SOCIAL ROLES AND HEALTH-RELATED BEHAVIOUR: A STUDY OF WOMEN IN LIVERPOOL

Thesis submitted in accordance with the requirements of
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CONTENTS

LIST OF TABLES AND FIGURES

Tables

Figures

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Research

1.1.1 The Changing Nature of Women's Everyday Activities

Conducting the research for and writing-up this thesis has been a constantly evolving learning process. It began with the recognition that normative social structures place expectations on women to be the *primary carer* at all stages in the life-course and that this is one of the major influences on their lives and the choices they make (Graham, 1983a; Finch, 1989; Finch and Groves, 1983). Those choices can include everything from level of paid work participation, with its implications for availability of resources, to the decision to take on the responsibility for a cared-for person in the first place whether that be a child or elderly relative. In the context of health and social care, this culturally defined domestic and caring role can be shown to be important not only in terms of the provision of care to others but also in relation to *women's own health and well-being*. Women are the primary health managers in the majority of households regardless of class or ethnic group. They are chiefly responsible for the way health services are used by children (Graham, 1984a and 1993) and are most likely to be providing labour-intensive care to a sick, elderly or disabled relative (Parker and Lawton, 1994). In terms of personal health and well-being, the combination and degree of participation in specific social roles has been shown to have an impact on physical and mental health (eg. Popay and Bartley, 1989) as well as women's health-related behaviours such

as the use of preventative services on their own behalf (eg. Pearson, Spencer and McKenna, 1990).

What emerged from the literature was the view that household-level involvement, and hence women's responsibilities, in the areas of health and social care may actually have increased in recent years (Pearson et al, 1993). This is because of the general shift in UK social policy towards the promotion of market forces, tighter controls on public spending and the privatisation of services in the public sector (Johnson, 1990; Le Grand and Robinson, 1984). Specifically, the *Health of the Nation* White Paper (Secretary of State for Health, 1992) placed considerably greater emphasis than hitherto on the need for individuals to respond to preventative screening programmes and adopt a healthy lifestyle. Measures aimed at reducing the length of hospital stays have increased the role of families in short-term after-care and the purposeful move in policy towards 'Care in the Community' (Secretaries of State for Health, Social Security, Wales and Scotland, 1989) has expanded the already considerable role of informal carers in looking after more permanently dependent people (Land, 1991). The latter policy shift is part of the development of a complex mixed economy of welfare in which statutory, voluntary and private sector social care providers are increasingly seen as *supporting*, rather than substituting for, the family (Wistow et al, 1994). When it is recognised that 'family' is essentially a proxy for women in their household contexts, the gender-specific impact of such a policy is clear.

Simultaneous with this intensification of pressures on women in their social role as family carers, a restructuring has occurred in the UK labour market such that the 'double burden' of paid and unpaid work is an increasingly common experience (Employment Department, 1990a). Growing numbers of women, particularly those who are married, are being drawn into 'flexible' forms of low-paid employment as the market for 'male' jobs continues to decline in many areas (Beatson, 1995; Hakim, 1987a). There are also increasing numbers of women in a position to choose to combine a career in a 'higher-status' job with their caring responsibilities (Hakim, 1991). This differential involvement of groups of women in the labour market has implications not only for the division of unpaid work within households but also for the gender-specific distribution of economic resources and levels of necessity to substitute help from the social network in place of income (Martin and Roberts, 1984). Whilst acknowledging that certain changes may have been needed in the structure of health and social care, the argument put forward in this thesis is that policy makers have not yet fully addressed the significant implications of those changes for households and individuals within them in the light of the wider social trends. It is the specific pressures brought to bear upon women that need to be explored.

The overall aim of this thesis is to advance a more *holistic* perspective on the processes which contribute to satisfactory health and well-being for individual people and to explore the implications for policy. It is critical to consider the combined effect of changing labour market participation and increasing responsibilities for health and social care on women in different social situations. Given the pivotal

position of women in the caring system overall, this follows through to raise questions concerning health and well-being for all. There is a need for new debates and forms of discourse to develop for the providers of health and social care to deal adequately with the issues involved. Health policy continues to be underpinned by the assumption that potential service users operate on a 'level playing field' of opportunity and this is patently not the case when it comes to day-to-day choices in the management of health within households (Pearson, 1992). As Rose (1993) states:

> "... The limits on women's everyday activities are structured by what society expects women to be and therefore to do ..." (ibid, 1993, p.17).

It is vital, therefore, that the implications of ascribed social roles on the ways individuals view their own personal health and health-related behaviours are more fully recognised. Such implications might be direct or mediated through alternative activities such as paid work. This is not, of course, to assume that 'carers' are a homogeneous group. From the outset of this research a broad life-course perspective is taken to the concept of caring. In writing-up the thesis, therefore, the term 'carer' has not been applied in the relatively narrow sense used by health and social care professionals of someone looking after a sick, elderly or disabled person; it covers the whole spectrum of responsibility from the care of an otherwise 'healthy' baby onwards.

In arguing for a holistic view of women's health and health-related behaviours, it is clearly necessary to attempt critically to unravel the concept of *health-related need* and avoid the current orthodoxy of discourse and practice

concerning which services are appropriate and when. It may, for example, be that accessible nursery facilities in a local area will do more for the positive 'health' of low-income women by alleviating some of the pressures involved in caring than anything the conventional health and social care services can provide. Another example of this unravelling of influences on individual well-being may be the fact that the service needs of the carer do not necessarily correspond with those of the cared-for person. Clearly, it is vital to explore the wider context of health-related need in the present climate of health and social care provision where the goals are for local 'needs-led' purchasing and increased choice and control' for the individual service user. In addition, a decisive shift in favour of a 'primary care-led National Health Service (NHS)' was announced at the 1994 Conservative Party Conference with a major expansion of the general practitioner (GP) fundholding scheme (Department of Health, 1994). Such moves continue to build upon a principle aim of the NHS Reforms which was:

> "... to assist and support the change in primary health care from a disease focused service towards a planned, supported and health oriented service" (Liverpool Health Authorities, 1993, p.3).

