THE HOME AS WORKSHOP: Women as Amateur Nurses and Medical Care Providers

NONA Y. GLAZER
Portland State University

The high-tech health service work done by amateur family caregivers in U.S. homes challenges the conventional division of the social world into public and private. Under new federal reimbursement systems, the diagnosis-related groups (DRGs), patients are being discharged sicker than before from hospitals and nursing homes, or after treatments in outpatient clinics. Health care facilities depend on a work transfer, *shifting their earlier responsibilities for the sick to the family. There, women family members do for free the work once done by paid health service workers in health care facilities, caring for family members who need their nursing and housekeeping services. Women's unpaid work knits together "public" and "private," demonstrating how capitalism reorganizes the labor process to make use of free service labor.*

> There are really no data on what is best for the patient. I ask doctors why they discharge patients or keep them for different amounts of time and the physicians themselves admit that they do not know because there are no data. We make judgments that are convenient to administrative decisions. (Director, Home Health Agency)

Erving Goffman (1961, 321-86) called the hospital the physician's workshop. Today, the home is an expanding workshop for paid nursing personnel who care for patients just discharged from outpatient clinics, nursing homes,

AUTHOR'S NOTE: *I am grateful to the National Science Foundation for a Visiting Professorship for Women in Science and Engineering, and to Virginia Olesen and Carroll Estes for hosting the grant at the University of California, San Francisco, in 1984-85. Thanks to my sister Fellows at the Bunting Institute, Radcliffe College, Harvard, in 1989-90, especially Erica Harth, Zella Luria, and Janet Seiz, and to Grant Farr, Steve Mintz, Bill Simon, Irv Zola, and Cheryl Zollars. Very special thanks to Joan Acker, Barbara Laslett, and Lee McKnight, and to the health service workers who gave so generously of their time.*

REPRINT REQUESTS: *Nona Y. Glazer, Department of Sociology, Portland State University, Portland, OR 97207.*

GENDER & SOCIETY, Vol. 4 No. 4, December 1990 479-499

and acute care hospitals. It is also the workshop for amateurs,[1] mostly women family members who are ancillary health care workers, doing unpaid labor essential to the U.S. health care system. Their unpaid labor has changed from housekeeping and minor nursing to encompass the administration and monitoring of complex nursing-medical regimens once done only in acute care hospitals by physicians or registered nurses (RNs) and specialists.

This organization of home health care delivery violates the sociological model of work as divided between the public and private spheres. Supposedly, the private sphere includes personal life and the family, where women do unpaid domestic labor, while the public sphere includes all else, including paid labor (Zaretsky 1976). While many sociologists recognize that the spheres are related, most focus on one or the other (Glazer 1984). They study health care delivery in the "public" sphere, from the perspective of paid providers such as physicians, hospitals, and insurers (Starr 1982), and less often, from that of patients (Corbin and Strauss 1988). As Olesen (1989) notes, informal caregivers in the private sphere in the United States have been neglected by sociologists, studied instead by gerontologists and nurse researchers (see, however, Abel 1989; Abel and Nelson 1990).

In this article, I abandon the concept of private and public spheres to reconceptualize health care delivery as a seamless web of social relations. I focus on the impact of the Social Security Amendments of 1983, which established a new perspective payment system for reimbursement for Medicare and Medicaid patients. Under the diagnosis-related groups, or DRGs, hospitals receive a flat fee rather than fees for each service, and physicians must, when feasible, use outpatient clinics rather than hospitalization. The result has been that patients need more home health services. To be reimbursed, these services must be restricted to those prescribed by a physician and given only to patients who need intermittent rather than 24-hour-a-day skilled nursing care (from RNs or other specialists); the patients must be recovering from an acute episode, rather than stable medically, and housebound.[2]

First, I will consider theoretical views of domestic labor, the concept of public and private spheres, and how contemporary health care delivery belies this division. Second, I will introduce a new concept, the *work transfer,* and describe how and why it has been used in the United States. Third, I will analyze how the DRGs result in a work transfer to women as family members whose experiences vary by race, ethnicity, and class, and what technical medical-nursing work they are expected to do. I conclude with a discussion of the implications of my analysis for social theory and for women.

The data on work transfer and home care in the United States today come from interviews with 65 health service industry workers in northern California, including administrators, home care RNs, licensed nurses, home health aides, discharge planners, and home health care agency managers. The interviews were conducted in 1984-85. I located interviewees through two referral chains, an administrator-manager chain and a staff chain.

Using a structured, open-ended guide, I asked especially about home health services before and after the DRGs were adopted. I obtained descriptions of daily experiences of home health from these interviews and from additional interviews with five educators at schools of nursing and training centers for licensed nurses and home health aides, and interviews with personnel from national home health care equipment companies.

I conducted the research to explore a theoretical issue, the conception of public and private spheres, and to gather data on how women's work as family members wove them into a single lived experience. Following Glaser and Strauss (1967), I ceased interviewing when I got no new information, viewpoints, explanations, and insights about paid and unpaid health care work.

THEORETICAL ISSUES

Three major interpretations of how unpaid domestic labor has fared under capitalism imply an indirect connection only to class relations, the political economy of capitalism, and the state. One view is that domestic labor was never brought into the process of capitalist *commodification.* Although women in the household use goods and services from the marketplace, their own labor power remains precapitalist (Bennholdt-Thomsen 1984; Mies 1986). The second view is that the energy spent by women in domestic labor has declined with the commodification of goods. However, given the loss of servants, ever-increasing consumption transforms wives and mothers into "cryptoservants" (Galbraith 1973) and makes "more work for mother" (Cowan 1983). My third view is that domestic labor is largely the *social reproduction* of the work force. On a daily basis, the labor of wives and mothers reproduces the present generation of workers and, by raising children, the next generation of workers (Laslett and Brenner 1989). These views of domestic labor as private, and "for" the family are exemplified in the now-superseded economists' definition of domestic labor as "leisure," in the classical Marxist view of housewives as outside capitalist relations of pro-

duction (Glazer-Malbin 1976), and in the traditional sociological view of the family as a system of interacting personalities, integrated in society by the mediating role of the husband-father as breadwinner (Parsons and Bales 1955).

