coverage. Women who have no employed partners or who are poor are thus left to rely on friends, families and charities, rather than insurance, for care. As services are de-listed and public care made less accessible, more people rely on insurance, thus increasing differences in the right to care.

Charitable and religious organizations rely on both governments and gift-giving for their funds. Both sources are frequently variable and unreliable, making it difficult to provide either stable care or stable employment. Tax deductions are intended to encourage support for these organizations, but they mean that those with money are making decisions about what care is provided and are doing so at government expense. They may also be able to use their financial clout to influence the criteria used for care.

Finally, individuals and families pay for care. As less care is provided in the public system and by insurance companies, more care must either be paid for out of private purses or be provided without pay. Those with economic resources will be able to buy care directly. And some women fall into this category. But most women have to find other means of getting or giving care. For those with few resources, this can mean they have and give no care at all. Even when paid care is provided, there are additional direct economic costs in providing care: costs such as drugs, bandages and equipment. Equally important, women pay in terms of their paid employment and their own health, in terms of opportunities forgone and control over their lives. Families may be disrupted or even sundered, especially with the increasingly universal assumption that all families can care. Women are more likely than men to be left alone to care.

In sum, **funding is about more than the money. It also is about how and with what criteria funding is provided. Each method of funding has an impact on access to care and on the nature of care.**

THINKING THROUGH SPACE

It is not only social locations related to gender, class, race, culture and age that matter. Physical location also plays a role in the nature of care provided and in the conditions for care.

In the move to shift care from institutions to communities, institutions have been portrayed as impersonal, bureaucratic, hierarchical, distant, expensive, lacking in privacy and even dangerous. By contrast, communities are characterized as personal, immediate, responsive to individual needs, cheaper, safer, private and more individual.

Yet institutions also mean more people, more equipment, more safety measures, more formal education and more opportunities for promotion. They also provide better pay and benefits to providers than communities do. Within institutions, people can work in teams that bring together a range of skills and provide mutual support. Such teams can also make both providers and care recipients feel safer and act more safely. They provide a place where you can go for help, a stable address for care. Moreover, institutions can provide some boundaries for providers and recipients, boundaries that help increase control and reduce some of the negative aspects of dependency. Equally important, public institutions funded on the basis of universal access can reduce gaps in access among recipients and help create decent working conditions for providers, while paid provision offers an important alternative or complement to unpaid care.

Communities, on the other hand, can mean isolation for providers and care recipients, isolation from both others with appropriate knowledge and others who can offer social support or protection. Communities can also be dangerous, with privacy hiding violence, ignorance or lack of the means to provide adequate care. Equipment and facilities are less likely to be designed for specialized care, and the crowding of care into inadequate space can have emotional costs for the whole community. And community providers tend to be low-paid or unpaid and seldom have benefits at all. Indeed, community care is cheaper primarily because the full range of costs is not counted and because the care may well be inferior to that provided in institutional settings. Perhaps most importantly, the gaps in care are much wider within communities both because it is less monitored or visible, and because there are large inequalities among communities in terms of their resources. Communities remove the boundaries, creating more personal connections while increasing dependency and reducing control. Moreover, the move to communities assumes people have communities that can and will serve their care needs. As people move more within the country and around the globe, their communities of support often disappear.

Households are also often ill-equipped to provide care. This is not only a problem of having such things as wheelchair access and room for a lift. The physical space may be unable to accommodate the demands for care without invading the space necessary for families to live, enormously escalating the tensions of daily interactions. Families vary significantly in their capacity to make such accommodations. And of course some families have no home at all.

The point is not to reverse the claims arguing that institutions are better than communities. Rather, **the point is to raise questions about the move out of institutions and suggest this be**

re-examined, taking a different perspective. Instead of setting these up as good/bad alternatives, we should be asking how can we make both better, injecting what is good about each into the other and thinking about the impacts on both providers and recipients. And when we are redesigning these spaces, we should also be thinking about how their internal physical structures promote or impede care.

Combined with a shift from institutions into communities is the development of giant institutions and the elimination of smaller ones. Justified as more efficient and effective, these massive structures are clearly important in providing high tech, skilled care. However, they also move care farther from home, making it difficult for care recipients to connect with their communities just as they need such support most. Indeed, all the issues raised about bad institutions can apply to them. While there is evidence to support a claim that some highly specialized care facilities are necessary, there is less to support the claim that most care institutions should take this form or that giant organizations are necessarily less expensive in the long term.