Although women as a group have been the main users of NHS services in the past, it remains to be seen how individual women can effectively respond to these shifts in focus towards prevention and healthy lifestyles. None of this is to consider 'health' and 'well-being' as taken-for-granted terms, but to recognise the need for a better understanding of what each might mean under different social circumstances and in different systems of social relations.

1.1.2 The Role of Place in the Construction of Meaning

This thesis is based on research about women living in particular places; the city of Liverpool at one scale and the suburbs of Netherley and Woolton at another. An important element of that research involves an acknowledgement and exploration of the role of space and place in the social construction of meaning and the actions and events which stem from it. There are aspects of the processes and behaviours surrounding household management of health, reported in this thesis, which exhibit significant 'locality effects'. The issue of whether or not such effects are causal is one previously addressed in the so-called 'localities debate' in the social sciences (see, for example, Cooke, 1989).

In this debate, Duncan (1989) and Duncan and Savage (1989) represent a view which is rejected in this thesis. They privilege a-spatial economic and social processes and argue that variation over space occurs as a result of the following mechanisms:

i) contingent local variation whereby spatial contingency or the pre-existing nature of a place affects the way social mechanisms operate and spatial contingency is an outcome of the earlier constitutions of social processes;

ii) causal local variation whereby social mechanisms are themselves locally derived because human actors monitor and respond to the varying contexts in which they find themselves;

For Duncan and Savage (1989), a locality effect occurs only in so far as a combination of complementary and locally derived processes and outcomes may produce some kind of local system or culture. In contrast, although Urry (1987) agrees that localities are economically and socially determined, he goes on to argue that locality can have an important influence in itself because the combination of determinants are so complex and variable at that scale. These local effects are, to an extent, dependent on the interconnection between processes at all levels of resolution from the international to the national and the local. In other words, contingency can have causal power.

Cooke (1989) would go even further to argue that locality is, in fact, proactive:

> "Local social processes are clearly an abiding feature of contemporary social life. Duncan and Savage's injunction to ignore them and settle on the structural level, supra-local, supra-national or whatever, in order to describe spatial variation in terms which deny agency to the social groups comprising localities, is both dated and redundant" (ibid, 1989, p.272).

For Cooke (1989), locality is as much a base around which people may mobilise as ethnicity, gender or class. Proactivity can, therefore, be seen as the activation of rights of citizenship. Cox and Mair (1989) take a similar view but, helpfully for the work set out here, refer to localised social structures based on the following:

i) local dependency whereby certain activities tend to be constrained to the local scale; and

ii) scale divisions of labour whereby roles in the social division of labour exist at different scales and their inherent social relations comprise the localised social structure.

They state that:

> "If people interpret localised social structures in explicitly territorial terms, come to view their interests and identities as 'local', and then act upon that view by mobilising locally defined organisations to further their interests in a manner that would not be possible were they to act separately, then it seems eminently reasonable to talk about 'locality as actor'" (Cox and Mair, 1989, p.198).

Massey (1993), however, would caution against seeing places as having single, essential identities. She argues in favour of places having multiple identities. Different social groups are configured in distinct ways in relation to the workings and interconnections of process and there are no easily defined boundaries to the social relations out of which places are constructed. Out of this dynamic, the specificity of place is produced:

> "Social relations always have a spatial form and spatial content. They exist necessarily, both in space (i.e. in a locational relation to other social phenomena) and across space. And it is the vast complexity of the interlocking and articulating nets of social relations which is social space ... A 'place' is formed out of the particular set of social relations which interact at a particular location. And the singularity of any individual place is formed in part out of the specificity of the interactions which occur at that location (nowhere else does this precise mixture occur) and in part out of the fact that the meeting of those social relations at that location (their partly happenstance juxtaposition) will in turn produce new social effects" (Massey, 1993, p.168).

It is clear from this and other arguments (eg. Massey, 1988 and 1994; Meegan, 1989 and 1995) that place is more than just context for social processes such as those which surround the management of household health needs. Places like

Liverpool and Netherley and Woolton are important in themselves for the contribution they make to the differential construction of social reality. This role is, however, best understood if:

> "Instead of thinking of places as areas with boundaries around, they ... [are] imagined as articulated moments in networks of social relations and understanding" (Massey, 1993, p.66).

It is this understanding which underpins the 'locality' aspects of the research set out here.

1.1.3 Research Objectives

In summary, therefore, this thesis is about the 'realities' of women's everyday lives in very particular places: the city of Liverpool and two of its outer suburbs, Netherley and Woolton. It is based on research which seeks to draw together largely discrete bodies of knowledge in the areas of labour market analysis, caring roles and health in order to examine the complex systems of social relations surrounding the definition and management of health needs for individuals within households. It looks, specifically, at the role and position of women in these processes and asks which groups are and are not well equipped to cope in the light of the changing structures of policy and provision in the areas of health and social care. The aim is to illustrate how important it is that purchasers and providers consider household and local circumstances particularly when commissioning for communities characterised by poverty and social exclusion. The overall point for the policy makers is that it is vital to involve local people, and women specifically, in an exploration of real priorities in the context of health needs and the appropriate provision of health and social care.

