

Hidden Health Care Work *and* Women

It Takes a Lot of People to Provide Health Care...

Ask Canadians “Who provides health care?” and they are most likely to mention doctors and nurses. The work performed by these health care professionals is critical, highly valued and is the most visible work in the health care system.

Public policy discussions, TV and news reports, government and health authorities—most of the time comments and debate on health care are also about doctors and nurses. Whether the issue is training, shortages, recruitment, retention, salaries or conditions of work, the focus remains on these health care professions only.

But health care systems function because of the work of many other workers, whose jobs are considered secondary or ancillary and their issues are relegated to the background. The jobs these people perform are absolutely necessary to the health care system and to the provision of care.

... and Most of Them Are Women

HIDDEN HEALTH CARE WORKERS

Imagine for a moment, a hospital or doctor's office without an adequate system of record-keeping. Imagine a nursing home without nutritious food. Imagine a health care facility that was not adequately maintained or one where the cleaning did not include special measures to reduce the spread of infectious disease. Imagine no one doing the laundry, fixing the meals, filing the test results. Imagine no one there to help the patients move to diagnostic facilities and no technicians available to analyze blood samples or operate x-ray equipment. Imagine no one answering the phones or staffing the reception desk. Imagine someone at home who is frail, ill or recovering from surgery and then imagine that this person has no one else there to help them out of bed or give them a bath, no one to fix meals, provide support or assist with the normal activities of daily life. Imagine that you enter an emergency room where none of the medical personnel speak your language and there is no one there to translate.

Clearly, doctors and nurses perform vital roles in the health care system, but without workers performing these *other jobs*, the health care system could not function and people would not receive the care they need and deserve.

Because these other workers are often overlooked, it makes sense to think of them as *hidden health care workers*.



WHY IS THIS WORK HIDDEN?

Some health care work is hidden, in part, because it is considered secondary or supplemental. In 2002, the Commission on the Future of Health Care in Canada drew a distinction between health care workers who provide direct patient care and others who were identified as *ancillary* workers. By labeling those who do not provide direct patient care as ancillary, the commission reinforced the view that such work is different from and not central to the provision of health care.

This ancillary work may be hidden because it takes place behind the scenes, but often it is invisible because it is taken for granted. Tasks that involve the daily restoration of order—the removal of garbage, the cleaning of floors, the changing of bedding, the preparation of food, the washing of dishes, the filing of records—are often only noticed when they do NOT occur. We become conscious of them in their absence, when the normal routine is disrupted.

Much of this hidden health care work is performed by women, doing jobs that have historically been defined as “women’s work”. These jobs often resemble women’s traditional work in the home. As such, they are commonly undervalued and assumed to require very little skill. Since policymakers focus their attention and priorities on medical diagnosis and treatment, these jobs are dismissed and not given the attention they require.

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HOW DO WE FIND THESE WOMEN?

If you were to go looking for detailed information about ancillary health care workers, you would find that important information about them remains hidden because of the way that census and labour force data are collected and categorized. Statistics Canada uses the North American Industry Classification System (NAICS) to categorize workers by the type of enterprise of their employer. Some people working in health care facilities are no longer classified as working in the health care industry because their work has been contracted out and their immediate employer is a cleaning or catering company, rather than a health care organization. This

approach to classifying workers underestimates the number of people working in health care. According to Statistics Canada, nearly half of the people working in the health and social assistance industry are not classified as working in health care *occupations*. Some data sets present information in very broad categories or are missing important information. Census data, for example, are frequently tabulated to present information on full-time, full year workers. This practice hides the realities of temporary and part-time workers, most of whom are women. Thus it is difficult for researchers to get a clear and complete picture of the health care workforce.

WHY IS THIS A WOMEN'S ISSUE?

What difference does it make if some health care workers are labeled 'ancillary workers'? What are the consequences if some health care workers are relegated to a secondary status, pushed to the margins or excluded by an act of definition? Why is this a woman's issue?

It makes a difference to the workers, because it creates a divided workforce where some are treated differently than others. When workers and the services they provide are labeled as 'ancillary', it becomes a way of isolating this work from the core services or main function of an organization. In health care, this means that workers and services defined as 'ancillary' can be more easily turned over to private, for-profit companies, while 'real' health care work is protected from such forms of privatization.