In a country the size of Canada, space is obviously about more than the size of institutions. Canada is a highly urbanized country, with many of our cities divided internally by race, culture and class. Where care is located within these cities, and the extent to which they respond to the particular needs of their different populations, are clearly questions that need to be addressed in thinking about care. Location can determine access not only in terms of the physical distance required to travel and the cost or availability of transportation, but also in terms of the cultural space between providers and care recipients. With sufficient populations that can demand and sustain them, cities may well be better placed to provide for a variety of needs. It is possible, for example, to offer respite services that can accommodate several languages, to build long-term care facilities that serve Catholics and to create community centres and programmes that cater specifically to Black teens.

These urban dwellers are often better placed than their rural counterparts. As geographers Greg Halseth and Allison Williams explain, the "general problem of service provision in small, geographically isolated, rural communities is exacerbated by government policy that fails to recognize the unique circumstances of these non-urban places."[18] Although rural areas, like other communities, are often portrayed as caring and sharing, there may be few people around to care and share as young people leave home in search of work, shopping moves to the city and fewer people are required to work the farm or the boat. Even women with economic resources may find it impossible to get paid providers to locate in these regions, and unpaid providers may find themselves working alone without a safety net. Those who are a minority within Canadian society are likely to be a very small minority in rural areas, leaving them with little choice about support for care that addresses their particular needs. Yet it is possible, as Halseth and Williams demonstrate using the example of rural Ontario, that with state support communities can build integrated public services that support "community wellness" for unpaid providers.[19]

Canadian-born residents may also be better placed than the foreign-born, because space may separate the latter not only from people who can provide care, but also from the culturally familiar. Even for the Canadian-born, however, frequent moves to follow education and jobs or, especially in the case of the retired, to seek cheaper housing, may separate both relatives and cultures. Lack of public transport can also make care problematic, especially for women, who are more likely than men to rely on such transport. Moreover, more and more women have to travel extensively for their work, moving them far from their care work, although this may change after the September 11th terrorist attacks in the United States.

Questions of space may also be viewed from the perspectives of the different people involved in care. For the daycare employee, the centre is a workspace, for the child, a play space, and for the mother a space which may be either supportive of her or undermining to her, or perhaps both at the same time. Similarly, a long-term care facility is a home for residents, a workplace for paid providers, and sometimes a space to be avoided by relatives who feel guilty about placing their mothers there. For families, home may be a place for entertaining friends, for the care recipients a place where they need quiet comfort, and for the paid care providers a workplace that should be ordered in a manner than meet their standards of care. Thus, each of the participants may have different, and conflicting, space needs. For example, the care provider may want a smoke-free workplace that has accessible equipment to help with lifts, while the care recipient wants to smoke in what is now home and may not want this home to be crowded with equipment that is a reminder of frailty.

Space is, thus, also about social relations. It can make better care possible or undermine care. It can promote or mitigate against conflict. It can support or undermine unpaid providers or do both at the same time. There can be space for a hug, an often unmeasured but critical component of care for provider and recipient; or a hug may be ruled out by the structural arrangements.

In short, space matters. Location also has an impact on the work of unpaid providers delivering care to people and seeking support in their caring. So does the kind of physical space in which care is provided. Although this section raises only some of the issues related to space and care, they should be sufficient to show that **physical location must be taken into account in understanding care.**

THINKING ABOUT TIME

Space issues are linked to time issues. Care is required and provided in different time frames, as well as in different locations, and the two may be related. So, for example, if hospitals are now concentrated in one urban centre, the time it takes for unpaid providers to get to their unpaid work will be lengthened. Indeed, the time it takes may make it impossible to provide this unpaid care. There may be space for a hug but no time. And like space, time can be viewed from number of different perspectives.

Perhaps the most obvious time issue is the difference between the short term and the long term. An emphasis on markets and costs encourages an emphasis on short-term financial expenditures. However, what is cheaper in the short term may be more expensive over time. The short-term view can mean increasing the workloads of paid and unpaid providers now in order to cut costs. But the long-term costs for the women who provide care may include deteriorating health, lost job opportunities, disrupted communities and poverty in old age. At the same time, it may mean deteriorating health for those who receive care. It is now fashionable in policy circles to stress the importance of the early years for later life -- that is, to take a longer view -- but children are too often examined as if they had no care providers who themselves have needs that must be addressed in order to offer good care. Care providers, too, grow old, and their needs in old age are influenced by the care they provide now and how they must provide that care.