1.2 Research Design and Methodology

1.2.1 The Importance of Appropriate Methods

The belief that a real understanding of the social processes of household health management and the impact of everyday choices on individual health-related behaviour is best achieved by allowing women to speak for themselves formed the main criterion for the choice of research methodology to be adopted. It follows from this that open-ended qualitative as opposed to quantitative approaches are appropriate since they allow for process and difference to be addressed in *real* social contexts and *real* time-space (Murphy and Longino, 1992). In addition, the realist approach provides the most appropriate overall tool for analysis (Sayer and Morgan, 1985; Sayer, 1992). This is because it offers a viewpoint which bases explanation not only on an understanding of the immediate causes of action but also on the conditions behind that action. It accepts the importance of human agency as well as the intrinsic meaning and beliefs attached to social practice, but regards actions and beliefs as negotiable, to be understood only in the temporal and spatial context in which they are observed (Dey, 1993). The realist approach, therefore, seeks to identify causal relationships, groups and processes whilst providing a context for seeing outcomes and meanings as contingent and changing. It privileges the impact of social structures on individuals within contingent circumstances and is, therefore, in concert with the concerns of those feminist writers who ask:

> "... what social relations define women's position in contemporary society? For it is these relations that constitute women into a social and spatial population sub-group: delimiting and defining their daily activities and spatial behaviour" (Mackenzie, Foord and McDowell, 1980, p.47).

In the context of this thesis, caring provides an example of a causal relationship. The need for care generates the necessity for its provision. The relevant causal groups would be 'carer' and 'cared for'. These may only be further defined but by *intrinsic* properties such as whether a cared-for person is a child or an adult, disabled or not disabled. The groups are causal because one cannot exist without the other and the existence of both is a *necessary* part of the caring relationship. It is *contingent* circumstances which determine how that relationship works out in practice. These include the historically and socially constructed relation which places the obligation on women rather than men to care (Finch, 1989). They also include the level of income available to purchase substitute care as well as the degree of more personal obligation built up over the life-course between the people involved (Qureshi and Walker, 1989). However, realist methodology reveals that even though an association may exist, for example between higher income and the receipt of outside help, a direct link between the two cannot be assumed. The level of obligation felt by the person called upon to provide care may, for example, be too great to allow this. In summary:

> "Processes of change usually involve several causal mechanisms which may be only contingently related to one another. Not surprisingly then, depending on conditions, the operation of the same mechanism can produce quite different results and, alternatively, different mechanisms may produce the same empirical result ..." (Sayer, 1992, p.108).

As Sayer (1992) proceeds to note, this seems unexceptional in itself. However, it is a viewpoint which allows the main criticisms of qualitative research to be dealt with. Those criticisms focus on the failure of qualitative methods:

> "... to provide a sense of the typicality or generality of events described" (Bryman, 1988, p.143).

The realist approach challenges the validity of generalisation in the first place and considers misguided the orthodox methodology of the quantitative survey and subsequent statistical analysis (Bynner and Stribley, 1979 reprinted 1990) because it:

> "... assumes that causation is a matter of regularities in relationships between events ... Realism replaces the regularity model with one in which objects and social relations have causal powers which may or may not produce regularities, and which can be explained independently of them. In view of this, less weight is put on quantitative methods for discovering and assessing regularities and more on methods of establishing the qualitative nature of social objects and relations on which causal mechanisms depend ... " (Sayer, 1992, p.2-3).

Sayer and Morgan (1985) and Sayer (1992) define this as a distinction between intensive and extensive methods (Table 1.1). It is intensive methods, such as the open-ended interview (Shoenberger, 1991; Thompson and Whelan, 1991), narratives (Graham, 1984a; Oakley, 1993a) or life and work history analyses (Bertaux, 1981; Dex, 1991; Hagemaster, 1992), which are appropriate for discovering causal explanation. They are used to work with causal groups in causal contexts rather than taxonomic groups linked by association only.

None of this actually denies that there is a role for extensive research techniques. It is simply the realist position that:

> "... methods must be appropriate to the nature of the object we study and the purpose and expectations of our enquiry ..." (Sayer, 1992, p.4).

Table 1.1: The Nature of Intensive and Extensive Research

	INTENSIVE	EXTENSIVE
Research question	How does a process work in a particular case or small number of cases? What produces a certain change? What did the agents actually do?	What are the regularities, common patterns, distinguishing features of a population? How widely are certain characteristics or process distributed or represented.
Relations	Substantial relations of connection	Formal relations of similarity
Type of groups studied	Causal groups	Taxonomic groups
Type of account produced	Causal explanation of the production of certain objects or events, though not necessarily representative ones	Descriptive 'representative' generalizations, lacking explanatory penetration
Typical methods	Study of individual agents in their causal contexts, interactive interviews, ethnography. Qualitative analysis	Large-scale survey of population or representative sample, formal questionnaire, standardized interviews. Statistical analysis
Limitations	Actual concrete patterns and contingent relations are unlikely to be 'representative', 'average' or generalizable. Necessary relations discovered will exist wherever their relata are present eg. causal powers of objects are generalizable to other contexts as they are features of these objects	Although representative of a whole population, they are unlikely to be generalizable to other populations at different times and places. Problem of ecological fallacy in making inferences about individuals. Limited explanatory power
Appropriate tests	Corroboration	Replication

Source: Sayer, 1992, p.243.

Extensive research can be employed but only where its limits are fully understood (Eyles, 1988; Graham, 1983b; Marsh, 1979). As an example, Sayer (1992) describes his examination of statistical data to build up background descriptive information for a study of behaviour in an industrial sector. The *patterns* identified at this broad level were then *explained* by switching to an intensive method which looked at individual firms. Despite continuing objections to intensive methods in some quarters (eg. Clarke, 1992), such an approach is also increasingly

recommended in health services research (eg. Sykes et al, 1992). Researchers in health are increasingly wary about whether surveys *per se* provide information appropriate for their needs (Jones, 1995; Leavey and Wilkin, 1988).