Privatizing public sector health care jobs has frequently meant job losses and wage cuts for a largely female workforce. Over 8000 unionized health care workers lost their jobs when B.C hospitals and long-term care facilities privatized ancillary services in 2003-2004. When the jobs were contracted out, the hospital housekeepers' wages were cut from almost \$20 an hour to \$10.50 an hour, and workers lost pension benefits, paid parental leave, long-term disability benefits and other protections that had been part of their collective agreement.

Treating 'ancillary workers' as second class workers also makes a difference to everyone working in health care, because the whole system runs on a complex division of labour with **every** part of the team dependent on the work of others. Finally, it makes a difference to patients, because the work performed by these so-called ancillary workers is critical to care.

To plan for and deliver good quality health care, we need to consider the whole health care workforce, not just a part of it. We need to look at the issues which affect ALL the workers who perform the broad range of tasks that keep the health care system functioning.

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WHAT IS THE HIDDEN HEALTH CARE WORK?

While women in these hidden positions are often labeled as ‘ancillary’, they define themselves as health care workers. Regardless of the specific nature of their jobs, Canadian research has found that hospital workers share a common bond of caregiving, loyalty to patients and devotion to their work.

Hidden health care workers are employed in many occupations. Some are employed in technical occupations: Medical laboratory technologists and technicians perform tests that are useful in supporting diagnosis and treatment. Medical radiation technologists operate x-ray equipment and administer radiation treatments. Others operate ultra-sound, electrocardiogram or other equipment.

Many hidden health care workers are employed as clerical workers, including medical secretaries, filing clerks, records managers, receptionists and switchboard operators. They handle vast quantities of information, maintain careful detailed records, and often deal with people who are ill or distraught. Hidden health care workers are also responsible for a variety of other services: cooking, food preparation, laundry, maintenance, cleaning and security services. They work in hospitals, treatment centres, ambulatory care services, doctors’ offices, nursing homes, residential care facilities, diagnostic services and home care programs.

Some hidden health care workers do provide direct patient care, but are still considered ‘ancillary’. Nursing aides, orderlies and patient service associates provide personal care and help move patients. Visiting homemakers, housekeepers and personal care workers offer care and support to people in their own homes.

Many of the tasks today performed by ‘ancillary’ workers were once performed by nurses or student nurses. It was only in the latter half of the twentieth century that nursing students stopped performing the domestic chores in hospitals, and a new more stratified division of labour emerged. But the line between nurses’ work and ancillary work is often blurred. If there is a shortage of clerks, nurses spend more time answering phones or filling out paperwork. If there is a shortage of cleaners or food service workers, nurses spend more time changing bedding, serving food or doing kitchen work and so have less time to spend with patients.

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MOST HIDDEN HEALTH CARE IS WOMEN'S WORK

Approximately 80% of paid health care workers in Canada are women, and this applies to hidden health care workers as well. Women make up the overwhelming majority of hospital workers. Women are 99.1% of the medical secretaries working in hospitals, 91.6% of hospital records managers and filing clerks, 96.3% of the hospital receptionists and switchboard operators. Women are 83.9% of hospital medical laboratory technicians, 81.2% of hospital radiation technologists and 85.2% of those who operate hospital ultrasound equipment. Women are 74.6% of the nursing aides, orderlies and patient service associates working in hospitals. Women are 86.7% of hospital food service supervisors.

Women are also the overwhelming majority of health care workers employed in nursing homes, residential facilities or private homes. In nursing homes and residential care facilities, 94.0% of the laundry workers, 81.9% of the light duty cleaners, 82.8% of the cooks and 91.1% of the workers in assisting occupations are women. Among those health care workers categorized as visiting homemakers, housekeepers and personal care workers, 91.5% are women.

A majority of those classified as light duty cleaners are women, while a majority of those classified as janitors are men. While both are responsible for indoor cleaning, male janitors are also responsible for building maintenance and outside work.