The focus on the short term also obliterates the way people move through periods of dependency and of providing throughout the life cycle. We are all dependent as children, but the majority of us in turn care for dependent children. The teenagers who today are suffering from depression may as adults support young people with similar concerns. Those who need considerable help after major surgery this week may next month provide care for a friend in similar circumstances. The same elderly who today are named as the threat to our health care system, were yesterday providing care and may still be doing so today in some form. People with life-long disabilities often also have periods in which they, too, can provide support, or they may provide this support in different ways.

Time is also about time of life. The needs and resources of women who arrive in Canada in their 60s are different from those who come as infants. The time for caring that a young woman beginning a career has is quite different from the time a retired woman has. The time a woman with young children and a job has is not the same as the time the mother without paid work and children at home has. However, in none of these cases can we simply assume any of the women has time to care.

The lumping of care into a single category may hide the significant differences in the time required for care. People who have day surgery usually require intense support for a limited period of time. Some people with disabilities require limited care each day for life; some require intense care for life. And their life expectancy may be short or long. Children require not only different amounts of time as they age, but also different kinds of time. The same is true of people with different illnesses. Care may take the same amount of time each day or a variable amount of time each day. It may be daily or occasional. It may be limited now but increase with every day. This care time is also related to space. It may be more possible to account for the needs of someone who is severely ill for a finite period of time within a confined household but much more difficult to do so if long-term care is required. Obviously, these time dimensions have significantly different consequences for providers. Women are more likely than men to do the care that is done every day and over long periods of time.

The time it takes to care may have clear boundaries and be spatially confined. This is more likely to be the case for paid providers and for men than it is for women and especially for those who provide unpaid care. Such boundaries are more difficult to draw when provider and recipient share the same space, when care needs are chronic or when a single person is the primary care provider. The lack of time boundaries can make independence and separation difficult or impossible. Providers can find themselves in situations in which they have no time for themselves, no time not at work caring.

Waiting times are also an issue. How long care recipients wait for an appointment or wait in line after the appointment is made has an impact not only on their time, but also on the time of the care provider. Some of this time is obvious as mother and daughter sit together in the emergency room. But the anxiety, as well as other health consequences, of such waits can also mean more time is required for the rest of care. Limits on care time also have obvious consequences for unpaid care. Within and outside institutions, women often find themselves making up for the care not provided because paid care time has been cut to a minimum and is often based on the assumption that unpaid providers will fill in the rest of the time. At home, care is often required 24 hours a day, but public care seldom is provided for more than a few hours. Similarly, respite time is often so short it simply leaves time for frantically getting other unpaid work done rather than time for respite.

Like space, time may appear differently to each of the participants. For the employer, time is money, and therefore every effort is made to reduce care to the most obviously necessary and easily measured tasks. This involves controlling, as precisely as possible, the time each person takes to provide care. For the employee, control may be as important as income, and control includes the capacity to decide how long to spend with each care recipient as well as on each task. For the care recipient, control over the time spent is equally important. This may mean getting care provided as quickly as possible or taking as long as possible, but in either case it requires some control over time. What is a long time for the provider may be a short time for the care recipient. As is the case with space, resources can help caregivers gain more control over their time. However, this is not necessarily the case because the woman executive may have no time to care, even though she has the money to buy time from someone else to provide care.

Those advocating for unpaid caregivers have frequently argued for time budget studies and have successfully argued for Census counting of care time. The purpose is to make the care visible so it can be valued and supported, financially or otherwise. Although the purpose is laudable, the solution of counting care time is problematic. Care time is hard to count, in part, because it is hard to define and the boundaries are so unclear. This is especially the case when it overlaps in households with other kinds of work, paid or unpaid. Moreover, those who provide care often do not define it as care time. So, for example, is baking cookies that will be eaten by a family that includes a disabled child leisure, domestic work or care work? And how long do cookies take? Does sitting down for a cup of tea with a neighbour dying of cancer count as care, and how long does tea take? Similarly, women who have been looking after their spouses all their lives may not count the laundry and cooking they do for their frail and dependent spouses as care time. In the effort to make care visible, the pressure on counting tasks and reducing care to such tasks may increase at the same time as the total time involved is underestimated. This underestimation, in turn, may serve as an excuse to send more care work home to be done by those whose time pressures are rendered invisible by these counting techniques.

