Who Cares? Women as Informal and Formal Caregivers

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Caring for the elderly, disabled, or ill children or adults involves several types of women caregivers. Informal caregivers work without pay to help sick family members, often in highly stressful situations. Specific social and economic factors may increase or reduce their burdens. Women formal caregivers working for pay in health care institutions are largely clustered in the lower levels of the health care pyramid. Their responsibilities and opportunities reflect changing trends in medical economics and practice.

This chapter examines two major types of caregiving, informal and formal. Informal caregivers are unlicensed and unpaid individuals, sometimes called “unaffiliated providers” (Abel and Nelson 1990:8). They work outside institutional settings, usually in the home and often with relatives. Formally licensed, trained, and remunerated caregivers include certified nurse’s aides, licensed vocational nurses, registered nurses, and physicians. They usually work in hospitals, clinics, nursing homes, or agencies.

The chapter also briefly mentions two other types of caregivers: (1) formally trained and paid “alternative” caregivers such as chiropractors, not usually included in western biomedical domains but within formal caregiving systems, and (2) culturally designated care providers, i.e., spiritual healers, granny midwives, rootworkers, and curanderas, who provide care, sometimes for pay, sometimes not, but almost always outside the formal health care system.

Informal Caregiving

A curious contradiction arises around women as care providers: on the one hand, women are expected to give informal care. On the other hand,
there has been considerable reluctance to prepare women and admit them to elite care provider roles in medicine. There has also been only grudging recognition of provider professions, such as nursing, in which women predominate.

Feminists disagree on whether women are “natural” care providers: some criticize this view as “essentialist,” meaning that a characteristic has been attributed to women as inherent in being female, rather than socially acquired or attributed or constructed in specific contexts (Schepers-Hughes 1992). Some have pointed out that thinking about caring as “natural” or “essential” to women obscures the complexities within caregiving (Fisher and Tronto 1990:39), which blends many seemingly opposed attributes such as autonomy and nurturance, reason and emotion, public and private (Abel and Nelson 1990:25). Others, although agreeing that essentialism is an erroneous way to view women's actions, nevertheless argue effectively for “maternal thinking,” an attribute they claim can be found in either men or women (Ruddick 1983).

Most feminist writing on informal care has not assumed that women have a natural tendency to do caregiving. Instead, the view here is that cultural demands in women's lives in the everyday world place them, much more frequently than men, in the job of informal caregiver or direct provider to the disabled, ill or elderly. In general, other than physicians, very few males undertake direct caregiving roles, especially not in the home.

Feminist Concern with Informal Caregiving

Feminists interested in women's health have gradually recognized informal care as an important activity done by women, but they have been slow to recognize the many differences among women doing informal care. Otherwise stimulating examinations of household tasks (Berk 1985) or emotions in a domestic setting (Hochschild 1987) did not include caregiving. British feminists began examining the gendered nature of informal care and its place in society (Finch and Groves 1982; Graham 1985; Ungerson 1983). They clarified the idea that, although caregiving was a labor of love, it was also work that could be analyzed in ways that would recognize women's labor. American feminist scholars quickly developed a parallel body of work that deepened the issues (Abel 1990a; Abel and Nelson 1990; Fisher and Tronto 1990; Glazer 1990) and extended the discussion to matters of ethics and moral boundaries (Larrabbee 1993; Tronto 1993).

However, these early feminist analyses of caregiving generally were based on married, able-bodied, middle-class white women with extended kin, a view that hid important features of caregiving in many women's lives. Early formulations of caregiving left no room for analysis of the caregiving experiences of women of color, disabled women, or lesbians (Graham 1993). Indeed, some researchers have questioned whether inferences about primary care providers based on the experiences of able-bodied white American women are applicable to women in nonwhite racial or ethnic groups (Hatch 1991).

Informal Care of the Elderly Infirm

Much of what is known in the social sciences about informal health care providers comes from studies on care of the elderly done by researchers in gerontology, public health, social welfare, nursing, medical sociology, and medical anthropology. This work reflects scholars' and policymakers' concerns about the aging American population (see chapter 17).

That literature shows that not only are most elderly Americans female, but most of those who care for the male and female elderly are also female. More than 70 percent of caregivers to the elderly are wives and adult daughters, though sisters and daughters-in-law are also frequently involved (Coward and Dwyer 1999). Paid providers in nursing homes deliver some of this care to ill, elderly females, but informal or hidden providers at home provide a substantial amount. One study found that the incidence of informal caregiving was highest among minority women (Montgomery and Datwyler 1990), which reflects the fact that frail, elderly women of color are underrepresented in nursing home populations (Abel 1990b:74).