This question of appropriate methods has also become one of the central concerns of feminist researchers. Some, such as Maynard and Purvis (1994), argue that there is an:

> "... orthodoxy which seems to have become a feature of discussions on feminist research methods. A gulf has been drawn between quantitative and qualitative approaches, with the implication that it is qualitative work, particularly the semi-structured or unstructured interview, which is quintessentially feminist" (ibid, 1994, p.3).

Others, however, recognise that the dichotomy between such approaches may be unhelpful (Brannen, 1992; Bryman, 1988; McLaughlin, 1991; Maynard, 1994; Kelly, Burton and Regan, 1994; Silverman, 1985). Some now combine both intensive and extensive methods (Christensen, 1993; Glucksman, 1994; Marshall, 1994; Qureshi, 1992) and, as a corollary to this, it has also been argued that multiple methods other than the in-depth interview are often appropriate within an entirely intensive research project (McCracken, 1988; Seidman, 1991). This combination of both extensive and intensive methods and the use of different intensive methods within the in-depth interview was the approach chosen for this thesis. Before outlining the research tools used, however, it is necessary to conceptualise the nature of women's everyday lives and household health management in terms of the realist perspective and to describe how it is that this approach can advance understanding in geographical work on health-related behaviour.

1.2.2 A Realist Conceptualisation of Women's Social Roles

In order to look at the role of households in relation to the changing nature of health and social care, it is essential to explore the social relations of the caring and domestic labour process. As explained in Section 1.2.1, in realist terminology, carer and cared-for are the causal groups in that process. These are the groups with causal power because theirs is the *necessary* relationship in the context of caring. The same groups would, therefore, exist across all societies both historically and today. Another necessary relationship which is relevant in the context of household social roles is that which constitutes the labour process outside caring. However, as also explained in the last section, contingent circumstances condition the outcome of these necessary relationships. In contemporary western society, capitalism and patriarchy form the key social relations upon which the caring and other labour processes are embedded. Modern industrial capitalism requires, for example, that a proportion of the overall labour process takes place outside the household and that this is, primarily, configured in terms of the exchange of labour power for a monetary wage. Capitalism also requires that caring and other types of reproductive labour are carried out, mainly by unwaged workers, in the domestic sphere. Hence, the profitability of capital is in part sustained because the costs of the reproduction of labour power are lowered by the fact that domestic labour is unpaid.

In addition, there is nothing in the intrinsic characteristics of the genders which assigns women to a primary caring role in the domestic sphere and men to paid employment. It is the contingent gender division of labour, socially constructed by the workings of capitalism and patriarchy combined, which maintains

these inequalities (Lonsdale, 1992). Capitalism has captured the pre-existing patriarchal social structures which underlie that organisation of labour (Delphy and Leonard, 1992; Finch, 1987a; Finch and Groves, 1983) and by exploiting them helps to perpetuate the established conditions (Hartmann, 1979). Just as gendered social roles have, in the past, been contingent upon the workings of capitalism and patriarchy so too are the ways in which those roles are now changing. Women have, for example, been increasingly drawn into paid employment in recent years. However, because they continue to be assigned to the primary caring role, women are often excluded from the better paid, higher-status jobs in the primary sector of the labour market. Instead they have become a major element of the cheaper and more 'flexible' workforce created in response to long-term structural changes in the UK economy (Beatson, 1995). The bulk of the expansion in women's paid work participation can, therefore, be accounted for by those who, in order to accommodate domestic commitments, take jobs in the lower-paid and unstable secondary labour market where part-time work is more readily available (Crompton and Sanderson, 1990; Hakim, 1987a; Rees and Willox, 1991).

Overall, as Williams (1989) notes, it is possible to view the welfare state as the *combined* expression of the two systems of oppressive power relations: capitalism and patriarchy. This is because it constitutes a set of interventions into the economy which, by supporting the family household based on the male wage and female domestic labour, ensures the production and reproduction of labour power in a way which maintains both capitalism and patriarchy. The family has been socially constructed into society as the basic unit of self support (Baldwin and

Twigg, 1991) and policies which increase the responsibilities of the household for health and social care continue to build on this situation (Wicks, 1987). The implicit ideological statement about which family members should care for sick, elderly or disabled dependants is, for instance, translated into a lack of formal support from the health and social services for women carers compared to men (Arber and Gilbert, 1989; Henwood, 1987; Parker and Lawton, 1994). It is this socially contingent nature of the caring labour process and the actual experience of caring which makes gender a primary dimension of this research.

1.3 Previous Research in the Geography of Health

It is one of the major criticisms of medical geography that it has failed to recognise the full implications of social relations as contributors to individual health and access to health care. Historically, writers in medical geography have concentrated on two main areas: i) the ecology of disease with an emphasis on distribution and diffusion; and ii) the spatial location and related use of health services (Jones and Moon, 1987; McGlashen and Blunden, 1983; Phillips, 1981). As Pearson (1989) argues:

> "... the emphasis ... has been on strictly *spatial* considerations and *aggregate* populations ... Spatial perspectives have undoubtedly shed important light on disease and health care problems, but in divorcing health matters from their broader social context, structural inequalities of class, gender and race in health and access to care have (with a few notable exceptions) been neglected" [original emphasis] (ibid, 1989, p.10).

It is the similarly held view of another critic that medical geography can only contribute effectively to an understanding of inequalities in the spatial and social

distribution of health, illness and the use of services if it employs socio-political insights in a move towards:

> "... a political economy of health and health care" (Mohan, 1989, p.176).

Where Mohan (1988a, 1988b, 1988c, 1990, 1991a and 1991b) does address the socio-political issues, however, even his analysis remains at the level of organisations and the broad spatial outcomes of provision rather than exploring the points of view of actual people.