Critiques of theories of separate domains date back to the 1970s (Kelly 1979; Rapp, Ross, and Bridenthal 1979; Zaretsky 1976). The "domestic labor debates" were an attempt by Marxist feminists to reconceptualize the boundary between paid and unpaid labor and the relation of women's uncommodified labor to capitalist production (Glazer-Malbin 1976). Empirically, health care has been slighted in research on housewives (Lopata 1971; Oakley 1974) and the household gender division of labor (Berk and Berk 1979; Berk 1980; Vanek 1974); in estimates of the economic value of a housewife (W. Brody 1975); and in debates on domestic labor (Fox 1980). Hence, theoretical critiques have not led to empirical research on the connections between health care labor in the public and private spheres.

Historical Roots

What has been called the ideology of two spheres developed in Euro-American societies in the late eighteenth and early nineteenth centuries. With variations by class, nationality, race, and ethnicity, men won status as citizens with individual political and civil rights and gained immunity from close government and church scrutiny (Habermas 1974, 89). In the nineteenth century, with the movement of free men and unmarried women into the factory system, household and commodity production became increasingly distinct. Yet the changes were uneven. For example, until the 1960s most married women worked in undercapitalized sectors, as "homeworkers," or in the informal economy as domestic workers, home launderers, and taking in boarders and lodgers (Lewis 1986). In the United States, married women entered the formal labor force in sizable numbers in the decades after World War II, with the growth of the service sector. Yet their domestic labor remains unwaged or in the paid informal underground economy. However, a "mutual infiltration" of private and public continues (Habermas 1989), and the use of women's unpaid work in the health care system is only a recent case.

Women's Work in Health Care Delivery

Conceptualizing women's unpaid labor in the home as one segment of health care work differs from most analyses, which treat technical health care as encounters between professionals and their clients, usually physicians and patients, sometimes RNs and patients. Because the dehospitalization of

people with acute illnesses and the extended use of outpatient clinics is new, most research has been on home care of the chronically ill (cf. Archbold 1982; Jones and Vetter 1984; Matthews 1987). Only a few sociologists have examined the impact of unremitting care on families in the United States as welfare services declined (Corbin and Strauss 1988), conceptualized caregiving as "work" (Carpenter 1980; Glazer 1988), researched the use of high-tech medicine by caregivers (Fox and Swazey 1974), or connected changes in women's paid health service work to women's unpaid family work (Glazer 1988).

Within the family in capitalist societies, women are responsible for two major activities: (1) Women engage in the social reproduction of the labor force. Women's nontechnical and technical health care work for husbands, partners, children, and other kin is one among the many tasks of social reproduction. (2) Women develop and maintain social relations and ideologies that support family members in their relations with service institutions, such as the health care delivery system. Domestic labor, therefore, entails another contribution that few theorists of work recognize: women's care of family members who are socially and economically dependent, namely, the retired and the sick who need physical and emotional as well as financial help (Strong-Boag 1986).

A NEW LABOR PROCESS: THE WORK TRANSFER

Women's domestic labor is used for health care through the work transfer. Managers change the labor process, that is, how work is organized, and do so repeatedly in efforts to maximize worker productivity, accumulation, and profit. Their techniques include a detailed division of labor and automation, job consolidation (the tasks of two or more jobs are combined), upgrading skills (not pay), and speedups (increasing the pace of work, the length of the working day, dropping the piece-rate). In manufacturing, employers' attempts to increase worker productivity by these techniques depend on the objects of labor (the parts of goods) being standardized and made interchangeable and the work being done at a controlled pace. In service industries, the objects of labor are clients or patients who need services, but unlike manufacturing, their needs are not standardized or interchangeable and cannot easily be forced to a measured pace. People want food *when* they are hungry, to shop *when* they find it convenient, and medical and nursing care *when* they are ill. Service workers must be on call continually, even though users make demands intermittently.

The work transfer designates another labor process: waged workers are eliminated or given new tasks, and the work that they did before is transferred to women (and sometimes, men) as family members. Hence, the free labor of women in families substitutes for the once-waged labor of workers. In health services, the paid labor is that of nursing personnel. Family members are mothers, wives, adult daughters and daughters-in-law of the sick, who provide the free domestic labor that completes a labor process begun outside the household. The completion is essential, not complementary.

Relying on the work of customers, clients, and their families has historical precedent in the United States. Starting in Chicago in the 1890s with "cafeterias," businesses adopted self-service to increase the productivity of their service workers (the cost of labor per unit cost of output). Retailers circumvented their inability to control shopper demands for services and overcame the "wasteful cost" of having sales clerks wait around for customers by replacing clerk-service with self-service shopping. They understood that the customer's labor could "contribut[e] to company and industry productivity" (Heskett 1986, 106) and that productivity could be increased by substituting the free work of customers for that of waged workers.

Managers in public agencies and nonprofit organizations, such as health care facilities, also have substituted "client" labor (and that of their families) for waged workers (Lovelock and Young 1979, 66). Historically, family members relied on each other, especially on women, for health care; but with the development of science-based medicine and the modern hospital, an elaborate hierarchy of workers developed to sell health care. Managers tried to increase the productivity of these workers: hospital administrators by reassigning work to patients and family caregivers, freeing waged professionals and ancillary health workers to do other work, but without reducing direct costs to patients (Blitzer 1981). In the United States, hospitals experimented with "hospitals without walls" (Koren 1986), "ambulant wings" (Tunstall 1960), "cooperative care" units ("New care unit" 1979; Gibson and Pulliam 1987), and "care-by-parent" units (Evans and Robinson 1983). Family members nursed, and patients and family caregivers did housekeeping, arranged treatments, and prepared meals (Tunstall 1960).