The emotional, financial, and physical burdens of informal caregiving are heavy for all women. Some single women give up social relationships in order to provide care (Burnley 1987). Other caregivers find that having to take charge of a frail parent or parents poses stressful issues of role reversal. One caregiver who has responsibilities for both her mother and mother-in-law commented: “With children you have more control. With a parent, you're only halfway in control, and I don't want to be in control of my mother. When we find ourselves in a position where she's forced to relinquish control, it makes everybody uncomfortable.” Her sister added: “There's an emotional/psychological thing about role reversal that's very hard” (Beth Wittenberg McLeod, San Francisco Examiner, 2 April 1995,
striking differences which reveal some of the distinctive pressures on female caregivers. Having a job lessened the time spent caregiving for males, but did not do so for employed female caregivers (Stoller 1983). Further, men perform caregiving differently. Among men and women who gave care after their spouse had cardiac surgery, men were able to find more resources and to get others to help more easily than were women (Rankin 1988; Miller 1990). One interpretation is that men approach informal caregiving instrumentally (in terms of tasks) rather than expressively (in terms of emotion or personal relationships). Moreover, friends and relatives, noting the unusual situation of a male being in the caregiving role, may be more likely to offer help (Horowitz 1985).

This and other studies also show that male caregivers report less emotional strain and stress than do female caregivers (ASPE-HCFA 1982:42; Chang and White-Means 1991; Montgomery and Datwyler 1990). Cultural expectations around gender not only influence who becomes the caregiver, but such expectations also shape how the caregiver performs informal care and his or her emotional response to the work.

Could more men become informal caregivers (Kaye and Applegate 1990)? Increasing male participation in informal caregiving would depend in part on expanded work leave policies which would provide such for employed males beyond what is now possible under the Family Leave Act. Equally significant, cultural expectations for both males and females would have to change considerably.

Sick Children and Family Members

Even in households where there is no care of an elderly person, women provide a great deal of informal care to household members, especially children. This is particularly problematic for large numbers of women who work outside the home. In 1993 almost 60 percent of all mothers with preschool children (under the age of six) were in the labor force, compared with only 32 percent in 1970 (Current Population Survey 1993). This dramatic increase holds for single, married, divorced, and widowed mothers (U.S. Bureau of the Census 1994:402). There are about 9.6 million working women with preschool-aged children. About 11.5 million preschoolers and 27.1 million children ages six to seventeen have mothers in the labor force (Current Population Survey 1993).

Women workers may use their sick leave or vacation time to do caregiving, inflating women’s sick leave use rates and giving the impression that
women themselves are “sicker” than men. Women workers take off between 5.6 and 28.8 days annually to take care of sick children (Landis and Earp 1987). This means that women utilize paid sick leave for their children, risking inadequate sick leave for their own illnesses. Estimates of the value of the time that employed women spend just taking children for medical visits range from $572 million to $1.1 billion (Carpenter 1988). Fathers are much less likely, or in some instances less able, to take time off to care for sick children. Working mothers’ informal care of sick or handicapped children is part of the larger problem of child care in contemporary American society, which lags far behind other industrialized nations in the availability of adequate, safe child care.

The Family Leave Act of 1993 provided up to twelve weeks of unpaid leave each year for both female and male employees of public agencies or businesses with fifty or more employees to care for newborn or adopted children, themselves, or immediate family members with a serious medical condition. Unlike such laws in other countries it does not provide coverage of salary (England and Nauelleau 1991). Moreover, many workers still do not have access to such leave because they work in smaller firms not included under the law. In the early eighties, 88 percent of U.S. businesses had fewer than twenty employees (U.S. Bureau of the Census 1984).

The care of nonelderly adults who are ill or injured also often falls to the women in the household or to female kin. Caregiving for persons suffering from AIDS-induced illnesses is, for example, a largely invisible service given by women kin and friends of the afflicted person (Schiller 1993) as well as by gay males (Turner and Pearl 1989).

Productive Aspects of Informal Health Care

Informal caregiving has two productive aspects, which are frequently overlooked or underestimated: the value to society of the care given and the importance of creating good health.

If “free” or unpaid services in the care of the institutionalized elderly were to be replaced with waged work, the cost would be $9.6 billion (Paringer 1983). Much of these dramatic costs come from the informal care of the elderly who are ill. In fact, this figure probably underestimates the value of informal care, for it does not reflect the value of lost wages to women who relinquish paid work to care for an elderly person. Not surprisingly, more women than men give up paid work to care for the elderly or take time off from work to do so and, if employed outside the home, to seek part-time jobs (Boaz and Muller 1992), which will mean diminished income in old age as a result of decreased Social Security benefits and/or pensions (Estes, Gerard, and Clarke 1984).

