Hierarchies of Caregiving

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As social workers, we understand that caring work is often undervalued in relation to other occupations and societal roles. Recent research on women's caregiving roles in the northern BC community of Quesnel gives voice to a related, and perhaps not surprising, theme about the hierarchical nature of caregiving itself and the notions of power and status embedded within. As social workers, we not only watch the women with whom we work struggle with (and within) these hierarchies, but we also face them in our own personal and professional lives.

RANKING TYPES OF CAREGIVING

The most transparent type of hierarchy can be seen in prioritizing the three types of caregiving that emerged in the project: paid caregiving (e.g. social work, nursing, support services, advocacy); family-based caregiving (e.g. caring for a spouse, child, friend, neighbour); and voluntary caregiving (e.g. formal volunteer positions with an organization such as Big Brothers/Sisters). Participants talked about these roles and the ways in which one can supersede another, usually in a somewhat predictable pattern with volunteer care provision having the lowest priority.

Women working in volunteer positions were often older or retired women who did not have children living at home and who did not have anyone else in the home for whom they were required to provide care. One of these women specifically identified that her volunteer work began when her ill husband, whom she had cared for in the home for a length of time, passed away. Another participant talked about the lack of volunteers to assist with the work at a care home, saying younger women were so busy with their paid work and families that they do not have time to volunteer these days. She indicated that this was creating a gap in services to clients in the care home. This example demonstrates the reliance on unpaid work to meet care provision needs in public institutions, as well as the economic pressures on women which force them to prioritize their caregiving activities.

Out of economic necessity, most women in the study positioned their paid caregiving before their family-based caregiving and could not afford to leave their jobs, even when a family member needed significant support. One participant acknowledged the competing pressures of paid and family-based caregiving: "If we [society] have the expectation that we will provide care [to family members] ... I think our workplaces need to support that". However, for most participants this was not a reality. Increasing unemployment levels resulting from general economic decline and, more specifically for Quesnel, the pine beetle epidemic and crisis in the forest industry, further compelled women to hang on to the jobs they had. When forced to choose between paid work and family-caregiving, women with access to financial resources would pay another woman to provide the family-based care that they were unable to provide, such as respite care for an in-home dependant or providing meals or housecleaning for the family. In cases where women did not have the financial resources to pay for help, family caregiving sometimes suffered. In one extreme example, a woman caring for a relative's children while also employed in caregiving work became exhausted from the multiple pressures. She could not afford to pay for assistance with the children and could not leave her employment. Ultimately she had no choice but to turn the children over to the care of the state through a voluntary care agreement with MCFD.

STATUS AND POWER WITHIN THE HIERARCHIES OF CAREGIVING

Another aspect of the caregiving hierarchy voiced by women in the project was embedded with notions of power and status. As one participant put it, where you work or who you work for in the social services field places you in a pecking order. From her perspective, the highest status social service caregiving roles are paid government positions, the next are community-based positions, typically those in non-profit organizations. Last are clients who are caring for children. Government positions are considered better paying and more stable and thus are seen as more prized positions, with the added notion that these are the 'real' Social Work jobs. Positions in non-profit or community organizations typically pay less, have fewer benefits and are less stable as they rely on a series of government contracts which may or may not be renewed. There is often less prestige and less power in these positions. In a society where money is used to demonstrate value and validity these sentiments may be unsettling, but should not be unexpected.

The funding process contributes to the power and status differences within caregiving fields. Most community organizations rely on government contracts from MCFD, health authorities and other government ministries for their survival. One participant working for a non-profit organization articulated the all too familiar situation in which she had to curtail or hide advocacy work so as not to jeopardize government funding of her agency or her job. Since most of the workers and clients in this participant's field of work were women, the power dynamics meant that the women in the government roles could, and often did, put pressure on the women workers in community agencies to in turn pressure women clients to comply with expectations. These pressures can become so ingrained in the organizational culture, that workers can lose sight of the extent to which funding relationships contribute to the status based ranking of caregiving work. In

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addition, in small northern communities, people's professional and personal lives frequently overlap and the power dynamics that are present in a work environment play out when meeting the same people in the grocery store or at a child's soccer game.

DOWNLOADING CAREGIVING RESPONSIBILITIES TO WOMEN

When speaking about care provision in a time of economic decline and crisis, it is not surprising that project participants voiced strong concerns about intensification and downloading of care work onto the shoulders of women. In particular, they identified budget cuts and policy changes that have taken place in BC since 2001 which resulted in increased unemployment, as well as fewer or more restrictive access to services in a variety of areas (e.g. transportation, child welfare, health care, long term and extended care). The cuts to funding and services put significant pressure on women to take on more and more of the caregiving responsibilities that used to be provided through a range of government-funded programs. In discussing the health care system's move to discharge patients as early as possible one woman, whose ill husband was sent home from the hospital, said: It is "good to be at home and not in hospital... but responsibility falls on family".

Several participants also talked about the northern, rural and remote context of service provision, highlighting the reality of limited services in smaller communities and prohibitive personal and financial cost of traveling to services in larger centres. For some women and their families, it meant they did not receive the care that they needed. One participant summed up the lack of health services in the north this way: "We're really proud of our universal health care. But it's not universal". Of her work, one social worker said: "What they [clients] really need are things that aren't really offered in our system". Another social worker added, "We stretched and bent and twisted our mandate" to try to meet clients' needs, adding that not meeting their needs can result in apprehending children instead of providing services that would keep them in the home.

Many participants indicated that funding and service cuts, combined with limited access to services in northern, rural and remote communities put pressure on women to provide increasing levels of care to people in their lives. The growing need to juggle multiple caregiving roles resulted in exhaustion, ill health or an inability to do everything needed. The process exacerbates the hierarchy of caregiving as women are forced to give up important roles, such as the woman who had to give up the children she was caring for to state care. In many cases a lack of services actually leads to increased costs to the system, rather than a cost savings which was the reason given for the cuts in the first place.

CHALLENGING THE HIERARCHIES

The hierarchy in types of care provision coupled with the increased pressure to take on multiple caring responsibilities, and the resulting in an inability to 'do it all', has personal implications for both workers and clients. With this kind of pressure women often feel failure and shame at being unable to do everything that is needed. In our practice, it is critical for social workers to be able to recognize and voice the structural connections to this pressure (such as budget cuts and lack of services) and to assist women to see that their inability to 'do it all' is a systemic rather than individual failure. It is equally important to make these structural links in the situations we face ourselves. Self-care remains more an ideal than a reality in the lives of many social workers.

It is also important to better understand how the dynamics of power keep women in different types of caregiving roles apart, leading to an 'us' and 'them' perspective which further individualizes the problems rather than facilitating an understanding of the structural dynamics. Identifying and talking about the power dynamics is the first step in bringing us together as women to challenge notions of levels of status in caregiving work. Ultimately, discussion is needed at all levels of society in order to shift culture, policies and practices that contribute to the hierarchies in caregiving. All caring work must receive recognition and support that reflects its fundamental and essential contribution to the maintenance and ongoing development of our society and of humankind. P

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