In sum, time interacts with space, and both matter. Time, too, is about social relations. **Time is a critical aspect of care: one that needs to be considered in order to understand the demands on providers and the alternatives available to them.**

EMPOWERMENT

Empowerment is, like globalization, a term covering many notions of how people gain and keep power.

In policy circles, it is often talked about as increasing choice. And choice, in turn, is intended to mean consumer choice or the right to buy. This is the kind of choice that is meant by the introduction of non-public health care services: services that could be purchased instead of using public ones. It is the kind of empowerment meant by a voucher system for purchasing child care or home care. There are, however, two basic problems with this kind of choice in addition to those described earlier as problems with markets in general in relation to public goods and services. First, when everyone uses the same public system they have an interest in ensuring that the public system is good. As soon as they can buy alternative care directly, they have less interest in maintaining a public system and indeed may object to supporting it. The result is poor care for the poor who are unable to afford the private system, and most of these poor are women. Second, consumer choices are usually individual rather than collective, and those with more consumer power have more choice. This, too, means greater inequality and even less choice for the many women without this kind of power. Consumer choice in care thus simply means more power for those who already have it and more work and less care for those who do not.

Empowerment is also often used to mean accountability, a concept that itself has several meanings. Increasingly, accountability in care means counting. In the name of accountability, ensuring quality and evidence-based decision-making, more and more data are being produced by care organizations. With all the new technology, we count the number of beds used and how frequently, the number of services provided and how often, the number of caesarian sections performed per surgeon and where they are done, the number of children taught by each teacher for how long, and the number of tasks performed per provider in how many minutes, to name only some of the numbers collected in this rush to accountability. Although such numbers are often useful in decision-making, much depends not only on what is counted and how it is counted, but also about what is done with those numbers. If they are used to justify decision-making by experts in ways that exclude women, then they can mean disempowerment rather than empowerment. Furthermore, arguments for accountability, defined as accounting in particular ways, may put considerable burdens on communities that must produce such accounts in order to be eligible for support in providing care.

Regionalization and de-institutionalization have also been characterized as forms of empowerment. Sending care and responsibility closer to home has been presented as a means of responding to local needs. Regionalization may mean more women are involved in decision-making in local boards, especially if they are elected. However, much depends on the resources and power these regional boards are given. If they are more about responsibility for cuts and decisions about creating services, then regionalization may be disempowering. Furthermore, local decision-making, especially under conditions of severe restraint, may mean that the needs of particular groups such as lesbians and immigrant women are ignored. Sending care closer to home could mean care recipients have more choices about how their lives are structured. But sending care closer to home without public service support simply means, under current conditions, more work for women and less control over their lives when they provide care. One woman who has looked after two very ill, elderly parents for years recently wrote us to say she was “under house arrest.” Clearly care closer to home has not meant empowerment for her.

For paid caregivers, power involves the right to make daily decisions about what should be done for and with a patient. It also involves a say over when, if, where and how they work. Restructuring has created considerable disruption for these workers in the process reducing their sense of security and control. Simultaneously, in the name of increasing efficiency, new managerial strategies have been developed precisely to reduce the control these providers have over their work. Although Total Quality Management and other such schemes have been introduced in the name of increasing participation, there is little evidence that they have actually empowered workers and some evidence to indicate that the schemes reduce the power of their unions. For unpaid providers, restructuring has also disrupted familiar service structures. This alone would not be a problem. Indeed, it may even be an advantage if it led to the promised “one-stop shopping” that provided access to a full range of co-ordinated services and those helping others to get care could save time and steps. However, when combined with cutbacks on care and limits to care, it may simply mean that there is co-ordinated denial, and that providers feel they have less say over what care is available to assist them in their care work. With paid workers entering households both to assess the need for and to provide care, unpaid providers may feel disempowered by rules set elsewhere and applied within their own homes by professionals who seem to have power.

The relationship between care provider and care receiver is also about power. How power is balanced depends to some extent on the alternatives available to each, as well as on their resources. Care receivers may be disempowered by their dependency, a dependency that increases as access to public alternatives decreases.

Empowerment is about gaining 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 decision-making in ways that have an impact, the right to equal pay and other employment protections or 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 and social support. The more resources are distributed by market mechanisms, the greater the disparities in resources and thus in power.

WHAT IS IT ABOUT CARE?

Care is a complex concept.