Most scholarly and policy discussions treat informal health caregiving as the provision of service and assistance during an actual illness. However, there is another side to the productive aspect of informal care. The informal caregiver often produces healthy (or unhealthy) conditions for the family by preparing meals, cleaning, and offering health advice to both children and adults in the home (DeVault 1991; Graham 1985). Thus the informal provider is a key figure in how children and other adults are taught to be healthy or not. But very few (Campbell 1975; Carpenter 1988; Cunningham and Irvine 1987; Mechanic 1964; Prout 1988) have looked at this important communication. Most other studies take a developmental approach that neglects parents’ part in childhood socialization to health and illness. This merits much more attention if the complexities and implications found in this part of informal caregiving are to be fully understood.

The informal caregiver is also a significant participant in both the informal and formal health care systems as illness or recovery occurs. She may informally discuss the process with family, friends, colleagues, or acquaintances and in that sense influence how others participate in the illness or recovery trajectory (Furstenberg and Davis 1984). She is an important negotiator and interpreter of health care activities (Graham 1985). Because these productive activities of informal caregivers are not included in the estimated value of informal caregiving noted above, women’s informal caregiving is a much more valuable resource than is commonly acknowledged.

Underexplored Issues

Black, disabled, and lesbian feminist writing has urged the centering of white experiences in women’s health and pointed to important differences among caregivers, deriving from race, disability, and sexual orientation (Asch and Fine 1993; Bair and Cayleff 1993; Stevens 1992). Yet there is still limited understanding of “how cultural variations in household structure and meanings of family responsibilities alter the caregiving experience” and, indeed, the very meaning of caregiving (Abel 1990b:74).
The few studies done provide glimpses of important issues worthy of further research:

- How strain and support systems differ among caregivers is still unknown yet crucial to fully understanding different care contexts. Differentiating caregiving obligations and tasks, as has been done in a study of black and white caregivers, would advance understanding (Horwitz and Reinhard 1995).
- The few studies about support and strain suggest that conditions under which support is received and from whom merit attention, including the contested issue of domestic service.
- Such questions as why and under what circumstances do men provide informal care and how is it different from that done by females have only barely been explored, yet they may contain important leads for the recruitment of men to caregiving.
- How cultural themes about illness and health play a part in informal care also needs to be explored: e.g., the importance of the concepts of nervous (nervous) and fallo mental (mental failure) for Hispanics caring for a mentally ill family member (Guarnaccia et al. 1992).

Trends That Have an Impact on Informal Care

Examination of these underexplored issues will become more urgent because a number of trends will increase the importance of informal caregiving at the same time material resources for support of caregivers will remain relatively unchanged (Alford-Cooper 1993) or perhaps even diminish.

Social Trends. More men and women will live longer. Between the years 2030 and 2050 the population age 85 and older will be five times larger than it was in 1995; about half will need help with routine activities (Selker 1993). No one knows whether there will be enough younger women to care for this population (Foulke, Alford-Cooper, and Butler 1993). Among other factors, large numbers of black, white, and Latino women, even those with young children, will continue to enter the labor force as they find more work opportunities and/or as the cost of living dictates the necessity for two family incomes and/or as the number of single mothers increases. In 1993, 58 percent of the civilian labor force were women, but by 2005 this percentage is expected to rise to 63.6 (U.S. Bureau of the Census 1994:395). This means that along with the emotional, physical, and occupational costs noted in this chapter, pressures on women caregivers who themselves are aging will also continue.

Economic Trends. Federally mandated reimbursement practices of dismissing very ill patients after shorter hospital stays shift the burden of care once given in clinics or hospitals to the household (Glazer 1990). Not only is the patient sent home early, but often complex care technologies (respirators, dialysis, and certain drugs) move from hospitals or skilled nursing facilities to private homes along with the patients. There untrained and technically unskilled caregivers are forced to assume the responsibility of giving safe care after only brief training in using the technology. These technologies, challenging even for professional caregivers (Kaye and Reisman 1991), are daunting for unskilled, informal caregivers. For dialysis patients and their informal caregivers, this relationship is fraught with anxiety and considerable strain as they attempt to normalize an unusual situation, a process which is by no means smooth and orderly for all such couples (Gerhardt and Brieskorn-Zinke 1986). People who live alone are particularly vulnerable in such situations.

Disease Trends. Reported AIDS cases among American women increased 5.7 times between 1981 and 1985 (1,098) and 1992 (6,312). AIDS in men increased 2.7 times, from 14,466 cases reported between 1981 and 1985 to 30,160 cases in 1992 (U.S. Bureau of the Census 1994:139). Although AIDS affects all social and racial groups, women of color have been particularly affected: in 1994, 77 percent of female AIDS patients were black or Latino. It is the fourth leading cause of death in women ages 25-44 and the leading cause of death among black women in that age group (Centers for Disease Control 1995). As the disease progresses, many of these women will be unable to care for children or elderly parents and will require care themselves. (For a detailed discussion of women and AIDS, see Stoller's analysis in chapter 18.)