More recently, Kearns (1993) has criticised mainstream medical geography for its continued focus on the bio-medical model of health and its failure to address important wider arguments in human geography:

> "Latterly a quest to synthesize ideas about the spatial structure of society with its constituent social processes has partially returned the concern of human geographers to the uniqueness of places ... Within the field of medical geography, however, a preoccupation with spatial relationships between individuals, places and institutions, rather than with the health-related characteristics of places themselves has continued to hold sway" (ibid, 1993, p.140).

In other words, medical geographers have not addressed the issue of the actual social processes surrounding health-related behaviours as they are mediated in space and time. Such views have sparked considerable debate about the nature and future direction of the sub-discipline (Mayer and Meade, 1994; Dorn and Laws, 1994; Kearns, 1994). At the same time, awareness is growing elsewhere in the social sciences of the generally inadequate exploration of the role of place in the social construction of health (eg. Macintyre, Maciver and Sooman, 1993). If they can only overcome their internal disagreements, therefore, medical geographers should be uniquely placed to advance the most current lines of enquiry in this field. By

way of a contribution to this process, this thesis draws on the concept of the fundamental link between social and spatial processes in order to examine the place of women in family health-related behaviours.

As explained in Section 1.1, the route into this exploration is the examination of women's everyday strategies for managing in time-space contexts as they are influenced by changes in policy towards and the provision of health and social care. As Pearson (1989) notes, it is a further criticism of medical geography that it has failed to consider the everyday practical constraints in this way:

> "Anyone reading the majority of recent geographical studies of health care could be forgiven for thinking that debates about the impact of personal mobility on individuals' perceptions of distance and social space have hardly permeated this field ... The predominant theme of studies of access to, and allocation of, health services has been a concern with the 'optimum location' of facilities and minimisation of (aggregate) service users' 'time-space'. Accessibility has been interpreted simplistically as physical distance and the time and effort taken to overcome it is often assumed to be the same for all people. Where the personal mobility of the service user has been a consideration, it has often been in terms of the relative time constraints of public or private transport rather than the more fundamental question of who can afford the time or money to travel at all" (ibid, 1989, p.11).

With a very few notable exceptions (eg. Coupland, 1982; Whitelegg, 1982), medical geography has consistently failed to consider the differential impact of distance on men and women. These links, for example between gendered social roles and transport deprivation, have been outlined by feminist researchers in the area of time-geography (eg. Tivers 1985 and 1988). Those such as Dyck (1989) have stressed the extent to which women's everyday experiences of spatial mobility and their movements in public space:

"... are constrained by the ideological claim that women's space is the private domestic arena" (Rose, 1993, p.18).

However, even the field of time-geography is now heavily criticised as masculinist, for example by Rose (1993). Specifically, she argues that time-geography is deficient because it fails to absorb the *full* importance of that which actually constitutes the private and domestic rather than the public within the social. In other words, it ignores the role of emotions and feelings of relation or attachment to others in the social construction of time-space. By expressing agency as a pathway, clearly bounded and delimited, time-geography not only regards people as neutral and totally rational individuals, it also disembodies them in other ways:

"... The unbroken border between inside and outside ... is also racist ... in time-geography there are apparently colourless bodies ..." (Rose, 1993, p.33).

By implication, a further criticism would presumably be that those bodies are also ageless. Time-geography, therefore, under-emphasises the great diversity amongst women which has become such an important consideration for feminist geographers as a whole (Bondi, 1990a and 1990b; McDowell and Pringle, 1992; Oliver, 1989; Young, 1990). At the simplest level, Pratt and Hanson (1993) note that the constraints experienced by women with caring responsibilities to dependants other than children have rarely been considered.

Rose (1993) also points out that, like the embodiment of its agency, there is little discussion in the time-geography literature of the nature of space itself:

"... it is taken for granted as the medium of social life ... It [time-geography] emphasises space as infinitude and unboundedness, transparency; it is simply everywhere, and what is stressed above all

> is the liberty possible in this space ... And even though time-geography focuses on constraints, its language is untouched by the experiences of being constrained, by the feelings that come with the knowledge that spaces are not necessarily without constraint" (Rose, 1993, p.34).

Time-geography has ignored, for example, the subjectivity of space as exemplified by the work of Pain (1991) and Valentine (1989 and 1990) on the effects of fear of attack on women's mobility. In addition, as Dyck (1989) argues, women's conceptions of space may actually alter. For instance, by watching their children play outside, women meet and develop networks with other mothers such that previously 'unsafe' spaces may be renegotiated as 'safe' in everyday meaning. In summary, therefore, time-geography as it is traditionally applied ignores the importance of different subjectivities and the differential nature of meanings attached to time-space. Not only are women's experiences of social reality different from those of men, they are also different from each other.

Despite its limitations, however, it would still seem possible to build on the general concept of time-geography or activity analysis in the context of women's management of household health, illness and health-care behaviours. Just as Massey (1993) has described places as "articulated moments" (p.66) in the workings of social relations and understanding, 'pathways' or outcomes in time-space can also be understood as specific articulations of contingent social and spatial relations and circumstances. If, far from considering it universal and exhaustive, we start from the proposition that time-space is negotiated and has attached and changing differential meaning, it would seem possible to examine how it is different for particular groups of women and for the same women in different situations. For

example, do women view the time-space constraints which exist in relation to health, illness and health care behaviours differently depending on which family member's health needs are being negotiated? By acknowledging the existence of diversity amongst women, by taking caring as the starting point and by recognising that it involves both 'labour' and 'love' (cf. Graham, 1983a), it is hoped that the approach to time-geography taken in this thesis will incorporate different subjectivities, emotions and feelings of relation to others. Such an approach aims to take forward a more critical view not only in the area of time-space analysis but also in medical geography. Finally, although the household is the focal point of the study this is not to assume that it should be treated as an aggregate unit. It is simply the point of departure for this thesis that the level of priority given by women to their own health needs cannot be understood away from the context of household management processes, that is, within the complex web of activity demands which women are required to resolve on a daily basis (Jones, 1989).