Queuing theory gives managers improved predictions of client demands for services but does not allow them to force patients, for example, to distribute their demands evenly over the working day to improve the productivity of hospital workers. Managers can, however, use the labor of clients (or their surrogates) and employ fewer service workers. Sending recovering (or dying) patients home to be serviced by family caregivers is just such a use of client labor.

Equally important, the sale of medical goods adds more to corporate profits and accumulation than the sale of service labor, given the difficulties of increasing productivity (Mandel 1975). Hence, in anticipation of an enormous market, corporations supplying home care goods tried to form partnerships with nonprofit visiting nurse associations, who would have provided all services. Most associations refused, well aware that federal reimbursements for supplies and equipment, not for their services, would support care for Medicare and Medicaid patients.

EFFECTS OF THE DRG REIMBURSEMENT SYSTEM

The new federal reimbursement system for Medicare and Medicaid patients applies business practices to human services and results in a work transfer. The DRG reimbursement system brings together assumptions from the manufacturing sector about standardization with those from the service sector about consumer labor. Hospital services are conceptualized as if treatments are identical and as if sick people are interchangeable, with identical needs and responses to treatments. Legislators know this homogenization is false, that some patients need longer hospital stays, more costly treatments, and so on, but concluded "that hospitals would make a few dollars on some patients and . . . lose a few dollars on others" (Committee on Aging 1984, 47).

Congress intended that the DRGs would force hospitals to be more efficient, but the flat fee simply gives them an incentive to discharge patients quickly and do as much as possible outside the hospital. The result, deliberately or inadvertently, is the work transfer with new work for women as family members.

The DRGs accelerated the long-term decline in average length of hospital stays and the greater use of nursing homes, home health service agencies, family caregivers, and self-care. Before the DRGs, the use of home health services rose from 8 per 1,000 Medicare enrollees in 1970 to 27 per 1,000 in 1980, but jumped sharply within two years of its start-up to 51 per 1,000 in 1985 (Health Care Financing Administration 1988a, 28; Health Care Financing Administration 1988b, 4; U.S. Bureau of the Census 1985, 371; U.S. Bureau of the Census 1987, 347). Furthermore, treatments such as knee surgery and cataract removal now must be done on an outpatient basis. Patients who once would have recovered in the hospital go home to self-care or family caregivers, with or without formal home health services. Health care will probably continue to be delivered in these ways as long as it is

considered cost-effective to insurers, who ignore the hidden cost of the transfer of work to family members (see U.S. General Accounting Office [1982] and Hammond [1979] for assessments of home health services, from 1965 to 1981, as not cost-effective, though patients may prefer them).

Whether or not it costs insurers less, it costs families more. According to federal estimates, "for every $120 of taxpayer money spent by home care agencies, an estimated $287 worth of unpaid services is provided by the homebound person's family and friends" (U.S. Department of Commerce 1978, 490). The industry estimates a $10 billion savings in wages because of unpaid family work (Paringer 1985). Of course, the "family and friends" are mostly women.

WOMEN AS CAREGIVERS

Changing reimbursement policies make more work for women; and the family, the sex-gender system, and race-class subordination make the work transfer possible. In the United States (and other societies with weak welfare systems), citizens have access to social resources, such as health care, through their membership in families. The ideology of "individualism: self-help, self-support, self-sufficiency" appears to reject dependency on other people and social groups, but "in practice, the unit of self-support is not the individual but the family" (Barrett and McIntosh 1984, 45). Those whose families lack money and know-how rely on welfare institutions or go without, while those who lack families buy help if they can afford it (Barrett and McIntosh 1984). In capitalist societies with stronger welfare systems, such as Sweden and the Netherlands, ironically, citizens claim social resources as individuals (Bystydzienski 1989, 678; Folbre 1987). To curtail welfare spending, the United States has been reducing state services and enlarging dependency on families. Canada and the United Kingdom, with their dissimilar welfare systems, have also been "dehospitalizing," shifting financial and work responsibilities to the family and the women within them. Dehospitalization is currently being discussed in Sweden.[3]

Health care can be shifted from the formal health care delivery system to the family and the women within it because of ideologies and practices of the "social relations of family tending," and because women continue to be responsible for unpaid domestic labor. Hospital administrators, middle-level managers, and discharge planners view "the family" as responsible for patients, for taking over when hospitals no longer give nursing care.

The Prevalence of Women as Caregivers

Women caregivers enable the family to be a "provider" unit (Jones and Vetter 1984; Littman 1974) and help prevent rehospitalization (Pesznecker et al. 1987). The price, however, may be the disruption of their personal lives (Finch and Groves 1980; Haber 1986). Because the extensive use of home health services for the acutely ill is new, available studies have examined only the chronically ill, but there is no reason to expect many differences. (In 1989, the U.S. federal government issued a request for proposals to study the household gender division of labor in home health care of the acutely ill.)

Women constitute from two-thirds to three-quarters of unpaid providers (Stone et al. 1987), as primary caregivers (Archbold 1983; E. Brody 1985) and even when family members share care (Matthews 1987). Women provide most of the care when men help ("Eldercare survey" 1988; Haber 1986), when a spouse (the wife or husband) is unable to care (E. Brody and Schoonover 1986), and when they are employed outside the home (Stoller and Stoller 1983). Men rather than women are likely to be the primary caregivers when patients have no daughters living close to them or when sons are their only children (Horowitz 1985). However, men caregivers are more likely than women to use support networks to relieve them of full-time responsibilities (Miller 1990).