A further and poignant problem arises: there was a fourteenfold increase in AIDS cases reported among children under the age of thirteen between 1981 and 1991 (U.S. Bureau of the Census 1994:125). The burden of pediatric AIDS care disproportionately affects black and Latino women. Between 1981 and 1993, of the 4,710 cases of AIDS in children under thirteen, 2,574 were black, 1,146 Latino, 942 white, 21
Asian-Pacific Islander, 15 American Indian/Alaskan Native, and 12 unknown (Centers for Disease Control 1993).

To the worries of child-rearing are added additional burdens for informal care during the stressful illness (Bonuck 1993; Strauss et al. 1991). Mothers are not the only relatives involved in caring for AIDSl infected children: grandmothers who may have provided long-term care to a son or daughter dying of AIDS are increasingly being called upon to care for their orphaned grandchildren (Lee 1994; Ward 1993). They are part of a national trend. In 1992, 865,000 children were raised by grandparents; in 1993 that number grew to over one million (New York Times, 21 November 1994). (For an extended discussion of grandparents' care of children in the black communities, see Jones and Estes, chapter 17.)

What will these trends—an increasing older population, more women in the labor force, reduction of patient time spent in institutional care facilities, growing reliance on use of care technology at home, increases in cases of maternal and pediatric AIDS—mean for women as informal caregivers? Obdurate cultural pressures on women to provide “free” informal care will continue. Deeper exploration of differential sources of strain and support for the many diverse contexts in which women do informal care is requisite. Until such differences are clarified, the processes of informal caregiving will not be fully understood, nor will policies on such caregiving be aptly framed to recognize or facilitate women’s extensive and undervalued work of informal caregiving. An example of policy mindful of differences that could be articulated at all levels where caregiving policy is formulated would be to fine-tune leave taking in small and large work contexts to accommodate issues of sexual orientation, gender, ethnicity, color, and disability.

**Formal Care**

“Formal caregivers” here refers to those who are licensed by the state to deliver care to patients or recovering patients in offices, clinics, hospitals, and at home. Their work is psychosocial, supportive, curative, and technical. Because many formal caregivers work in all three modes simultaneously (Butler et al. 1987:135-36), this chapter discusses caregivers without drawing the distinction made in much of the literature between caring and curing. For example, a physician can give supportive care, assess the patient technically via tests, and prescribe all in five minutes.

In return, these caregivers receive fees or salaries, whereas informal caregivers’ labor, though valuable and time-consuming, is rarely remunerated.

Although this chapter focuses on female caregivers within the health care system, it is important to remember that there are many other caregivers, some formally trained and licensed, some not, from whom women from diverse economic, cultural, and social contexts seek help, sometimes at the same time they receive care from formal health care providers. Licensed, trained practitioners include chiropractors, homeopaths, osteopaths, acupuncture. As is true of medicine and dentistry, relatively few women, including women of color, are found in the ranks of these “alternative” or “concurrent” caregivers. Unlicensed healers and caregivers occupy recognized, culturally designated roles, such as midwives (Mexican American midwives) (Spector 1991), and lay and medical (Davis and Ingram 1993; Holmes 1990), rootworkers (Fox 1989; McGuire 1988; Singer and Garcia 1989). Aside from these cultural roles there are herbalists, vitamin therapists, masseuses, and biofeedback therapists who are licensed in some states. All are socially and culturally situated in many ethnic/racial groups and social classes. These caregivers may have come to their work through spiritual inclination or accumulated experience. They may learn their trade as apprentices or through a formal course of instruction. Primarily female, they have long provided significant care. Sometimes this care can be more sensitive to different women’s situations than that offered by scientific medicine in the health care system precisely because it emerges from and recognizes specific cultural and social aspects of those diverse situations. A good deal of research remains to be done on women’s use of alternative practitioners and on the practitioners themselves.

**Feminist Views of Physicians and Nurses**

Although feminist scholars early analyzed the situation of women in medicine (Lorber 1975), they were slower to examine or even recognize nursing as a possible topic for feminist analysis. Some feminists in the 1960s deemed nursing inappropriate for “liberated” women: they saw “maleness” as the standard for useful work, a perspective which ruled out nursing because of the diverse nurturing, caring aspects and the fact that most nurses are female (Lewin 1977).7

Later feminist historical analyses (Melosh 1982; Reverby 1987), as well as work by nurse scholars (Cleland 1971), and social scientists (Lewin and
Olesen (1980), shifted away from such androcentric thinking to examine nursing's many complexities as a caregiving profession and the experiences of nurses in a “female” profession. As was the case with feminist analyses of informal care, recognition of the history and particular situation of non-white nurses was also slow. Hine's (1985, 1989) history of black nurses documented the long struggle for recognition and equitable treatment within the profession and more generally in the health care field.