Care necessarily involves a relationship, whether the care is provided by paid or unpaid strangers, friends or family. It involves a relationship because it is people who need care, people who must communicate, respond and relate. It is, thus, a reciprocal rather than one-way process. It is a relationship that often involves intimacy and may involve dealing with our most intimate or personal needs, even our very definitions of self. And because this is a human relationship, it also involves emotions. The emotions may be strong or relatively weak, sometimes one and then the other or both at the same time. They may involve love or hate, and often these contradictory emotions simultaneously. They may be mainly about concern for another human being who has needs that may well be ours someday. They may be about how others perceive our needs.

The care relationship brings together individuals who have specific histories, specific locations and specific needs. It involves whole, complicated people embedded in networks of social relationships. And this is as true of the care providers as it is of the care recipients. While there are clearly general patterns of needs and there are clearly ways we can develop general strategies for addressing them, each relationship requires a sensitivity to the particular persons involved. So, for example, it is necessary to develop procedures for treating Alzheimer's disease, but how those with Alzheimer's are treated depends on their circumstances and conditions. Someone who has survived the Holocaust may have a particular aversion to any form of restraint, while someone who was born in Japan may need particular kinds of food in order to feel safe. What is vital is specialness rather than sameness at the level of care in the individual case. Rules need to be interpreted in the context of the specific; equity needs to be defined in the context of understanding difference.

Care relationships are, thus, diffuse rather than clearly defined. The boundaries for care are usually difficult to draw in terms of what is done, how long it is done and where it is done. Care work is about much more than a series of tasks precisely because it involves verbal and non-verbal communications, and emotions that are difficult to make visible and measure, specify on paper and assign as discrete items. Certainly we can tease out tasks that are part of care. And we can determine skills required for the work. Indeed, recognizing the skill involved in caring is essential if we are to ensure care is made not only visible and valued, but also safely delivered. Recognizing the skilled nature of the work is also necessary if we are to ensure that we do not assume that all women can and should provide all care. We can also outline needs in quite detailed ways. But the process that transforms procedures into care is much more blurred and more difficult to express. So are the boundaries on needs. Certainly we need to have some boundaries, otherwise care work will be endless and especially burdensome. We need as well to draw some lines to make sure that caring about someone does not mean you must care for them. We have to realize, however, that especially because care is about people's needs, the boundaries cannot easily be precisely determined according to standardized rules and procedures that fail to allow considerable individual judgement and control.

The character of care relationships varies with individuals, locations, external pressures and training. Notions of professional distance, created by training and pay, shape the emotional involvement, but if distance means complete detachment it is hard to think of it as care. Skills need to be acquired, often certified and certainly practised, but some of them are acquired through experience and early in life in ways that are hard to recognize or assess through formal educational means. Those who are paid and highly educated are more likely to have authority than are those who are not, and they are also more likely to share the care with others than are unpaid caregivers. For unpaid care providers, the responsibility may be defined as the result of a relationship, while for paid ones responsibility may be defined in terms of professional oaths and ethics. Nevertheless, both paid and unpaid providers feel responsible for the people who need care. What we need are strategies to ensure that it is possible to fulfill these different responsibilities without creating more inequalities among women and without locking in or reinforcing poor care.

The nature of care contrasts sharply with the notions, practices and pressures in most labour market work. In the market, efforts are made to define work in terms of tasks, to have clear boundaries in time and space, to promote distance, to develop standardized procedures and to define equity as sameness. Responsibility is achieved more through hierarchy, pay and bureaucratic control than through relationships or guilt. Like the boundaries between private and public, however, the boundaries between care work and other forms of work are becoming even more blurred.

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."**[20] It is, in other words, important to recognize what is valuable and critical to keep the care in care, wherever it is done. **But, we would add, it is necessary to do the same in the private sphere, as well**. While precise boundaries and standard procedures limit the possibilities for choices and care through paid work, lack of boundaries and procedures may limit choices and care through unpaid work. Similarly, recognizing the whole person, their special needs, their personal histories and the emotional aspects of care is critical, but placing too much emphasis on both may make caring impossible to achieve in either sphere by paid or unpaid providers. There are dangers in the stress on relationships 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. The failure to recognize relationships may make care work like factory work, limiting possibilities for both providers and recipients.

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 is the objective, not the problem.**

GUIDELINES FOR THINKING ABOUT CARE

1. Both lumping and slicing are required. It necessary to understand not only what women share and how they differ, but also to take different approaches to the same issues and situations. It is equally necessary to resist definitions of women as ‘natural’ caregivers, exposing the social relations, processes and structural arrangements that create women as primary carers and do so in different ways for different women.