Race and Class

Not all women experience the work transfer in the same way, because recent changes in hospital use differ by age, race, and family income. Between 1983 and 1985, the admission of children dropped more than for others, 19 percent compared to 11 percent (Moss and Moien 1987, 5), presumably with mothers doing more home care. The admission of African-American patients decreased over twice as much as European-Americans, 27 percent compared to 11 percent. Admission rates of those with family incomes under $10,000 declined by 19 percent, compared with 11 percent for those with incomes over $35,000 (Moss and Moien 1987, 7). Patients with private insurance stayed in nursing homes longer than Medicare patients who went home sicker (as measured by a case-mix index), whether or not home health services were available (Morrissey, Sloan, and Valvona 1988, Exhibit 3, 59).

Women cope differently, depending on class. Women from upper strata are less likely than others to care continuously for their elderly parents (who also rely on friends) and are less likely than the poor to be in the same

community as their parents. Women from households with high incomes may hire substitutes for themselves, such as private-duty RNs, nurse assistants, and attendants. In contrast, working-class women rely on home care nurses and home health aides. Finally, the government discriminates against the poor, giving less service to indigent Medicaid patients than to elderly Medicare patients.

GOING HOME SICKER: WHAT AMATEURS DO

> We joke. We say, "Patients will go from ICU [the intensive care unit] to the home" or "We will be operating on the patient's kitchen table." (Director, Home Health Services)

Home care has been conceptualized by sociologists in such a way that they ignore the medical and nursing content of the work and see it as a variation on the usual domestic chores of women—transportation, emotional and social support, homemaking, and personal care. But "care" now encompasses a range of nursing-medical tasks as well. Most important, family caregivers "practice" nursing and medicine, monitoring patients for everything from reactions to change in medication to medical crises requiring emergency readmission to hospital. Women use high-tech equipment to deliver treatments for acute and chronic conditions and to treat systemic infection and cancer. They supervise exercises and give mechanical relief to patients with breathing disorders, feed by tubes those unable to take food orally or digest normally, give intramuscular injections and more tricky intravenous injections, and monitor patients after antibiotic and chemotherapy treatments.

The work can be difficult for families to do, made more so because of hospital-staff cuts. Because patients are sent home sicker and because there are no aides to help them do so in the hospital, patients must also recover basic functions at home. Hence, there is more work for both family caregivers and home care RNs.

Professional Technology

Family caregivers cope with the high-tech equipment designed by biomedical engineers and physicians for use by registered and licensed nurses and therapists who have received training in using them. These new technologies did not drive the increase in home services; the federal government

simply refused earlier to pay for their use in the home. Most of the equipment was used in hospitals from 5 to 19 years before Medicare and Medicaid paid for in-home use.

The most frequent home treatments are chemotherapy, intermittent intravenous antibiotics, apnea monitoring, phototherapy, parenteral nutrition, nasal-gastric feeding, and oxygen supplementation. Home equipment differs from the hospital's only in operating details, such as not being "heavy-duty" or lacking special features. Family members learn from oncology, respiratory, and intravenous RN specialists how to use and clean equipment, such as infuser pumps, intermittent positive pressure breathing equipment, and nasal-gastric tubes, which are becoming common in home care. Patients and their family caregivers learn to care for tracheostomies, administer oxygen, do "wet-and-dry" wound treatments, and change dressings on still draining wounds (which are infected easily), give injections, do peritoneal dialysis, turn patients to prevent bed sores, use a Foley catheter to empty bladders, and refill infusion pumps with morphine packs and check for accurate dosage. Family caregivers learn to give intravenous treatments, which include cleaning tubes inserted into the chest wall, irrigating catheters inserted in veins that allow drawing blood or giving nutrition, chemotherapy, or antibiotics into the heart.

According to one home health agency director (with an unflattering view of hospital nurses), what patients and their family caretakers must learn can be very technical, but it is easily taught because "even simple people can learn to do things that [hospital] nurses do." The work that they learn may be fairly simple, such as breathing exercises, or complex, such as how to keep equipment from being a conduit for dangerous bacteria into the heart. Family members may learn from written instructions the details of symptoms that require emergency help, or they may learn them from experience. Protocols for intravenous antibiotics give minute directions:

> 1. Remove the bag of antibiotic solution from the refrigerator 15 minutes before administration to allow it to warm up. 2. Draw 0.5 mL (50 units) of heparin-saline solution into a syringe and replace the cover on the needle. . . . 12. Carefully dispose of all your apparatus, especially the needles, so that no one will accidentally be injured. If you use a coffee can with cover, this may be brought to the hospital pharmacy later for proper disposal. (Kind et al. 1979)

By the mid-1980s, a wide range of self-instruction was available for distribution by hospitals, home health agencies, and home health supply and equipment companies to patients and family members.

The Labor Process for RNs

For nurses, the labor process in home health care altered between 1965 and 1985. In the earlier years, home health agencies provided the entire family with considerable help with daily activities. Care has been reduced and limited to patients, and technical care has grown. For example, in 1970, if a nurse learned that her patient's children were drug or alcohol abusers, she treated them, and could visit the home several times a day. By 1985, nurses could be responsible for only the patient; and, according to one of my informants, "concerned with the children insofar as it upset and hindered the patient from becoming independent and stable." Case loads increased from 15-20 to 40-50 more seriously ill patients.

In the late 1960s, visits could be made seven days a week. Patients mostly had cardiac problems or diabetes, and secondarily, needed wound care or treatments for impacted bowels. Today, RNs teach patients and family caregivers how to do most wound care and treat patients for bowel impaction only if they are already in home care. Twenty-five years ago, RNs did a wide variety of nontechnical work, such as foot soaks and baths and nail cutting, now done by aides or student podiatrists. Earlier, few cancer patients received treatments at home, and most died in a hospital, not at home. Now RNs do hyperalimentation and intermittent intravenous treatments for dying cancer patients and most recently, for AIDS patients.