Immigrant women who were born outside Canada make up 9.5% of the labour force. However, immigrant women are over 20% of medical laboratory technicians, nurses' aides, and visiting homemakers; they are also more likely to be employed as laundry workers and light duty cleaners. Workers belonging to visible minorities make up 13.4% of the Canadian labour force, but visible minority workers are 19.9% of medical laboratory technicians and 18.5% of the nurses' aides, orderlies and patient service associates, and 23.5% of dry cleaning and laundry supervisors. Black women and men and Filipino women and men are overrepresented in positions as visiting homemakers, housekeepers and related occupations, occupations for which they are often over-educated and under-employed.

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WHY IS THIS WORK CRITICAL TO CARE?

While everyone's health is influenced by their social and physical surroundings, those who are ill or in a weakened physical condition are especially vulnerable to unhealthy conditions. A safe, clean environment, accurate information, good food, and social support are critical to health and to the prevention and treatment of disease. These determinants of health are just as important inside the health care system.

Sometimes the work of cleaning, laundry, and food preparation is assumed to be the same whether it takes place in a hospital or a hotel. But this assumption overlooks the special nature of this work when helping patients get well.

Keeping rooms and equipment clean and safe in hospitals, clinics and nursing homes requires special attention, not only because patients are already sick or weak, but also to prevent spreading infectious diseases. When the importance of this work is not recognized, it can lead to serious problems. Health Canada estimates that each year 250,000 Canadians acquire infectious diseases while in hospitals or other health care settings, and over 8000 people die as a result of hospital-acquired infections. Recent Canadian studies found that cutbacks in housekeeping services in health care facilities were associated with the spread of infections of *C. difficile*, and other contagions.

Preparing and handling food safely is also critical to patient health and recovery. Making sure that people have food that meets their special dietary needs is particularly important when people are ill or weak. Helping people eat is integrally related to the provision of social and emotional support. When people have become vulnerable and dependent on others, how they are offered food is an important component of sensitive, compassionate care and respectful treatment. Patients may require special diets and schedules that will not interfere with diagnostic procedures, anesthesia, surgery or other medical interventions. For these reasons, food services in health care facilities have special requirements that make them different from food services in hotels or commercial buildings.

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Clerical work in health care is also critical to good quality care. It requires knowing a specialized vocabulary and careful attention to details. Small errors in patient records can have dangerous consequences. Accurate record-keeping and timely communication of health information and test results are necessary to ensure that patients receive appropriate treatment without delay. Clerical work also requires special skills to gather information or communicate clearly with people who are ill, injured, or upset.

Personal care work is sometimes considered ancillary work because of its low status, even though it is clearly an intimate form of direct patient care. Personal care workers do more than the physical tasks of dressing, bathing, feeding, lifting, brushing teeth, changing bedding, or preparing food. They provide comfort, encouragement, listening and a shield against loneliness. They often deal with people who are feeling vulnerable, frightened, dependent, angry, sad or overwhelmed. They must have the patience and flexibility to provide care to people whose memory may be failing or whose physical and emotional needs change over time. Personal care workers are often juggling complex situations where there is conflict between the patient's wishes, the advice of health care providers or the views of other family members.



MANY ESSENTIAL
HEALTH CARE
WORKERS ARE
OVERLOOKED

WHAT ARE THE ISSUES FOR WOMEN?

Low Pay

Many hidden health care workers are poorly paid, although workers in the health care sector do tend to earn more than those in similar occupations working in other sectors of the economy. One tenth of hidden health care workers have earnings that place them below the poverty line.

In 2000, a woman working as a home support or personal care worker in Canada had average annual earnings of \$16,008. If she happened to work full time, for the entire year for a health care employer, her annual earnings would average \$23,218. The average annual income for a woman working as a light duty cleaner was \$12,920. If she was employed full time, year round in the health sector, her annual earnings would have jumped to \$23,929.

In 2005, a single person living in a large Canadian city needed an income of \$20,778 and a single parent with two small children would have needed to earn \$27, 630 to be above the poverty line (both figures, after tax). Even working full-time, year-round, neither a hospital cleaner, a home support worker nor a personal care worker earn enough to support a family above the poverty line.

