Women, Gender and Unpaid Care-giving
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Introduction
Care-giving – and the health and well-being of those who provide care – has gained increased attention in recent years. Various factors are credited with playing a role in bringing both paid and unpaid care issues to the forefront, including the demographic shift towards an aging population, the increased number of people living in the community with long-term health problems, as well as changes in family structure, which have left fewer people available within a household to provide care. In this case study, we examine the gendered dimensions of unpaid care-giving, demonstrating that gender stereotypes, roles, and expectations play a large part in who provides care, the type of care that is provided as well as the economic and health implications of providing care.

What Does Care-giving Entail?
There are many different perspectives on what care-giving encompasses. Although care-giving is often equated with eldercare, it also includes caring for children and youth (with or without disabilities) and dependent adults. Similarly, care-giving is typically understood to involve caring for individuals with short- or long-term physical, cognitive or mental health problems or limitations, but care-giving also includes raising children and the everyday tasks associated with this responsibility.

Care-giving comprises a wide range of activities, including tasks carried out within the home, such as meal preparation, cleaning and laundry as well as work outside the home, such as exterior house repairs, yard maintenance and snow removal. Many caregivers also provide transportation to help care recipients with errands, grocery shopping, getting to appointments as well as navigating, negotiating and accessing services. Caregivers responsibilities may include assistance with daily personal care tasks, such as eating, bathing and toileting as well as essential everyday jobs, such as the management of medications and finances.

Who Cares?
By conducting a sex- and gender-based analysis, we see that there are significant differences between women and men when it comes to care provision. The most visible difference is that women are consistently more likely than men to be caregivers – both paid and unpaid. The fact that women are primarily responsible for care-giving duties has a lot to do with gender stereotypes, which portray women as “natural nurturers” and, thus, care-giving as women’s work.

Demographic Shifts in Nova Scotia and Their Repercussions on Care-giving
Over the past 50 years, the number of seniors aged 65 or older who live in Nova Scotia has more than doubled. In addition to having one of the highest populations of seniors in the country, the average age of Nova Scotians (41.8 years) is higher than that of any other province. Low fertility rates and out-migration of younger people of child-bearing age have contributed to the increasing age of the province. Nova Scotia faces an urgent need for action to support caregivers given the aging population will likely increase the demand for care-giving while, at the same time, the number of potential caregivers will decline.
Who Does What Kind of Care-related Activities?

Gender differences are also visible when it comes to the types of activities women and men perform; these also tend to align with traditional gender roles. Men take care of outdoor work (e.g., mowing the lawn) or household maintenance (e.g., painting), while women perform the majority of daily personal care-related tasks (e.g., dressing, eating, brushing teeth and grooming) as well as the bulk of household chores (e.g., making beds, preparing meals, cleaning and vacuuming).

In addition, women typically undertake the most personal and emotionally intense types of care, such as bathing, changing incontinence garments or colostomy bags and providing emotional support. They are also involved in many demanding and time-consuming activities, including administering medications, making daily decisions on behalf of the recipient, lifting individuals with physical limitations and taking care recipients to and from appointments. In addition, women caregivers provide the vast majority of care in acute situations, following a crisis or hospitalization and for individuals with on-going high care needs, such as children and adults living with severe disabilities.[1] In other words, it is women who are expected to provide care on a daily and on-going basis, which leaves them with little flexibility to manage paid work or engage in social and leisure activities, while men are more likely to engage in care-giving activities that are less frequent, more simple to plan, and easier to organize around other commitments.[4]

What Are the Economic Implications Associated with Care Provision?

The high frequency and intensity of care-giving activities women engage in results in gender-specific economic consequences.[1] For example, women experience more employment interruptions due to care-giving responsibilities and are twice as likely as men to change their work patterns to fulfill those duties.[3] Working women often find themselves having to take time off from paid employment to attend to unpaid care-giving responsibilities. Many female caregivers are forced to use sick leave to attend to others,[9,10] leaving them without time when they themselves are sick. Moreover, women often scale down to part-time hours or give up their paid employment altogether to

Who’s Caring in Nova Scotia?