1.4 Research Tools

As noted in Section 1.2.1, the approach chosen for this thesis was the combination of both extensive and intensive methods and the use of different intensive techniques within the in-depth interview. The specific research tools employed will be described in detail in Chapter Five. They can be summarised here as follows:

i) A focused literature review of the prevailing system of social relations within society as a whole and the family and household in

particular. This was an exploration of contingent circumstances and social relationships as they impact on women in their general everyday lives and, specifically, in the context of health and social care.

ii) The selection of the study areas of Netherley and Woolton, two adjacent electoral wards in south west Liverpool. These areas were chosen to provide the best available spectrum of social groups across the city as well as geographical consistency in terms of health and social care provision.

iii) A postal questionnaire which aimed to locate women in Netherley and Woolton who represented the broad spectrum of social circumstances in Liverpool. It was never the intention statistically to test relationships between social characteristics and health and health care use across the data generated by the 324 respondents. Instead, the aim was to locate households in meaningful causal groups in order appropriately to select a cross-section of participants for the second-stage intensive interviews. Although the questionnaire approach can be criticised on the basis that it imposes 'prior structure' on the research topic (Maynard, 1994), it did mean that the most diverse range possible of processes of household health management would be revealed in the interviews. An entirely 'qualitative snow-balling' approach may only have located women in

social situations with similar contingent circumstances (Graham, 1984). In addition, although the questionnaire was theoretically informed by previous research evidence, the open-ended nature of the interviews allowed for any unintended 'assumptions' to be altered by the women themselves.

iv) Analysis of the postal questionnaire responses by hand and using the computer technique of Correspondence Analysis (Greenacre, 1984; Phillips, 1994) in order to locate women in relational space. They were depicted on the basis of the differential nature of their caring and labour market roles as well as household structure, economic and social resources and place of domicile. This is an approach in line with the realist philosophy to privilege difference rather than similarity and relation rather than association. The process identified groups from which to select interview participants configured not by the intrinsic properties of the women themselves but by contingent circumstances and the characteristics of the person being cared for.

v) In-depth interviews with a sub-group of 37 women selected to cover the range of groups identified by the analysis of postal questionnaire responses. As mentioned earlier, these interviews combined a number of intensive research methods. For example, each woman was asked to keep a diary of everyday activities for up to a week before and this was used as the basis for discussion throughout her

interview. Not only were the questions open-ended but the women were also asked to imagine their reactions to hypothetical health situations in the form of vignettes (Finch, 1987b). The overall aim was to examine the differential effects of inequalities in paid employment participation, unpaid work and available economic and social resources on women's response to their own personal and family health needs. Those inequalities include divisions not just between men and women but also amongst women themselves. The impacts on health needs were explored through the reported response of the interview participants to the short and long-term symptoms of themselves and family members and their use of a range of health care on their own and others' behalf. Since it was not the intention to produce generalisable results, it was possible to concentrate on what might seem a relatively small number of women at interview. Talking to 37 women was quite adequate for the purpose of examining process and the impact of social relations in real contingent circumstances.

1.5 Structure of the Thesis

Chapters Two-Four draw previous research evidence together in order conceptually to examine the contingent social relations and circumstances of women's everyday lives generally and, specifically, in relation to health and social care. Chapter Two provides an over-view of the changing ideological and policy

context for the provision of health and social care in the UK. Its specific focus is upon the mis-match between:

i) the supply-side emphasis on market forces and assumptions about a 'level playing field' of opportunity; and

ii) demand-side inequalities in health, illness and health care experience and behaviour.

These inequalities are then examined in detail in Chapter Three where the focus is the inter-relationships between women's socially prescribed domestic and caring role and their paid employment participation. The chapter highlights how women are increasingly taking on both paid and unpaid work and explores their specific role as household health managers. It provides evidence to support the argument that inequalities exist not just between the genders but *amongst* women themselves in terms of social roles and resource distribution. Inequalities based on class, socio-economic position, race and age all affect women's experiences in the light of wider social trends and the changing structures of health and social care.

Chapter Four builds on this notion of diversity amongst women in order to take the discussion of contingent social relations and circumstances to the level of the family and household. A decision-making framework for health as household activity is developed and used to illustrate how women are differentially equipped to respond to the demands of the recent health and social care reforms. The discussion points to the variety of ways in which health, illness and health care behaviours are underpinned by time-space constraints and outlines how time-space

experiences depend on the interaction of such contingencies as social role demands, health status and the availability of economic and social resources.

The aim of Chapters Two-Four is not to pre-judge household management strategies but to allow for subsequent analysis of real contingent circumstances in a particular place - Liverpool - to be theoretically informed by the wider debates. Chapters Five-Nine, therefore, bring the discussion to the specific localities chosen for the present research. First, an expanded explanation of the research methods outlined above is provided in Chapter Five. In Chapter Six, the important role of locality in contingency is examined. The contingent social relations and circumstances which exist in Netherley and Woolton are described using secondary information sources as well as patterns revealed by the postal questionnaire analysis. The focus is the historically-derived characteristics of gendered social roles in the Merseyside labour market, the socio-economic conditions now experienced by a significant proportion of the population and related health statistics which illustrate the potential size of the caring task locally.

