

Womancare – Health Care: *Power and Policy*

By Martha Keniston Laurence

This paper is about women, aging and health care; about policy, power, and the control and distribution of resources for that health care in Canada in the 1990s.

To be female, old and sick is to be truly a 'powerless out' in a society which reveres that which is male, young and healthy. Women, mostly alone, comprise the overwhelming constituency of geriatric care consumers in this country. Women with two jobs (one at home and one in the paid labour force) comprise the overwhelming constituency of geriatric care providers. The increasing numbers of both present a serious dilemma at a time when the whole system of care is under assault.

Public rhetoric and the Canada Health Act would lead us to believe that health care is a right and something we can take for granted in Canada in 1991. However, if we look at the allocation of health care dollars and, indeed, at the decision-making apparatus whereby decisions regarding those allocations are made, we need to question that rhetoric. In fact, most of our health care expenditures are restricted to the arena of medicine; decisions regarding distribution of the resources are made by physicians.

Medicine and health care are not synonymous. Medicine, as taught and practised in Canada, is the clinical, scientific and technical diagnosis and treatment of disease and illness defined in biological terms. Health care is the overall development and maintenance of persons' and populations' optimal levels of function in physical, social, emotional, psychological and spiritual spheres. Medicine is *one* component of health care.

Discussion about allocation of resources to the elderly often revolves around the influence of ageism and bias against old people in society in general, and the right of older people in an environment of limited resources to the high tech opportunities of modern medicine.¹

The focus is misplaced. In fact, it is the low tech medical and health related services that are of equal importance in geriatric care. It is the health related services that maintain persons' function and quality of life and often keep them from needing the more expensive high tech facilities of modern medicine. The organization of the system of health care delivery concentrates power and control in the hands of an elite profession dominated by men. It decides on the allocation of health care dollars, with the result that the health related services, so germane to health care of the elderly, are accorded only a nod of marginal recognition and piece of the resource pie. We can debate the concept of ageism as an influencing factor in this process, but **SEXISM** is the more pervasive underlying dynamic at work. It is with this concept that I shall examine the health care of old women.

Women, Society and the Organization of Health Care

We live in a patriarchal society in which women are primarily relegated to the private domain (their participation in the paid labour force notwithstanding), while men dominate the public domain.² This traditional view of social organization provides the guiding protocol for functions and power distribution of men and women in our society. Men manage the public domain, which governs, legislates, sets policy and controls the allocation of resources (money, power, authority, services, opportunities). Women manage the private domain, which provides the male power (bearing and caring for children) and the support structures that maintain and nurture the public domain: the private domain does not set policy and has little say in the distribution of resources.

Our health care system is a microcosm of the society as a whole; the place and treatment of women in the society at large is paralleled in the system that delivers health care (Figure I). It is reflected in its division of labor and assignment of chores, roles and tasks, decision-making power, authority and control. Men dominate the power structure and control the system of rewards; women fulfil the subordinate and private domain functions of support, care, ministering and nurturing, as nurses, social workers, occupational therapists, physiotherapists, and so on. And the majority of care recipients in the system are women and children who are defined by society as weaker, more dependent, less capable, sicker^{3, 4}. We live in a society that values and rewards power and status in the public arena and views as less significant the roles and functions performed in service to and in support of those who do the "real" work of running the society — those who hold the positions of power in the public domain. This system of recognition and control is replicated in the health care system (Figure II).

When we get to geriatric health care, we have an even more pronounced microcosm of society. Almost everyone is female. There are a few filtered scraps of male power that make it into the old age world in positions of authority (such as medical directors, geriatric consultants and administrators). Within the society at large, the concept of old is not one of high status, of power or desirability. Within the world of medicine, geriatrics is far removed from the excitement, power and status of razzle-dazzle, acute, high tech curative medicine. Geriatrics is not a speciality which attracts large numbers of aspiring new and young physicians and is not an arena into which many resources are directed.

The development of acute geriatric assessment units, short

term rehabilitation units and day hospitals within the periphery of organized medicine is an attempt to incorporate geriatric care and make it more acceptable within the definitions of medicine (active versus chronic care). This marginal inclusion of geriatrics is in response to the demand and considerable financial implications of treating the sick elderly.

Geriatric medicine, however, makes a clear delineation between these more active and demanding treatment interventions and long-term care — which happens somewhere else. We move outside of this organized, contained and more clearly defined realm of geriatric medicine proper to embrace the notion of HEALTH CARE for the elderly. This includes the range of health related services and supports (VON, Meals on Wheels, etc.) which enable individuals to function with a modicum of independence, perhaps in their own homes or a variety of community living designs, or in institutions of long-term care such as chronic, extended care and nursing home facilities.