The Formal Caregiving Pyramid

The distribution of formal caregivers takes the shape of a pyramid with very few women at the top, where the largest salaries are found, and a great many women at the bottom, where salaries are modest.

1. Physicians occupy the top level. Eighty percent are white males, with a smaller number of women, also mostly white (U.S. Bureau of the Census 1994:407). As is true in all levels, even in this highly paid sector of the health care system, women earn only 59 percent of what men receive (Butter et al. 1987:144).

2. A much larger middle level comprises primarily registered nurses, mostly white females with a few women of color. In 1988, 7.1 percent of employed registered nurses were black and 2.4 percent were Latino (U.S. Bureau of the Census 1994:392). Also here are licensed allied health personnel, such as nurse midwives, physical therapists, and dietitians who are primarily white females (Muller 1994:189). Salaries here are much lower. But again, men receive higher remuneration than women. For instance, 71.5 percent of physical therapists are women, but they earn only 67.4 percent of what male therapists receive (Butter et al. 1987:144).

3. The bottom and largest level consists mostly of licensed vocational nurses, licensed practical nurses, and health aides. Almost a third of these women are black or Latino (Hart-Brothers 1994:206). Their work is critical, particularly for hospitalized women or those residing in a skilled nursing care facility. Again, men earn more than women in these positions.

Changes and Their Implications

The general shape of the pyramid of health caregivers has remained the same since the American health care system began to diversify and include such roles as aides and LVNs early in this century. However, some changes have occurred within various levels where numbers of women or women of color have increased.

Looking first at the top level of physicians, in recent decades more women have entered medical school and are now practicing. Women applicants increased from 28.3 percent in 1979 to 41.8 percent in 1992-93. In 1969-70, 9.2 percent of enrolled medical students were women. By 1992-93 this number had risen to 39.4 percent. The increase in practicing women physicians has also been dramatic: in 1970 7.6 percent of physicians were women; in 1992 this rose to 18.1 percent and is expected to reach 29.4 percent by 2010 (Bickel and Kopriwa 1993:141-42).

Numbers of women of color have also increased in medicine. In 1988, for instance, 65 percent of black medical students were women. Predictions are that 39.3 percent of black and 22.8 percent of Latino physicians practicing in 2000 will be women (Hart-Brothers 1994:210-13).

Looking at changes in other levels in the pyramid, over the decade of the 1980s there were small increases in numbers of women of color enrolling in and graduating from nursing programs that lead to becoming a registered nurse (university or four-year college baccalaureate programs, community college associate of arts programs, and hospital programs) (Hart-Brothers 1994:211). Black women enrolled in such programs in larger numbers than any other minority group (National League for Nursing 1991:113). Although their numbers were small, they were also the largest minority group studying for graduate degrees or doing postdoctoral work (American Association of Colleges of Nursing 1995:18). These changes in the general shape and composition of the pyramid are positive but minor. Most women of color will continue to be found at the bottom in the rapidly growing health aide category. Diminishing funding for baccalaureate nursing programs further depresses possibilities for poor women to enter at this level, thus perpetuating the racial and class differences in the profession (Glaser 1991; Manley 1995).

Women Caregivers' Diverse Experiences

Irrespective of the profession, many women preparing for and practicing in formal caregiver roles experience situations in which racial and/or sexual issues demean or discriminate against women. Two general types of situations occur. The first is interactional. Here discrimination ranges from verbal behavior such as slurs or sexually tinged comments to invidious statements about competence or their very presence in the health
care system on through physical behaviors such as unwanted physical contact or the request for sexual favors in return for grades or promotion. (See Britton in chapter 19 on sexual harassment.) The second is structural and institutional. Here discrimination includes being overlooked or neglected for promotion or receiving a salary less than males or whites in the particular level. (The shape and nature of the pyramid of care attests to this second type.)

Looking first at interactions, speaking of her experiences as a medical student, Vanessa Northington Gamble, a black physician, remembered the doubly painful experience of racial and sexual slurs (1990:59): "Wearing a lab coat and carrying a stethoscope, I walked into a patient's room... and introduced myself as a student doctor. ... Later the white male intern came out of the patient's room. 'You know what that guy asked me,' he laughingly announced. 'Why didn't that girl clean up while she was in here?' My being mistaken for a maid became a joke on the ward team, all of whom, other than myself, were white and male."