Chapters Seven-Nine outline processes at the scale of household management as they were revealed through the lens of the everyday lives of the women interviewed. The chapters are structured to reflect the decision-making framework outlined in Chapter Four. Chapter Seven seeks to illustrate the nature of caring dependency on women and the time-space constraints and inter-relationships between household divisions of paid and unpaid work. Chapter Eight examines the unequal divisions of economic and social resources within families and households and

illustrates the relationship between resource availability and paid and unpaid work participation. In this way, the context is set for the discussion, in Chapter Nine, of health, illness and health care decisions in the interview households. This final empirical chapter will examine the issues raised by the interview participants in relation to their own health and social roles. It will also describe divisions, specifically, in household health, illness and health care labour and the health-related deployment of economic and social resources. Finally, the chapter seeks to assess the position women take in the order of priorities for household and family health needs.

In Chapter Ten, the thesis returns to the broader theoretical, policy and practice agendas. It opens with a summary of the ways in which the research has attempted to advance theoretical debates in both medical and time-geography. The discussion then moves on to explore the implications of the research for the local design and delivery of health and social care. It suggests lessons for national perspectives which can be taken from the Liverpool experience. The chapter focuses, for example, on women's potential responses to *Health of the Nation* priorities and emerging conflicts between the needs of social care users and their carers 'in the community'. The overall argument is for a more sensitive 'bottom-up' approach to be adopted to change if the health and social care services are to become truly responsive to the needs of actual people.

CHAPTER TWO

THE CONTEXT FOR HEALTH AND SOCIAL CARE

2.1 Introduction

As explained in Chapter One, a major category of contingent circumstances pertinent to the management of health-related needs within households is the nature of policy towards and the provision of health and social care. This chapter will outline the background to recent reforms in those areas (Sections 2.2 and 2.3) and describe the outcomes for potential service users (Section 2.4). It moves on to illustrate the impact of the social relations of class, gender, race and age on health experience (Section 2.5) and health-related behaviours (Section 2.6). These constitute the main inequalities on the demand-side which render the implicit supply-side assumption of a 'level playing field' of opportunity inappropriate.

2.2 The Ideological Context for Health and Social Care

2.2.1 The Changing Political Environment

The NHS was established in 1948 on the basis of a general political consensus that it would mean a healthier and more productive population and so represented an investment in the country. It was also argued that the provision of a free and comprehensive service, which took health care out of the market-place, would ensure its socially just allocation to individuals on the basis of need rather than ability to pay (Klein, 1989). Once established, the NHS:

> "... institutionalised paternalistic expertise not so much because of the power of the medical profession but because of faith in the power of medical science. It is precisely this emphasis on creating an instrument for the deployment of paternalistic expertise, rather than a system of health care responsive to consumer demands (whether articulated through the political or economic market) which makes the NHS unique in the Western World" (Klein, 1984, p.86).

During the first thirty years of the NHS, successive governments concentrated their energies largely on a Keynesian-style management of the economy for growth. Few conflicts arose over the relative roles of state and private welfare and changes in health care policy were mostly in emphasis and organisation only. However, in the light of economic decline and problems of inflation and high unemployment following the 1973 oil crisis, commentators began to raise serious questions concerning the costs of social provision. It was argued that the economy could no longer meet the rising costs which were seen to have stemmed from higher expectations on welfare and the increased power of trade unions in public sector wage bargaining (Gough, 1979; Hadley and Hatch, 1981). Expenditure on the NHS alone had risen from 4.1 percent of GNP in 1951 to 6 percent in 1975 and its share of total public expenditure increased from 11.8 percent in 1950 to 14.7 percent in 1988 (Papadakis and Taylor-Gooby, 1987). This represented a fourfold rise in NHS costs in real terms over the forty year period since its inception (Ham, 1992). Such an increase in expenditure can be attributed to a number of factors including the greater use made of health services generally by an ageing population and the higher number of medical interventions now possible due to advances in medical technology.

The welfare state had also begun to receive criticism on grounds other than simply its cost. It was argued that the system had been unsuccessful in its aims of resource redistribution because middle class people had made greater use of services, relative to need, than those primarily intended to benefit (Hadley and Hatch, 1981; Le Grand, 1982). Specifically in relation to health care, the Inverse Care Law established that higher standard services were less available to the poorer social classes who need them most (Hart, 1975). It has consistently been shown that middle class men and women pay more visits to their GP per illness episode and are more likely to attend for specialist consultations than their working-class counterparts (Whitehead, 1987). Doctors spend more time and communicate more effectively with middle class patients and they also remember more of their personal details (Stacey, 1977; Wilkin et al, 1987).

However, whereas writers on the political left argued that improvements were possible through the adjustment of state structures (Hart, 1975), those on the right favoured a reduction of administrative controls and direct political involvement and the expansion of market forces in the public sector (eg. Bacon and Eltis, 1978). Bosanquet (1983) sets out the right-wing view in detail. The basic argument was that, beyond certain minimums like the preservation of law and order, collective choice through state actions always produces less efficient outcomes than those determined by private choice in the market place. In terms of health care, this would mean greater 'consumer sovereignty' as a means to improve efficiency with those unable to pay supported by a voucher system or general subsidies (Green, 1987). Minford (1984) even advocated the view that health care should be regarded

as an "ordinary service industry" (p.viii) where doctors' partnerships, hospitals, ambulance services and 'nursing firms' compete in a market completely independent of government intervention.

As Conservative leader in the late 1970s, Margaret Thatcher represented a particularly influential school of thought in her party which largely followed the right-wing arguments outlined above (Gamble, 1988; Johnson, 1990). Table 2.1 summarises the claims made by this group of New Right politicians concerning the welfare state. It is these ideas which have been significant in framing the government's approach to the NHS since the early 1980s. At the same time, Pierson (1991) claims, a "sea change" (p.154) took place in public opinion away from the support of collective solutions to problems of social need towards a preference for provision to satisfy individual welfare. He argues that it was this change which opened the way for politicians sympathetic to the ideas of the New Right to effect cuts in welfare entitlement and a 'restructuring' of social spending and provision. However, he also counters this argument with the view that, although public opinion is critical of some aspects of the system, there is little evidence of a large-scale backlash against the welfare state. In particular, the principle of a universal, needs-based health service has received consistent public support in opinion polls. It would, therefore, seem that the altered approach to health and social care provision:

> "... rather than being an inevitable response to changed circumstances, the end product of a progressive road to reform or the result of ideological consensus about the mixed economy of welfare ... is based on the ascendancy of a particular set of values and beliefs in the long-term structural conflict between the social classes in Britain" (Walker, 1984, p.27).