The resources peter out rather dismally at this stage of delivery. In general, we also move from insured services to uninsured services, from those paid for by the government's universal system of health care to those for which the individual is financially responsible and/or is relegated to the rolls of social assistance and welfare when their personal resources run out. The proportionate allocation of resources reflects the social value and posi-

tion accorded to both women and old people in our society. Being both a woman and old is rather akin to a marriage of the disenfranchised. Women in Canada can anticipate being poor and left to our own devices in old age^{5, 6}.

Government Policy and Community Care

The political trend in this country is one detrimental to women, families and the old. In these politically conservative times we are experiencing a reassertion of the male power model of dominance. The women's movement has been met with renewed efforts to keep women in our secondary position and role as supporters and nurturers. We have been excluded from the hallowed halls of power and control. For as far as women have come, we still do not participate at levels that control policy and decision-making in societal and government arenas. We may be visible in recent years in medical training programs, but women do not come near the structures of control and decision-making in teaching, professional and regulatory associations. The mere presence of twenty or thirty elected female politicians and a couple of high profile cabinet ministers does not mean that the voices of women are recognized, reflected or represented^{7, 8}.

The social reality of our times and the redefinition of family seem to be ignored in the current political climate. Family

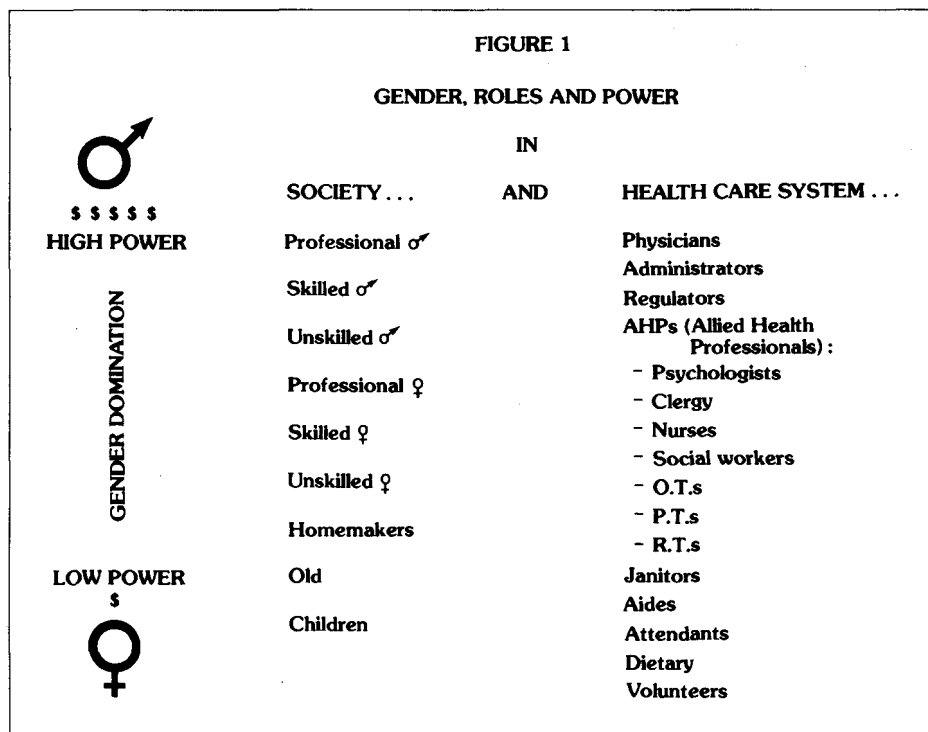
structures of the nineties reflect a changing and evolving world of the past three decades. Our model from the fifties was the Cunninghams — him (out in the world earning the bread), her (maintaining the family home surrounded by the white picket fence, smiling), two children (elder male, younger female). It is this romanticized image to which the pro-family movement of the nineties is reaching back in its effort to reassert traditional gender roles with their clear delineation of power. This rhetoric provides a rationalization for the dismantling of services and supports which, within a climate of collective responsibility and social commitment, offer certain basic quality of life rights for all members.

But the Cunninghams are no more. Our fifties model is, in reality, a minority among family designs for which terms such as single parent, blended, reconstituted, two career, dual earner, and so on, more immediately come to mind. Images associated with the white picket fence (nuclear family in single family dwelling) are far from the majority of actual family living arrangements today.