Cheryl M. Killion, a black nurse doctorally prepared in anthropology now at the University of Michigan School of Nursing, recalled from her student days that many patients could not believe that a black woman was studying to become a registered nurse (1990:244). One problem for students who experience these regrettable incidents is that there are still very few female role models or mentors from underrepresented groups on faculties of health professional schools, though minority faculty should not be the only faculty responsible for counseling and supporting students after such events.11

Between 1990 and 1992, 60 percent of women medical school graduates reported sexual harassment (Lenhart 1993:155). One woman stated: "The incident which made me angrier (and I do not anger easily) was when, at the conclusion of the afternoon rounds, the chief resident stated that I could now come and 'service' him and the third-year resident in the call room. This was not said in a flirtatious manner; it was very derisive in tone. It was obviously meant to anger me and it did" (Silver and Glicken 1990:530). This statement, a type of verbal rape, erases the woman as medical student and reduces her to sexual object. Female medical school faculty have also experienced sexual harassment, such as Dr. Frances Conley's widely published resignation from the Stanford University Medical School Department of Neurosurgery in 1991. Some reforms have occurred with new procedures for reporting and handling such complaints.12

Problems of institutional discrimination against women in medicine reflect biases among key decision makers, group dynamics, and sexual stereotypes (Lenhart 1993:156). Women are overlooked for promotion, refused maternal or family leave, excluded from important professional contacts and referral, and given salaries smaller than males at their level. These often result in high stress and low morale. As Sharyn Lenhart wrote, "It is remarkable that so many women physicians persist, excel and succeed" (150). Nurses, too, experience discrimination both in practice and academic settings, often complicated by their subordinate status.

**Issues to Be Explored**

The extent to which education for medicine and nursing are gender and diversity sensitive is a major research question which bears on both would-be caregivers undergoing professional socialization and the very act of caregiving once in practice. The extent to which concerns about women's issues have entered professional school curricula varies. Since the early 1980s, baccalaureate and graduate nursing education has included materials in some required and some elective courses on women's health that go beyond a maternal and child focus.13

Not surprisingly because of turf struggles among and between medical specialties and medicine's orientation to women patients, medical curricula have not advanced to the same extent. A small movement in this direction has recently emerged in a struggle among feminist medical educators over the utility of a new women's health specialty. Though the American Medical Women's Association drafted a core curriculum for such a specialty in 1992, it remains a contested possibility and not widely found in medical schools (Johnson 1992; Wallis 1992, 1994). Proponents argue that training in such a specialty would avoid the biologized view of women common in medicine and encourage taking the woman patient as a whole person, resulting in better care. In an era of economic reform where services are fragmented, it would offer a better chance for integrated care for all women in various subgroups (Hoffman and Johnson 1995; Johnson 1992; Johnson and Hoffman 1994). Others sympathetic to the problems of adequate health care for women fear that such a new specialty would become marginalized and argue instead for "mainstreaming" women's health issues in all the medical curriculum or for an interdisciplinary (nonmedical) master's degree in women's health (Harrison 1992, 1994). Internists, now at the helm of primary care, are quickly expanding their practices to include routine gynecological services such as Pap smears and birth control prescriptions.
Regarding racial, ethnic and cultural diversity in professional curricula, the extent to which these materials enter nursing and medical curricula also varies. Where medical anthropologists or sociologists have been influential for medical school curricula, materials reflecting diversity appear, but these are not widespread instances. Nursing, which includes a number of nurses doctorally prepared in anthropology and sociology and has generally been more receptive to social scientists, has moved farther in this respect. But even here critics urge greater cultural sensitivity in education and in research training (Barbee 1993; Jackson 1993).

With respect to sensitivity to both gender and diversity, thoughtful research on medical and nursing curricula, with concurrent attention to increasing the now small numbers of female faculty from minority groups, seems imperative if future formal caregivers are to be well prepared to deliver sensitive care.

Trends and Their Implications

Many of the trends noted in the section on informal caregiving will also influence formal caregivers. Of particular interest is the emphasis on cost cutting in health care delivery because it intersects with the growing numbers of women in medicine.

More physicians in general now end up in health maintenance practices (see discussion of HMOs in chapter 8) or other group practice, rather than solo practice. This trend will continue and even grow. One commentator even boldly predicted that women physicians could well be the salvation of the health care system because they accept less pay and more subordinate roles (Butter et al. 1987:148). Cost containment emphases could also lead to utilization of other less highly paid caregivers, such as nurse practitioners, particularly those specialized in areas where many women seek care: family, primary medicine and ob-gyn. This is now the case in many HMOs. How exactly the growth in number of female physicians relates to the growing popularity of nurse practitioners is a question which turns on the tensions between economic reform and quality (see chapter 23). Whatever the case, it is clear that women formal caregivers, as women so often have been, are regarded as an economic element in the nation’s struggles for health care reform.