While national statistics show that 11 percent of Canadians provide unpaid care, the percentage is much higher in Nova Scotia. It is estimated that over one third (36 percent) of Nova Scotians provide care to someone who is experiencing an illness, disability or health-related limitation. Care recipients are primarily seniors suffering from long-term health issues. Caregivers in Nova Scotia provide unpaid care most often to family members, including parents, spouses, in-laws, children and grandchildren.[1] Additionally, 25 percent of individuals in the province provide care to friends, neighbours and/or co-workers.[1]
make room for their role as caregiver, while men typically remain in the workforce. As a result, many women lose employee benefits, such as healthcare insurance and pensions.

Reduced hours of work, low rates of employment and lower wages also make it more challenging for women who provide care to support themselves. Consequently, many female caregivers find themselves having to rely on other sources of support in order to survive (e.g., disability pension of the care recipient or social services). Furthermore, caregivers commonly find themselves in situations where they are paying out-of-pocket for assistive devices and transportation costs as well as home and health care services. Consequently, it is not uncommon for caregivers – most of whom are women – to experience money-related worries, financial insecurity, substantial debt and even poverty.

What Are the Health Impacts of Care-giving?

Care-giving is often a rewarding and positive experience, but it is also work. The emotional and physical demands of care-giving can negatively affect the health of caregivers. One study has shown that during a period of informal care, almost half of care providers experienced a substantial decrease in their overall health. Physical health problems are common, in part because caregivers are not given adequate training for the work they perform. Care-giving tasks – such as lifting and bathing without proper technique or adequate assistive devices – lead to various types of physical injuries. Furthermore, given the stress of the job, caregivers have an increased vulnerability to illness and chronic disease. Headaches, chronic back problems, arthritis, high blood pressure and gastric ulcers are all common physical ailments reported by caregivers.

In addition to physical health implications, care-giving also takes its toll on the mental well-being of care providers, especially those who are on call 24 hours a day, 7 days a week. For many, the demands of care provision result in significant lifestyle changes. For example, caregivers often endure a lack of spontaneity and privacy in their lives, experience unwanted transformations in their relationships, become socially isolated and no longer have the time to do activities they enjoy. These changes, as well as other challenges caregivers face, have significant psychological and emotional implications, including feelings of frustration, anger, helplessness, loneliness, worry, guilt, etc. In addition, many care providers become overwhelmed, exhausted and/or burnt-out by the magnitude of responsibilities placed on them. It is also not uncommon for caregivers to experience sleep deprivation and depression.
We know that women are more likely than men to experience the impacts of care-giving for several reasons: women are more likely to provide care; they are more often involved in intense types of care-related activities\(^\text{[1, 8, 11]}\) and they experience “role overload” as caregivers, mothers, family members, partners and paid workers.\(^\text{[14]}\) Statistics show that female caregivers over the age of 45 are three times more likely than males to report health problems.\(^\text{[8]}\) Gender studies have also consistently shown that more women than men experience higher levels of stress and burden,\(^\text{[7, 10, 15]}\) even when doing comparable tasks. Moreover, a recent study revealed that mothers who care for a child with a disability or chronic condition have the same low health status as daily smokers, while the health of fathers is unaffected.\(^\text{[17]}\)

**How Are We Addressing the Needs of Caregivers and the Individuals for Whom They Provide Care?**

The federal government has recognized the importance of addressing issues around care-giving. In 2004, the Government of Canada introduced the *Compassionate Care Benefit*, a program of the Employment Insurance Plan that would provide up to six weeks of financial assistance for people in paid employment who need to take time off work to provide care or support to a gravely ill family member at risk of dying. While this employment insurance benefit was an important step in the right direction, it has not been used by caregivers to the extent expected.\(^\text{[18]}\)

One reason for the underutilization of the program is its tie to employment insurance, which leaves many care providers ineligible. For example, caregivers who are unemployed, self-employed, work part-time, or who are seasonal/temporary/contract employees do not qualify, with women comprising the largest proportion of these groups.\(^\text{[18]}\) Therefore, the majority of caregivers – women – are not able to benefit from this governmental response.