Training Amateurs

Amateurs are supposed to learn high-tech care as well as basic and simple tasks. To RNs, teaching is a return to a traditional core of professional nursing, patient education, which physicians had taken from RNs in hospitals. Patient education is a central responsibility of the home care RN, who begins it while the patient is still in the hospital, and continues it during home visits. The goal is to ensure that the patient and family caregivers take over as much nursing as possible.

Nurses fought for the legal right to do procedures that were once the monopoly of physicians, procedures sufficiently complex that the RNs learn them in in-service training courses. Ironically, and ambivalently, they now find themselves teaching amateurs to do them. Some RNs see this work transfer as devaluing their professional status, and the language they have been told to use to report their failures as demeaning. To ensure reimbursements, managers suggest such explanations as: "I could not find anyone in the home who was willing to learn to [change dressings on a wound, change a catheter, clean a Heprin lock, and so on]" or "I am going out twice a day

because no family member is able to learn injection techniques." But most RNs try to find caregivers who can learn the regimens.

Aides also give support in home health, and new restrictions on their work make more work for family caregivers. Before 1980, aides did a wider variety of personal care and housekeeping tasks during 3- to 4-hour visits. Now, their visits have been shortened and fewer, and they can do less housekeeping. Some aides feel more professional, seeing their work as becoming more like that of RNs, as they do simple wound care and teach patients how to recover bladder and bowel control.

Nurses as Unpaid Providers

RNs clash with the Medicare-Medicaid bureaucracy over what services patients need. For example, the Medicare reimbursers have been reluctant to provide services to patients after outpatient laser treatments for cataracts. They will not pay for home services to persons that nurses describe as "stable," which is translated to mean "chronically ill with no likelihood of improvement" and, hence, ineligible for coverage. After the end of their own working days and on weekends, some home care nurses become "unpaid" caregivers, filling syringes for *ex*-patients discharged from home health care after their diabetes has stabilized.

Reimbursement requires detailed documentation ("If you haven't written it, you haven't done it" [Morrissey-Ross 1988].), and agencies hire RNs to review all bills before sending them out for reimbursement. These in-house reviewers train RNs in the language to ensure reimbursements. High rates of rejection are dangerous: The agencies not only lose money, but many rejections can lead to federal sanctions that exclude them from treating Medicare and Medicaid patients. A home health RN I interviewed mused:

> I was congratulated by my supervisor on my charting finally being up to [how] she wants it and that I was an example of how to do good charting. I just had to snicker when she said that. I said, "That's wonderful. I have become a professional liar."

RNs are informal advocates for their patients, ensuring continuing services by how they write the documents submitted to reimbursers. For example, "patient is better" must be written as "[better] than at last visit," to prevent the reimbursement agency from interpreting the phrase to mean "recovered completely," denying payment and terminating home health services. Churchgoing, visits to an offspring's home, and—for those living in single rooms without cooking facilities—trips to a restaurant cannot be

"charted," because reviewers interpret these activities to show that the patient is not housebound.

Home Caregivers

My respondents described the difficult problems families and home care agencies surmount. The extended household kinship system of an immigrant Vietnamese family allowed a woman dying of cancer to do so at home. Her husband, the only English-speaker, helped the RN teach other adults to administer chemotherapy and monitor the patient, and to feed her, administer pain-killers, and so on. A community-based friendship and acquaintance network cared for a dying patient living alone, with the help of a home health RN, chore workers, and, eventually, hospice help. An RN prepared audiotaped directions on catheter care work for a man unable to read English ("Creative teaching" 1985).

However, not all amateur caregivers are willing or able to learn high-tech home care because of age, attitude, lack of skills, or other responsibilities. A coordinator of a health services agency at a major hospital, with 30 years of experience, described the anomaly of family care: "The highest level of care being done is in the home, but the people who are asked to do this are unskilled family members and/or minimum wage level paid workers."

Home health care delivery is embedded in regulations, training, and licensing, with different workers being limited by law to specific responsibilities. For example, though there are variations by state, RNs may do intravenous drips but licensed vocational nurses (LVNs) may not; LVNs may change dressings on wet wounds, but aides may not; and so on. Under cost containment, however, rules about training have been abandoned, and legal definitions and restrictions ignored as medical-nursing work is shifted to family caregivers.[4] The most skilled workers in home health care, RNs, who usually must have a baccalaureate degree (BSN), teach the least skilled persons involved in health care delivery, patients and family caretakers, how to do technical nursing work. Limited in-hospital teaching of patients by nurses during hospitalization or right after clinic treatment, during times of emotional upset, or the brief training of patients and patient family members by a home health RN over a few visits is supposed to produce an adequate level of technical competence. If family members cannot be trained and a patient qualifies for Supplementary Security Income, an RN may be hired to train a minimum-waged "chore worker" to do the nursing work that family members are not available to do.

Home care RNs also work with caregivers who may be unable to do the necessary work or unable to provide emotional support. Family members may refuse to learn nursing procedures because of anger at being asked to care and old resentments against the patient. A home health nurse described the wife of an elderly man who "expressed her anger at years of a sour marriage by passively just not learning what needed to be done." Patients must cope also with the psychological and emotional limits of caregiving spouses. Some caretakers seemed unable to learn rigorous routines, such as sterilizing lines for parenteral feeding, or carried out the routines irregularly. Friends may need to be recruited to care for sick persons whose partners are unwilling or unable to do so, or who lack family.