The low levels of pay for cooking, cleaning, laundry and personal care work in the health care system can be traced to the devaluation of women's unpaid domestic work. It is often assumed that these tasks require little skill and that women, by nature, are able to cook, clean and provide care to the sick.

In the health care and social assistance industry in 2001, the average hourly wage for men was \$19.32 and the average hourly wage for women was \$17.51. There also important differences in what women and men are paid to do the same work. On average, women working as full-time medical laboratory technicians in 2001 earned 87.2 cents for every dollar earned by men in the same occupation. Women working as full-time radiation technologists earned 74.8 cents for every dollar earned by men. On average, full-time female radiation technologists working in ambulatory care facilities earned only 60% of male earnings for the same work. In some areas however, the wage gap between women and men has been nearly eliminated. For example, among full-time hospital workers, women operating ultrasound equipment and women working as nurses' aides earned 97% and 94% respectively, when compared to the earnings of men in the same occupations.

Part-Time Work

Data that reports only on the earnings of full-time, full year workers do not provide a complete picture of the wage gap between women and men, as women are more likely to be employed in part-time work.

Within the health care and social assistance industry, 26.5% of the women working as secretaries and 31.1% of the women working in clerical occupations are employed in part-time positions. Among women employed as medical laboratory technicians, 25.5% work part time, as do 28.2% of women working as medical radiation technologists. Nearly one-third of the women working in technical and related occupations in the health and social assistance industry are working part time, while only 10.6% of the men in these occupations are part-time workers. Among women working as nurses' aides, orderlies or patient service associates, 38.9% were employed in part-time positions. Among women working as personal care and home support workers, 41.3% were working part time. Men working as personal care and home support workers also have a high rate of part-time work, 31.3%.

Lack of Benefits

While many hidden health care workers are unionized, and do receive paid sick leave, pensions and other benefits through their union contracts, there are still many who are not unionized and do not have these benefits. Frequently, hidden health care workers in the most precarious jobs are not eligible for paid sick days. Many are not covered by supplemental health or dental benefits. Many are not covered by employer pension programs, so their future financial security is also at risk.

Without paid leave, some workers in the health care system cannot afford to take time off when they are sick. If they are not covered by supplemental health benefits, they may not be able to afford medication or other treatments. The lack of benefits can lead to their own health suffering. And if they go to work sick, they can put other workers and patients at risk.



Workplace Health and Safety

Health care work is hazardous. In one survey, 97% of workers in long-term care facilities reported becoming sick or injured as a result of work.

Health care workers are routinely exposed to infectious diseases. Sometimes they deal directly with patients who are contagious, but they are also exposed through the air, the bedding, the dishes, the bathrooms and other contaminated surfaces. With proper care, the risks of infection can be greatly reduced.

Health care workers also encounter physical violence, harassment and verbal abuse from patients, patients' relatives, and co-workers.

Health care work frequently involves moving and lifting patients. The physical exertion can lead to strained muscles and serious back, neck and shoulder injuries. Health care workers who work alone in private homes or in under-staffed facilities may be at greater risk because conditions lead them to work beyond their own strength and capacities.

Health care workers also develop health problems as a result of being on their feet for long periods of time or being required to move heavy equipment. Cleaners are exposed to harsh chemicals and sharp objects.

Workers who experience high levels of stress as a result of demanding workloads, coupled with little control over their work are at greater risk of developing both physical and mental health problems. As a result of cutbacks, technological changes, and new management practices, many health care workers face increasing demands at work, while those in lower status occupations have very little control over their work. Add to this the stress associated with job insecurity, long hours, unpredictable schedules, and the difficulties of balancing work and family time demands. All these factors place health care workers' own health at risk.

It is therefore not surprising that workers in health care miss 50% more work because of illness and injury than the average Canadian worker.

Because research in occupational health and safety has tended to focus on the risks associated with male occupations and has overlooked workplace hazards faced by women working in traditionally female jobs, this gender bias has resulted in the development of a field of research that either fails to see women because it is focused on men, or sees women only through the lens of biased assumptions that distort their real experiences. However there have been some recent studies of women in the health care workplace, and that research has described a range of health hazards which women routinely encounter on the job. These include exposure to infectious agents and toxic substances, heavy lifting that results in musculoskeletal injuries, workloads and time pressures that create high levels of stress, and lack of control over working conditions.