When it was convenient for the national interest (for example, during the forties when Canadian men were involved in the war effort), women worked in the factories and built the armaments to support that effort. When the war was over, women were expected to go back to the private domain and resume their role as supporters, nurturers, bearers and carers of children from a position of dependence on men. It is highly questionable whether the Cunninghams ever really existed. The model they portrayed was certainly a very oppressive one for women; and it did not work despite the best efforts of both women and men.

In the nineties our reality is that the majority of women participate in the paid labour force and they do so for economic survival — their own, their children's, and their family's. Most women do two jobs because of unchanged expectations and behaviours in the private domain, where they continue to fulfil the traditional functions of nurturing and caretaking of everyone in their family and their living space. They also still make significantly less money for the same work as men in the paid labour force. Men have not assumed co-responsibility for the functions of the private domain^{9, 10}.

In tandem with the resurgence of tradi-



tional family rhetoric, we have been faced with policy shifts in health and social services which move the provision of those services into the private sector, the community, and the family. In an effort to achieve relief from the growing financial burden of taking care of the mentally ill, the developmentally disadvantaged, the old and infirm, government policy has embraced community care as the preferred, more humane site and system of care. However, even the promised community support services meant to accompany this process have never really materialized; the burden of care has fallen on the family.

During the same period we have experienced a notable increase in numbers of very old people for whom supports and services are needed to maintain their community base. While keeping the old folks at home may be a desirable option, the system of supports and services to assist in that lifestyle are not in place: the job is being done by women already carrying the load of two jobs. We are confronted with risks to women's health at all levels, to those providing the care and to those receiving it. Shifting responsibility for care from the state to the individual places in jeopardy those with the least power to defend or fend for themselves — the old, frail and female.

Family Care Means Womancare

Community care means family care and family care means womancare. This results in the burden on caregivers whose own health and well-being is also being put at risk. Terms such as "sandwich generation" and the "caught generation" have established themselves in gerontological parlance to describe this population of women; there is frequent testimony to the stress load they bear^{11, 12, 13}.

Though not loudly acknowledged in the public rhetoric, our formal (low paid) and informal (unpaid) designs for caregiving are dependent on women and presume they will do the job. It is the women who are providing that care. Rimmer, Ungerson and Graham (1983) talk about the care giving cycle in which women may find that they care successively for children, elderly parents and a sick husband.¹⁴

And then they die.

So What Do We Do About It?

Activate and politicize. We need to make visible that which is currently invisible. And women will have to do it in the face of opposition, since it is in the best interests of the current political agenda to perpetuate and exploit the caring work of women which literally counts for nothing.¹⁵

One can imagine both the haste and the nature of response which would be occasioned if women who are engaged in the caring work went on strike! To do so — even to think about it — is contrary to women's very training, socialization and, perhaps, nature. Women will continue to provide the care, despite risks to their own health. Most women do not question the efficacy of assuming that responsibility in the first place. We have been schooled in familism and it gives meaning to our existence.

Change will happen through either breakdown in the current system or conscious intervention. The former is unlikely to happen because the stress, burn-out and breakdown is on an individual basis; it does not impact on the system because it constitutes part of the invisibility of the work. The cost is born by the women involved — the providers and recipients of the care.

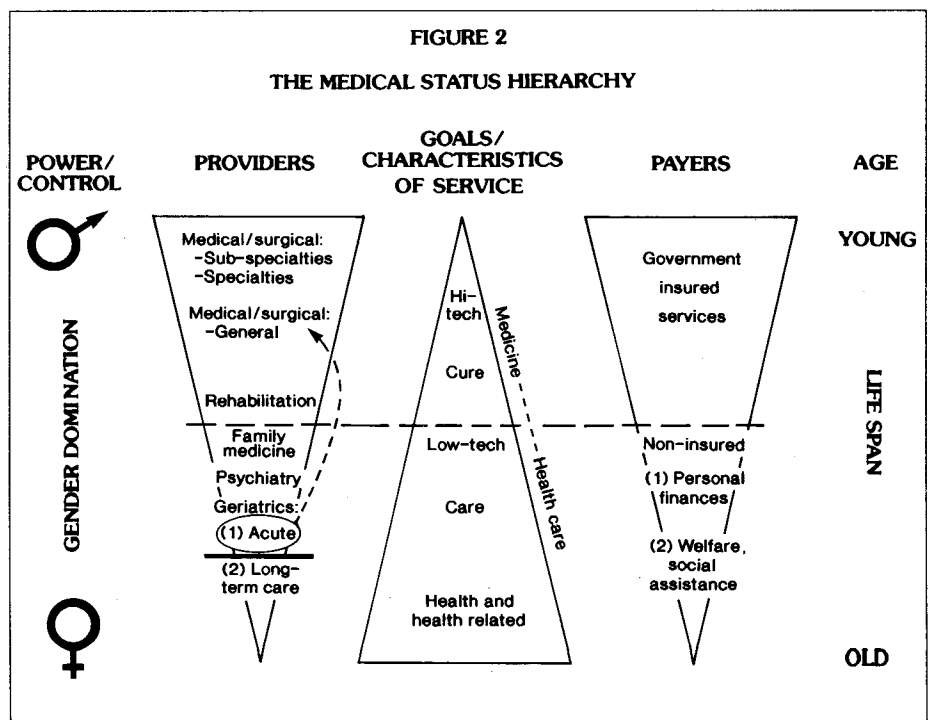
Women who reach the point of no longer being able to cope and/or whose health has already been placed in jeopardy may question the fairness of the situation, while