A sex- and gender-based analysis of care-giving shows that in order for care policies, programs and services to be useful, they must reflect the needs of both women and men who have different experiences of care-giving. Failure to take sex and gender into account can leave large numbers of care providers without vital supports and services, which happened in the case of the *Compassionate Care Benefit*. While

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**Nova Scotia’s Continuing Care Strategy**

The Nova Scotia provincial government made a commitment to addressing the needs of care providers as well as those in need of care and assistance by introducing a *10-year Continuing Care Strategy*.\(^\text{[16]}\)

Their vision is to have every Nova Scotian live well in a place they can call home. The government hopes to achieve this goal by implementing a high-quality, client-centred, accessible, and affordable continuing care system that would:

- Acknowledge the role of individuals and families have in achieving maximum health and independence
- Celebrate and support local initiatives that help people stay in their homes and communities as long as possible
- Ensure that caregivers and healthcare providers are adequately supported
- Offer a range of services to children, youth, adults and seniors

A main focus of the strategy is to put forward a comprehensive caregiver strategy, which will include a wider range of supports to meet the social, economic and health needs of caregivers. In addition, the strategy outlines a plan to improve system navigation to increase access to services as well as increased public awareness to get care providers and recipients the information they need.

Another objective of the strategy is to support community initiatives by increasing the number of in-home and community services to allow for the highest level of independence and quality of life for both care providers and recipients. The strategy includes commitments to expand home care and respite options, improve transportation to increase mobility, provide care within the educational system, develop a palliative care program and work towards an integrated healthcare system.

These are all important steps in addressing the needs of care providers in the province. However, one major shortcoming of the *Continuing Care Strategy* is that it does not address sex and gender. Without a sex- and gender-based analysis, it is likely that the diverse needs of female and male caregivers will not be met, regardless of the programs and services implemented.
Changes to the federal care program would result in greater numbers with access to the service, there are also other supports that could be implemented to alleviate some of the financial stress that caregivers experience as well as improve their overall health and well-being.

In order to provide unpaid (and paid) caregivers with sufficient financial support, direct and indirect compensation programs need to be introduced. Indirect compensation practices could include such items as refundable tax credits that do not compromise other benefits or pensions. Another example would be healthy workplace programs that accommodate employees who are also care providers. Direct compensation could include such things as subsides or full payments to cover the costs of out-of-pocket expenses. As well, paid time away from work to fulfill care-giving roles would be an immediate way to help lessen the financial and other pressures confronting caregivers.

Policies, programs, services and supports also need to be put in place to address the health and well-being of caregivers. One way to address health implications would be to increase the number of hours and level of service of respite and home care in order to give caregivers the relief they need. Allowing caregivers more respite would give them the opportunity to participate in activities that would have a positive impact on their physical, emotional and mental well-being. Furthermore, health promotion strategies that address the health consequences of care-giving and provide the necessary resources to support both care providers and their recipients would be valuable.

Conclusion

Care-giving is still very much seen as women’s work and it has not received the attention it deserves. While care-giving can be a rewarding experience that brings pleasure to both care providers and recipients, it can also be a strenuous responsibility for caregivers. It is, after all, work. This case study illustrates many of the gender differences associated with care-giving, demonstrating the importance of sex- and gender-based analysis for the health and well-being of caregivers, recipients,
and their families. It is especially important for policy makers, service providers, and healthcare professionals to conduct a sex- and gender-based analysis when examining issues around care-giving, otherwise policies, programs, and services will not be effective and will fail to meet the needs of those they are intended to help.

References