Contracting Out

In recent years, governments and health care organizations have attempted to privatize parts of health care work by contracting out so-called ancillary services. Private, for-profit companies have been engaged by hospitals, nursing homes or regional health authorities to provide laundry, cleaning or food services. Often this has meant job losses, wage cuts and loss of benefits for the workers.

There are several factors that lead to contracting out. Proponents of privatization claim that the rising costs of health care threaten to overwhelm government budgets. They argue that one way to reduce health care expenditures is to transfer ancillary work to private, for-profit firms where it can be done more efficiently, at lower cost. At the same time private companies providing food and cleaning services in hotels and commercial buildings are seeking to expand into new markets. The large potential market in health care facilities offers new business opportunities, including opportunities for international cleaning and catering firms that have greater access to Canadian markets as a result of liberalized trade agreements. Privatization of ancillary services works in their interests.

We need to question the assumptions and logic of privatizing services. Government spending on health care in Canada is not out of control. Contracting out ancillary work will not make much difference to health budgets. Private, for-profit enterprises are not more efficient. Their need to generate profit makes them more costly than non-profit enterprises. Their emphasis on reducing labour costs has detrimental effects on workers and on the quality of services provided.

HOW CAN WE HAVE A HEALTH CARE SYSTEM THAT PROMOTES AND VALUES THE WORK WOMEN DO?

Health care work comes in many forms, and each occupation contributes to the success of the health care system. Effective teamwork within healthcare requires the participation of all workers, regardless of their occupation.

Cleaning, cooking, caring for people and keeping things organized are essential to promoting health and healing and need to be recognized as important work. This would mean challenging traditional attitudes that devalue women's work. This would mean recognizing the skills required to perform these jobs, and raising the status and pay of such work. It would also mean including health care workers in decisions about the organization of their work. Their knowledge and experience should inform decisions about work schedules, workloads, job duties, safety measures and training requirements.

Struggles to improve the status of women in the workplace and the conditions of women's work have often been led by women organized in unions. Between 1965 and 1990, many Canadian health care workers joined unions and secured collective agreements that improved their wages and working conditions. In an effort to improve their economic status and reduce the wage gap between women and men, women workers have mounted campaigns to receive equal pay for work of equal value. Unions representing health care workers have played a significant role in these struggles for pay equity. But in recent years, the proportion of health care workers protected by union contracts has declined.

Public, non-profit provision of health care is the most efficient and equitable way to ensure that Canadians receive the care they need. Privatization of services within health care poses a threat to working conditions, workers' rights and the quality of care. Improving conditions for health care workers promotes their health and improves the quality of patient care. Therefore, moves to privatize this work or management practices that lead to lower pay, increased workloads, greater job insecurity and deteriorating conditions of work are part of the problem, not the solution.

What we need is political and government will to support the public health care system Canadians value so highly based on non-profit delivery and dedicated to ensuring decent employment for all members of the health care team.

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The material presented here is based on a report prepared by Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon for the National Network on Environments and Women's Health in 2006. That report has been considerably expanded and transformed into a book by the same authors titled *Critical to Care: The Invisible Women in Health Services* published in 2008 by the University of Toronto Press. We thank Kay Willson for her work on this document.

selected resources

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who we are and what we do

Women and Health Care Reform consists of Pat Armstrong (Chair), Madeline Boscoe, Barbara Clow, Karen Grant, Margaret Haworth-Brockman, Beth Jackson, Ann Pederson and Morgan Seeley. We are a collaboration of the Centres of Excellence for Women's Health, the Canadian Women's Health Network and Health Canada's Bureau of Women's Health and Gender Analysis, funded through the Women's Health Contribution Program. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. For more information on our work, visit our website at

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“Caring is gendered work and work done by women is less likely to be seen as skilled or rewarded as skilled. This is particularly the case for those skills learned mainly at home by large numbers of women; the kinds of skills required in ancillary work.”

(Armstrong, Armstrong and Scott Dixon, 2006)



Thinking Women:

A Series on Health Care Reform and Women