Sometimes caregivers, such as elderly wives, have multiple problems, may be too poor to hire relief workers, and must struggle along without respite. Medicare refuses to pay for night relief. Hence, elderly wives may have to care for newly discharged stroke patients who require 24-hour care, but not "skilled nursing," until the stroke patient improves sufficiently to be ambulatory. Frail spouses may try to cope with patients who need complicated dressing changes or who are incontinent. Nurses may teach these caregivers but find on a return visit that they cannot continue to tend. A new caregiver must be found and taught, but Medicare does not allow endless repeated teachings, so RNs may have to terminate their services without having taught anyone the work that needs to be done. In such cases, patients are likely to get sicker and be readmitted to the hospital.

Nurses treat patients in homes that lack the basic equipment needed for recovery. For example, some homes do not have adequate heat, many lack tub bars, and few have wheelchair ramps. Poverty makes some homes unsafe and unhealthy because of unsanitary conditions. Finally, family members may feel overwhelmed and very frightened to have a terminally ill member or a person with breathing or bleeding problems at home, and their fears overcome their desire to assist, preventing them from learning necessary skills.

Despite these drawbacks, many health workers, and more and more patients and their families, see inpatient health facilities as dangerous places, psychologically and medically, and if not dangerous, impersonal and far less attractive and pleasant than home and family. Thus, home care is highly desirable to many sick people. The state supports home care for fiscal reasons, and corporations support it to save on benefits. But home care is difficult for many families, and the work transfer gives women caregivers, particularly, a new burden. High-quality home care is expensive and requires

a substantial infrastructure that would include increased and adequate discharge planning, funding to make homes suitable for recovery (e.g., the installation of a rail for a bathtub and wheelchair ramps), more rather than fewer housekeeping services, the delivery of prepared foods, and respite for family caregivers. Home care requires a more humane and realistic definition of *housebound* that accepts sociability with friends or religious activities as contributing to recovery. If implemented, these additional services would make home care more costly to insurers and defeat the purpose of calling upon women and the family to take on new responsibilities.

HOME CARE AND THE WEB OF SOCIAL RELATIONSHIPS

In the current practice of home health care, delivery work is a seamless web of social relations that spills over any purported boundary between public and private spheres. In this web, women's work as family members is critical but semivisible, partly because whatever women do is devalued, even if it may be romanticized too. But the cloudy perceptions of how women's work in the family shores up capitalist social relations has another source: It is the continuing theoretical commitment of the social sciences to a bifurcated view of the social world.

Tending to patients under the formal supervision of home health service agencies requires coordination, willingly or not, between professional health care workers and family caregivers, who do much more than glorified housekeeping. Health care workers, mostly women, and family members, also mostly women, are locked together in the performance of highly technical health care. Recognizing the real and lived links between the performances of unpaid and paid workers would give a more accurate picture of the contemporary U.S. health services industry and the continued dependence of capitalism on women's unpaid domestic labor.

Conceptualizing the social world as neatly divided into the private and the public spheres may have made sense of social change in the late eighteenth and nineteenth centuries. The factory system replaced the household economy as a basic form of subsistence, the marketplace became a major source of goods and services, and political and civil rights were extended to propertyless men. The dichotomy had an ideological meaning that was used to justify the development of civil society with its realm of intellectual and moral privacy (Habermas 1989) and to justify the household as free from state and religious authority.

Today this archaic view of the privacy of the home and its separation from the core of social life (the economy, politics, education, and so on) obfuscates our understanding of social relations. It hides the labor of women (Weinbaum and Bridges 1976). It masks the success of corporations in redefining human services according to business values and practices and in reconstructing the home as a new health care marketplace that depends on self-care and women's domestic labor.

The public and private spheres may make intuitive sense to medical sociologists who have observed the emergence of the modern hospital, the professionalization of medicine and nursing, and the transformation of hospitals from poorhouses and small businesses into corporate investments (Bergthold 1987). But the dichotomy hides the complexity of the health care labor force, the work of women as family members in home care, and how social policies depend for their implementation on the everyday activities and unpaid labor of women (Glazer forthcoming). It continues the outdated concept of the family as some remnant of the preindustrial world, rather than as a fundamental unit from whence women's domestic labor can be drawn for use by corporate capitalism, enabling consumption of goods with the least social costs to businesses.

The work transfer focuses on the changing relationship between paid and unpaid work, particularly between the paid service work and unwaged domestic service labor done by women. But the social processes by which changes are constituted in women's paid service labor and women's unwaged domestic labor reflect microcosms of class, racial and ethnic, and gender relations in advanced capitalism. The changing relations between paid and unpaid service labor reflect also the hegemony of capitalism, demonstrating the power of corporate capitalism to redefine family responsibilities and to extend women's responsibilities for tending without provoking organized resistance by the public.

Furthermore, the work transfer is not limited to health care: The redesign of work in which the customer or client must do tasks once done by waged workers has been used to change other female-typed service jobs. For example, automatic teller machines in banking displaced women clerical workers and substituted a new division of labor, between men who work as cash-replenishers of the machines and women and men bank customers. Nor is health care the only human service affected. After budget cuts in Portland, Oregon, the police adopted a new policy of do-it-yourself reporting of home burglaries, vandalism, and petty property crimes, requiring victims to go to

their local precincts to file reports. Some are more problematic: relying on mothers and fathers to fill in for the teachers lost to the schools when budgets have been rejected by voters; expecting would-be welfare clients to complete do-it-yourself intake forms on the reception room computer, when the information so obtained is used to decide on their eligibility for services. Supposedly more efficient and evenhanded than welfare aides, the computer also eliminates the humane judgments of the aides and may force would-be aides into the ranks of those they could have serviced.

The paid and unpaid service work reorganized by the work transfer shows a seamless web of work done by women. Change in one, paid work, prompts a change in the other, unpaid work. Health care was always partly work done in the home, but modern medicine and a highly profitable health care industry kept the unpaid work of women as family members marginal. The new changes in reimbursement have brought the family and women back to the forefront of the invisible support for continuing profits in the health services industry and placed the low-waged service work of health workers at risk. Changes via the work transfer are cumulative and interconnected, forcing more self-service work from women in the alleged service society and expelling some women from low-paid service work. But the changes may continue to hide those services done for free under the rubric of the private work of consumption.