guiltily placing their elder in an institution. Most likely, they will view it as their personal failure and weakness, rather than a normal response to abnormal circumstances. There is lower probability that women will be able to recognize, much less assert, an opposing view: that the state has a collective responsibility for the provision of health care to all members, women of all ages included.

Conscious intervention. We do have the numbers and the technology of modern communication whereby we can make public the abuses of a system which relies, in part, on the isolation and silence of its subservient members. We can publicly legitimize and normalize the stifled and suppressed voices of women who feel the unfairness as they struggle to survive under their burden. We can publicly question the allocation of resources in a system that rewards the glorification of high tech medicalization of health care while embracing a model of care predicated on an outmoded definition of the place of women in society.

One element of empowerment is understanding our position and making sense of the confusion that invariably arises when our experience and the rhetoric do not jive.

The process of change is long term. It is essential to acknowledge and include in the policy planning process the social realities of the redesigned family and women in the paid labor force. Likewise, we need to accept that women will act for



change according to their orientation and comforts. It is important to remain focussed on the voices of women being heard in all arenas and allow for the differences between our strategies.

We can fight for provision of the promised augmentary services and supports in the community; we can fight for recognition of the service and burden that women are currently carrying. Ultimately we need to aim for change in the basic system — societal and health care provision. We can work in agencies, associations, government, and the formal political spheres. Since our numbers need to be felt in all areas, there is room for each of us to make our thrust where we feel most effective.

We are capable of building strength through networks and numbers. For the first time in history we are dealing with a national women's movement; our capacity to communicate through the new technology eventually will enable us to share equally in control of the social systems through which we organize and run our society.

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¹² Briar, K.H. and Ryan, R. (1986). "The Anti-Institution Movement and Women Caregivers." *Affilia*, Vol. 1(1), 20-31.

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¹⁵ Waring, M. (1988). *Counting for Nothing: What men Value and what Women Are Worth*. Wellington, N.Z.: Allen & Unwin.

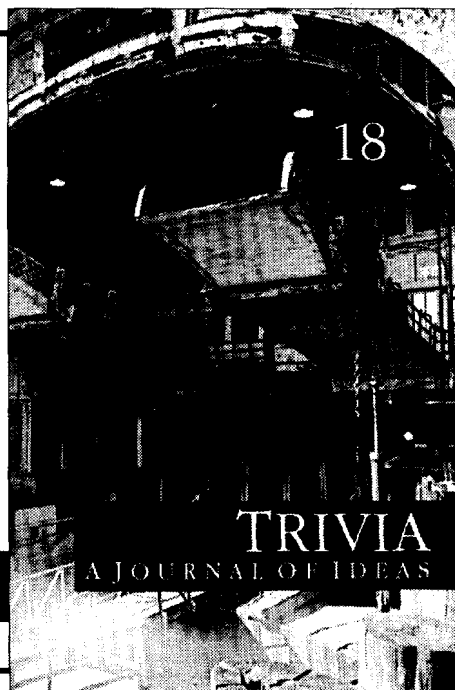
Martha Keniston Laurence is an Associate Professor, Faculty of Social Work, Wilfrid Laurier University, Waterloo, Ontario. Her areas of teaching and research are women, geriatrics and the health care system. Currently on sabbatical leave, she is spending the year in the Department of Psychology, University of Waikato, Hamilton, New Zealand.

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