The related question, and one of deep concern in this book, is whether and how increased numbers of women, including women of color, as physicians and nurses, will make a difference in terms of providing care sensitive to the needs of diverse women patients. This question carries within it hints of the essentialist view of women’s nature discussed at the outset of this chapter, that women by nature are more caring and humane. It also overlooks diversities in practice settings as well as cultural, structural and economic realities in care delivery. Yet it also acknowledges the deeply gendered nature of social life.

The evidence thus far is equivocal on whether increased numbers of women physicians will make a difference, a question which seems to assume that humanizing practice lies solely with the doctor and is not a shared responsibility or an organizational issue. By the end of medical school there were no gender differences around humanistic or psychosocial issues, even though women students had indicated greater interest at the outset (Dufort and Maheux 1995). One study, however, found that in practice settings there was no difference between men and women regarding technical care, but women seemed to communicate sensitivity and caring more effectively (Arnold, Martin, and Parker 1988). Other evidence indicates that women patients are more likely to get mammograms and Pap smears if the physician is a woman (Lurie et al. 1993).

Longtime observers of medicine have argued that not until there is a critical mass of women physicians (a larger numerical aggregate) with authority and power and interested in aligning with others such as nurse practitioners to reform the system rather than perpetuate professional dominance will the full impact of a caring or humanistic view be felt (Lorber 1984, 1985; Stacey 1988). Whether women physicians will choose locations where they work with underserved populations is a related question of interest. Many of the settings where women physicians have chosen to work to date are those which provide care to these populations (Bowman and Gross 1986). It is likely that women physicians, including women of color, will be providing much of this care. Women graduates of one medical school tended to work in impoverished areas more than their male colleagues (Hart-Brothers 1994:207).

Conclusions

Informal and formal caregiving stand as equally important sectors in health and illness where women of all social classes, racial and ethnic groups, able-bodied and disabled, and of different sexual orientations make crucial contributions as yet not recognized. Differentiating and acknowledging those
contributions, so critical to humane care of the suffering and decent care of the well, are critical tasks for feminists in an era of increasing differences.

NOTES

1. That men and women differ in their responses to and management of informal caregiving in no way suggests that such care is without strain for male caregivers. One man reported: "As time went by [the parents] needed more and more help. . . . So I gave up my job in Mountain View and moved to my parents' place. I was naive enough to think I could take care of my parents myself—a big, big mistake. I would have become seriously ill had it continued" (Beth Wittgen McLeod, San Francisco Examiner, 9 April 1995, A17).

2. In 1993 the percentages of working mothers with children between the ages of six and seventeen had increased for single mothers to 79.2 percent, for married mothers to 74.9 percent from 79 percent in 1960 and for divorced or widowed mothers to 78.3 percent from 65.9 percent in 1960. (The 1960 figures for single mothers is not available.) Increases for working mothers whose children were under six were: single mothers—47.4 percent in 1993 (1960 not available); married mothers—59.6 percent in 1993 from 18.6 percent in 1960; divorced or widowed mothers—60.0 percent in 1993 from 40.5 percent in 1960 (U.S. Bureau of the Census 1994:402).

3. Some feminists have argued that employment of domestic servants constitutes exploitation of women by other women, whereas others rejoyn that this work provides paid employment. Paid domestic services can be a means of support for informal caregivers who can afford them. In other cases, paid domestic service constitutes the informal care. The percentage of women of color who work as domestic servants is disproportionate relative to their numbers in the population (53.3 percent are black or Latino) (U.S. Bureau of the Census 1994:407). Women of color and white women who do domestic work themselves are without back-up for informal care needs in their own families (Collins 1990; Graham 1991; Nakano Glenn 1980; Palmer 1990; Rollins 1985).

4. Anticipated increases in numbers of home health aides (estimated to be between 128.7 percent and 140.6 percent between 1992 and 2005 (U.S. Bureau of the Census 1994:639) probably will not provide relief. Many women caregivers could not afford such paid services because of their low earnings, which remain considerably less than men's. In 1993 median weekly earnings for males and females were: white males, $23.1, white females, $19.7, black males, $21.9, black females, $24.6, Latino males, $21.7, and Latino females, $23.6 (U.S. Bureau of the Census 1994:429).

5. Quite aside from the transfer of the technology of care, medical technology creates other problems in informal caregiving. Utilization of medical technology to save or extend lives of endangered newborns can increase informal caregivers' burdens. Such infants are often multiply handicapped and require extensive care, which puts substantial stress on vulnerable families (Morse 1979). Use of such technology creates a different caregiving problem for disabled women. Among disabled women's groups, divisions occur between those who object to technological preselection of "defective fetuses" and mothers of disabled children who argue that their lives are consumed by the care of these children. One feminist critic, herself the mother of a disabled child, has observed that the sometimes overwhelming difficulties of rearing such a child can impede the caregiver's own struggles for independence (Hillyer 1993).