NOTES

1. In its Old French origins, *amateur* means "lover of an activity." I chose it to underscore that women tend for love as well as duty. In its English usage, amateur refers to activities done without professional training.

2. For purposes of determining eligibility for services and reimbursement by insurers, *acute* refers to unstable medical conditions for which patients are presumed to need 24-hour-a-day nursing by a "skilled," meaning, registered, nurse. *Unstable* patients are en route to recovery or to death. *Acute* contrasts with *chronic* illnesses or disabilities, in which conditions are considered stable – at least momentarily – and for which skilled nursing care is presumed to be unnecessary 24 hours a day. Persons with chronic illnesses are discussed in this article only if they have a recent acute episode. Patients in home health care straddle the boundaries, requiring only some skilled nursing care, but are not medically stable.

3. Information from Joan Acker (personal communication).

4. Most U.S. states have tort laws that prohibit interspousal lawsuits, including over "malpractice" or malfeasance in providing home health care services (Isabel Marcus, personal communication).

REFERENCES

Abel, Emily K. 1989. Family care of the frail elderly: Framing an agenda. *Women's Studies Quarterly* 1 (2): 75-86.

Abel, Emily K., and Margaret Nelson. 1990. *Circles of care.* Albany: SUNY Press.

Archbold, Patricia C. 1982. An analysis of parentcaring by women. *Home Health Care Services Quarterly* 3:5-26.

Barrett, Michelle, and Mary McIntosh. 1984. *The anti-social family.* London: Verso.

Bennholdt-Thomsen, Veronika. 1984. Subsistence production and extended production. In *Of marriage and the market,* edited by Kate Young, Carol Wolkowitz, and Roslyn McCullogh. London: Routledge & Kegan Paul.

Bergthold, Linda A. 1987. Business and the pushcart vendors in an age of supermarkets. *International Journal of Health Services* 17:7-27.

Berk, Richard, and Sarah Fenstermaker Berk. 1979. *Labor and leisure at home.* Beverly Hills, CA: Sage.

Berk, Sarah Fenstermaker, ed. 1980. *Women and household labor.* Beverly Hills, CA: Sage.

Blitzer, Carol. 1981. Cooperative care unit cuts costs 40% at NYU hospital. *Business Insurance* 15 (28 December): 3, 27.

Brody, Elaine. 1985. Parent care as a normative family stress. *Gerontologist* 25:19-29.

Brody, Elaine, and Claire Schoonover. 1986. Patterns of parent-care when adult daughters work and when they do not. *Gerontologist* 26:372-81.

Brody, Wendyce H. 1975. Economic value of a housewife. *Research and statistics note.* DHEW Pub. No. (SSA) 75-11701. Washington, DC: GPO.

Bystydzienski, Jill M. 1989. Women and socialism: A comparative study of women in Poland and the USSR. *Signs* 14:668-84.

Carpenter, Eugenia S. 1980. Children's health care and the changing role of women. *Medical Care* 18:1208-18.

Committee on Aging. Select Committee, United States House of Representatives. 1984. *Building a long-term care policy: Home care data and implications.* Comm. Pub. No. 98-484. Washington, DC, December.

Corbin, Julie, and Anselm Strauss. 1988. *Unending work and care.* San Francisco: Jossey-Bass.

Cowan, Ruth. 1983. *More work for mother.* New York: Basic Books.

Creative teaching. 1985. *Caring* 4:17.

Eldercare survey shows need for benefits. 1988. *Employee Benefit Plan Review* 43 (September): 13-14.

Evans, Robert, and Geoffrey Robinson. 1983. An economic study of cost savings on a care-by-parent ward. *Medical Care* 21:768-82.

Finch, Janet, and Dulcie Groves, eds. 1980. *Labor of love: Women, work, and caring.* Boston: Routledge & Kegan Paul.

Folbre, Nancy. 1987. The pauperization of motherhood: Patriarchy and public policy in the United States. In *Families and work,* edited by Naomi Gerstel and Harriet Gross. Philadelphia: Temple University Press.

Fox, Bonnie, ed. 1980. *Hidden in the household.* Toronto: Women's Press.

Fox, Renee, and Judith Swazey. 1974. *The courage to fail.* Chicago: University of Chicago Press.

Galbraith, John Kenneth. 1973. *Economics and the public purpose.* Boston: Houghton Mifflin.

Gibson, Kathy R., and C. Beth Pulliam. 1987. Cooperative care: The time has come. *Journal of Nursing Administration* 17 (3): 19-21.

Glaser, Barney, and Anselm Strauss. 1967. *The development of grounded theory.* New York: Aldine.

Glazer, Nona Y. 1984. Servants to capital: Unpaid domestic labor and paid work. *Review of Radical Political Economics* 16:61-87.

———. 1988. Overlooked and overworked: Women's paid and unpaid labor in the U.S. "cost crisis." *International Journal of Health Services* 18:119-37.

———. Forthcoming. *Servants to capital: Women's paid and unpaid work in retailing and health services.* Philadelphia: Temple University Press.

Glazer-Malbin, N. 1976. Housework. *Signs* 1:905-21.

Goffman, Erving. 1961. The medical model and mental hospitalization. In *Asylums.* Garden City, NY: Doubleday Anchor.

Haber, David. 1986. In-home and community-based long-term care services. *Journal of Applied Gerontology* 5:37-50.

Habermas, Jurgen. 1974. The public sphere (1964). *New German Critique* 3:46-55.

———. 1989. *The structural transformation of the public sphere.* Cambridge: MIT Press.