2. **Contexts matter**. Contexts are most notably provided by global tendencies and realities, states, markets, communities and families. Contexts also include notions about these, as well as about women, race, culture, sexuality, equity and age. All play a role in shaping women’s caring, although the role they play is contradictory. It is important to recognize that these contexts are created by human hands, including those of women. There are, thus, choices to be made and women participate in these decisions, albeit often in unequal ways.

3. **It is important to assess boundaries and overlaps linking public and private spheres**. Recent developments have served to blur boundaries between private and public sectors of the economy and between formal economy and household. While private and public spheres in both senses of the terms have always influenced each other, the influence may well be stronger the more boundaries are blurred. In any case, it is necessary to explore not only how each influences the other, but also how the structure of boundaries influences women’s caring.

4. **Payment is critical**. What the costs involved in care are, who pays and how do they pay are all questions that need to be addressed in understanding women’s caring. The costs include much more than money and the methods of payment much more than providing financing. As access to resources becomes more critical in accessing care, differences among women increase.

5. **Time and space are factors in care**. Time and space are both resources and limitations and are linked to each other and to differences among women.

6. **Empowerment must be defined in ways that understand that power is about access to resources**. The resources are material, political, social and symbolic and profoundly influence whether women can participate in making decisions about their own lives.

7. **Care is the objective, not the problem**. All human beings want and need care, although their needs and wants vary with for example age, location and ability.

The reason for developing our understanding of women’s work, in general, and their caring work in particular, is in order to allow this understanding to provide the basis for creating conditions that allow women the right to care in ways that take their needs and capacities into account.

ENDNOTES

1.Pat Armstrong and Olga Kits, “One Hundred Years of Caregiving in Canada,” Ottawa: Law Commission, 2001.

2. Deborah Stone, “Caring by the Book,” in Madonna Harrington Meyer (ed.), *Care Work: Gender, Labor and the Welfare State.* London: Routledge, 2000, p. 91

3. Miriam Glucksmann, *Cottons and Casuals: The Gendered Organization of Labour in Time and Space*. London: British Sociological Association, 2000, p. 16.

4. Berit Brandth and Elin Kvande, “Flexible Work and Flexible Fathers,” paper presented to the conference on “Rethinking Gender, Work and Organization,” Keele University, England, June 2001.

5. Emily K. Abel, “A Historical Perspective on Care,” in Meyer (ed.), *Care Work,* p. 8.

6. See Kathryn Ward (ed.), *Women Workers and Global Restructuring*. Ithaca, NY: Cornell University Press, 1990.

7. Grace Chang, *Disposable Domestics: Immigrant Women Workers in the Global Economy*. Cambridge, MA: South End Press, 2000.

8. Christopher Pierson, *Beyond the Welfare State: The New Political Economy of Welfare.* Second Edition. Oxford: Blackwell, 1999, p. 130.

9. Pierson, *Beyond the Welfare State,* p. 125.

10. Ian Gough, *Global Capital, Human Needs and Social Policies*. New York: Palgrave, 2000, p. 16.

11. Naomi Klein, *No Logo: Taking Aim at the Brand Bullies*. Toronto: Knopf Canada, 2000.

12. Dexter Whitfield, *Public Service or Corporate Welfare: Rethinking the Nation State in the Global Economy*. London: Pluto, 2001, pp. 18-19.

13. John Shields and B. Mitchell Evans, *Shrinking The State: Globalization and Public Administration “Reforms.”* Halifax: Fernwood, 1998.

14. Carroll L. Estes, Karen W. Linkins and Elizabeth A. Binney “Critical Perspectives on Aging.,” in Carroll L. Estes and Associates, *Social Policy and Aging*. London: Sage, 2001. p. 31.

15. H. Land and H. Rose, “Compulsory Altruism for Some or an Altruistic Society for All?” in

---

P. Bean, J. Ferris and D. Whynes (eds.), *In Defense of Welfare*. London: Tavistock, 1985.

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

17. Gillian Pascal, *Social Policy: A New Feminist Analysis.* London: Routledge, 1997, p. *75.*

18. Greg Halseth and Allison Williams, "Guthrie House: A Rural Community Organizing for Wellness," *Health and Place* 5, 1999, p. 29.

19. Halseth and Williams, "Guthrie House."

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