6. A poll done in the San Francisco Bay area in April 1995 showed that 46 percent of all women surveyed had tried an alternative practitioner in the past year. (San Francisco Chronicle, 17 May 1995, A12).

7. This uninform feminist view failed to recognize complexities in nursing and the fact that many women find highly satisfying careers in this work. It was particularly curious given the commitment of nurses to feminist causes: nursing leaders in the 1920s strongly supported the suffrage movement, and the American Nurses' Association early endorsed the Equal Rights Amendment.

8. In 1980-81, 6.6 percent of RN students were black and 2.6 percent were Latino. By 1989-90, 10.3 percent were black, 3.0 Latino, 2.6 Asian/Pacific Islander, and 0.5 American Indian (Harr-Brothers 1994:212). (Figures were not given for Asian/Pacific Islanders and American Indians in 1980.)

9. In 1994, 8.9 percent of baccalaureate students, 6.1 percent of master's students, and 5.3 percent of doctoral students were black—compared with Asian women who were 3.1 percent of master's students, 3.1 percent of doctoral students, and 3.6 percent of postdoctoral scholars or Latino women who were 2.5 percent of master's students, 1.6 percent of doctoral students, and 3.6 percent of postdoctoral scholars. Less than 1 percent of students in the master's and doctoral programs were Native Americans (American Association of Colleges of Nursing 1995:18).

10. However, the demand for skilled baccalaureate nurses, which has created a surge of registered nurses with diplomas or associate of arts degrees entering programs where they can become prepared at the baccalaureate level, may increase numbers of minority nurses at the baccalaureate level. Seventy-seven colleges have programs designed to bring LPNs to the associate or bachelor's degree level, and 542 have programs to take RNs through the baccalaureate degree. Enrollment in RN-baccalaureate programs has steadily increased: 20.7 percent in full-time students and 4.7 percent in part-time students in 1994 (American Association of Colleges of Nursing 1995:1, 6).

11. Though the numbers of full-time women medical school faculty doubled between 1960 (7,171, or 15.6 percent) and 1992 (15,475, or 22.2 percent), the percentage of women from underrepresented minority groups was still less than 10 percent of all women faculty (Bickel and Kopriva 1993:142).

In 1990 less than 6 percent of all full-time nursing faculty were black, less than 2 percent were Asian, and less than 1 percent were American Indian or Latino (National League for Nursing 1991:212).

12. Dr. Conley was later rehired. In spring 1995 Stanford University took disciplinary action against two medical school professors for sexual harassment (San Francisco Chronicle, 23 April 1995).

13. There are 130 nurse practitioner programs that offer master's level preparation in family, ob-gyn, or women's health practice and 110 programs that give post-master's
work in these areas (American Association of Colleges of Nursing 1995:40-41). In the mid-1980s when the editors of this book directed three national summer institutes on faculty development in women, health, and healing, the majority of enrollees were faculty from community colleges and collegiate nursing programs.

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Older Women: Income, Retirement, and Health

VIDA YVONNE JONES AND CARROLL L. ESTES

Vida Jones and Carroll Estes use their sociological approach to studying aging and health policy to identify critical issues and trends in aging women's health situations. Social policies affecting older women's health need careful scrutiny and redesign to reduce gender discrimination, especially for women of color who remain disproportionately disadvantaged in terms of economic resources in old age.

It is always simpler to categorize and make general assumptions—identifying groups of people with certain views, images, and characteristics—than it is to address existing and complex heterogeneity. Women, racial and ethnic groups, and the elderly are often categorized. The real world is not that simple, however, and people do not fit neatly into homogeneous groups.

The United States is aging. In 1940, 9 million Americans (6.8%) were over 65. By 1980 the number had risen to 25.7 million (11.3%), and Rice (1989) projects that by the year 2030, 64.6 million Americans (20%) will be 65. Older African Americans' chances of surviving past 65 are much lower than those of Caucasians. Native Americans and Alaskan Natives in reservation states are also less likely than white Americans to survive to age 65 (U.S. DHHS 1991). Women generally outlive men. In 1992, life expectancy was 73.2 years for white men, 79.8 for white women, 65.0 for black men, and 73.9 for black women (National Center for Health Statistics [NCHS] 1996). As a result, we have more elderly women than elderly men.

The elderly population exhibits a stunning diversity: people who are over 65 (the young old), those over 85 (the old-old), those who are healthy and active, those who live with chronic illness and disability, those who are frail and institutionalized, those who live independently in their own homes or within residential and other care settings, those who