Hammond, John. 1979. Home health care cost effectiveness. *Public Health Reports* 9:305-11.

Health Care Financing Administration. 1988a. *Use and cost of home health agency services under Medicare: Selected calendar years 1974-86.* Research brief No. 88-4. Washington, DC.

———. 1988b. *1988 HCFA statistics.* HCFA Pub. No. 03271. Washington, DC, December.

Heskett, James. 1986. *Managing the service economy.* Boston: Harvard Business School Press.

Horowitz, A. 1985. Sons and daughters as caregivers to older parents. *Gerontologist* 25:612-17.

Jones, Dee A., and Norman J. Vetter. 1984. A survey of those who care for the elderly at home: Their problems and their needs. *Social Science in Medicine* 19:511-14.

Kelly, Joan. 1979. The doubled vision of feminist theory. *Feminist Studies* 5:221-27.

Kind, A. C., D. N. Williams, G. Persons, and J. Gibson. 1979. Intravenous antibiotic therapy at home. *Archives of Internal Medicine* 139:413-15.

Koren, Mary Jane. 1986. Home care—who cares? *New England Journal of Medicine* 314:917-20.

Laslett, Barbara, and Johanna Brenner. 1989. Gender and social reproduction: Historical perspectives. In *Annual review of sociology, Vol. 15,* edited by W. Richard Scott. Palo Alto, CA: Annual Reviews.

Lewis, Jane. 1986. The working-class wife and mother and state intervention, 1870-1918. In *Labour and love,* edited by Jane Lewis. Oxford: Basil Blackwell.

Littman, Theodor J. 1974. The family as a basic unit in health and medical care: A social behavioral overview. *Social Science Medicine* 8:495-519.

Lopata, Helena Z. 1971. *Occupation: Housewife.* New York: Oxford University Press.

Lovelock, Christopher, and Robert F. Young. 1979. Look to consumers to increase productivity. *Harvard Business Review* 57 (3): 66-76.

Mandel, Ernest. 1975. *Late capitalism.* London: New Left Books.

Matthews, Sarah H. 1987. Provision of care to old parents. *Research on Aging* 9:45-60.

Mies, Maria. 1986. *Patriarchy and accumulation on a world scale.* London: Zed.

Miller, Baila. 1990. Gender differences in the spouse management of the caregiver role. In *Circles of care,* edited by Emily K. Abel and Margaret K. Nelson. Albany: SUNY Press.

Morrissey-Ross, Mary. 1988. Documentation: If you haven't written it, you haven't done it. *Nursing Clinics of North America* 23:363-71.

Morrissey, Michael, Frank A. Sloan, and Joseph Valvona. 1988. Shifting Medicare patients out of the hospital. *Health Affairs* (Winter): 52-63.

Moss, Abigail J., and Mary A. Moien. 1987. *Recent declines in hospitalization: United States, 1982-86.* Advanced data no. 140, 1-15. Washington, DC: National Center for Health Statistics, U.S. Dept. Health and Human Services, 24 September.

New care unit to cut hospital costs by 40%. 1979. *American Nurse* 11 (20 May): 1-6.

Oakley, Ann. 1974. *Woman's work.* New York: Vintage.

Olesen, Virginia. 1989. Caregiving, ethical and informal: Emergent challenges in the sociology of health and illness. *Journal of Health and Social Behavior* 30:1-10.

Paringer, L. 1985. Forgotten costs of informal long-term care. *Generations* 9:55-58.

Parsons, Talcott, and Robert F. Bales. 1955. *Family, socialization and interaction process.* Glencoe, IL: Free Press.

Pesznecker, Betty, Barbara Horn, Joanne Werner, and Virginia Kenyon. 1987. Home health services in a climate of cost containment. *Home Health Care Services Quarterly* 8:5-21.

Rapp, Rayna, Ellen Ross, and Renate Bridenthal. 1979. Examining family history. *Feminist Studies* 5:174-200.

Starr, Paul. 1982. *The social transformation of American medicine.* New York: Basic Books.

Stoller, E., and E. L. Stoller. 1983. Help with activities of everyday life: Sources of support for the non-institutionalized elderly. *Gerontologist* 28:64-70.

Stone, Robyn, Gail Lee Cafferata, and Judith Sangl. 1987. *Caregivers of the frail elderly: A national profile.* Washington, DC: National Center for Health Services Research.

Strong-Boag, Veronica. 1986. Keeping house in God's country: Canadian women at work in the home. In *On the job,* edited by Craig Heron and Robert Storey. Montreal: McGill-Queen's University Press.

Tunstall, Patricia. 1960. Hospitals without nurses. *Practical Nursing* 10 (5): 14-15.

U.S. Bureau of the Census. 1985. *Statistical abstract of the United States, 1986.* Washington, DC: GPO.

———. 1987. *Statistical abstract of the United States, 1988.* Washington, DC: GPO.

U.S. Department of Commerce. 1978. *U.S. industrial outlook, 1960-1987* (excludes 1981). Washington, DC: GPO.

U.S. General Accounting Office. 1982. *The elderly should benefit from expanded home health care but increasing those services will not insure cost reductions.* Washington, DC: GPO.

Vanek, Joanne. 1974. Time spent in housework. *Scientific American* 231:116-20.

Weinbaum, Batya, and Amy Bridges. 1976. The other side of the paycheck: Monopoly capital and the structure of consumption. *Monthly Review* 28:88-103.

Zaretsky, Eli. 1976. *Capitalism, the family and personal life.* New York: Harper & Row.

Nona Y. Glazer teaches sociology and women's studies at Portland State University. She will soon publish a book on the work transfer *in retailing and health services with Temple University Press* – Turnabout: Women's Unpaid and Paid Service Work in U.S. Retailing and Health Services, 1912-1985.