Table 2.1 New Right Views of the Welfare State

1	**The welfare state is uneconomic.** It displaces the necessary disciplines and incentives of the market-place, undermining the incentive (of capital) to invest and the incentive (of labour) to work.
2	**The welfare state is unproductive.** It encourages the rapid growth of the (unproductive) public bureaucracy and forces capital and human resources out of the (productive) private sector of the economy. Monopoly of state provision enables workers within the public sector to command inflationary wage increases.
3	**The welfare state is inefficient.** Its monopoly of welfare provision and its creation and sponsorship of special/sectional interests lead to the inefficient delivery of services and a system which, denuded of the discipline of the market, is geared to the interests of (organised) producers rather than (disaggregated) consumers. Generally, as governments extend the areas of social life in which they intervene, so policy failures mount.
4	**The welfare state is ineffective.** Despite the huge resources dedicated to it, welfare state measures fail to eliminate poverty and deprivation. Indeed, they worsen the position of the poorest by displacing traditional community-based and family-based forms of support and entrap the deprived in a 'cycle of dependence'.
5	**The welfare state is despotic.** It constitutes a growth in, at best, the enervating hand of bureaucracy and, at worst, social control of individual citizens and, in some cases, whole communities, by an overweening state, In many such cases the victims of state control and manipulation are those same deprived citizens that it is claimed the welfare state exists to assist.
6	**The welfare state is a denial of freedom.** Its compulsory provision of services denies the individual freedom of choice within the welfare sector, while its heavy and progressive tax regime can be represented as 'confiscatory'.

Summary: The welfare state is an ill-conceived and unprincipled intrusion upon the welfare- and liberty-maximising imperatives of a liberal market society. It is inconsistent with the preservation of freedom, justice and real long-term welfare.

Source: Pierson, 1991, p.48.

Johnson (1990) distinguishes three themes which summarise the aims of government social policy during the 1980s. First, the extension of central control over powers and expenditure at the local level. The remit of local authorities, for example, was reduced by measures such as the compulsory sale of council houses

and the opt-out scheme for schools. The scope for health authorities to operate was diminished by the introduction of general management and the market. Second, the move towards privatisation in all aspects of the economy and welfare provision. This focus underpins the following initial discussion of social policy (Section 2.2.2). Third, the promotion of inequality which is discussed in relation to health and social care in the next chapter.

2.2.2 The General Nature of Social Policy in the 1980s and 1990s

The argument that increased government spending was a major cause of industrial decline was originally put forward by Bacon and Eltis (1978). As Keegan (1984) explains, this view was actively incorporated into Conservative philosophy and monetarist policy:

> "The November 1979 White Paper 'The Government's Expenditure Plans 1980-81' ... linked the public sector spending objectives with monetarism. 'Public expenditure is at the heart of Britain's present economic difficulties', it stated. ... Another strand ... was the need to reduce the size of the public sector in order to 'create room' for the expansion of the private sector. This argument was sometimes put in terms of the need to prevent the public sector from 'crowding out' the private sector" (ibid, 1984, p.138).

In addition, commentators on the political right (eg. Hadley and Hatch, 1981; Minford, 1984) argued that large organisations such as the NHS were expensive and inefficient because of 'rigidities' which stemmed from their heavily professionalised and unionised nature. As Johnson (1990) explains, it was a widely held view that decision-making at the top of the service hierarchy was unresponsive to the point of delivery. The lack of individual accountability and competition was also criticised because it was seen to remove incentives to prevent continuous cost increases. Finally, groups of employees at all levels were believed to pursue their own

sectional interests often at the expense of overall organisational goals (Gamble, 1988).

State structures were, therefore, deemed to be over bureaucratic inhibitors of economic efficiency. Hence, public expenditure has been subject to progressively tighter controls and the emphasis has been on privatisation in order to 'free up' the market place and so mobilise capital and intensify innovation and competition. In the latter context, Le Grand and Robinson (1984) argue that the state can involve itself in an area of social and economic activity in any of three ways: provision, subsidy or regulation. The process of expansion of private provision can, therefore, be understood as the reduction of government activity in any of these areas.

In particular, business principles and discipline have been applied to public services together with new technologies. The requirement for contracting-out of support services by local authorities has been expanded and service provider organisations such as hospitals have been able to opt-out of local public control becoming independent organisations within the NHS. Health authorities have also been encouraged to 'market test' their services (Ascher, 1987). Individuals have been encouraged to opt-out of public pension provision into private schemes and private medical insurance has been advocated for those who can afford it (Harrison, Hunter and Pollitt, 1990). In some instances, state services have been directly reduced. The policy of Care in the Community, for example, has relied on the greater involvement of families in caring for sick and elderly dependents. Several nationalised industries have been privatised in order to reduce the drain of their

losses and subsidies on the public purse and to realise their considerable assets to offset against public spending.

The government has aimed to increase competition in the market-place by reducing legislative regulation of the quality, quantity and price of commodities (Dunn and Smith, 1990). One of the latest pieces of legislation to this end was the 1994 Deregulation Bill. Exchange controls and minimum wage legislation have also been removed and the power of the trade unions curbed in order to encourage the private sector. Labour market de-regulation has meant the truncation of workers rights, for instance, to sickness benefits and against unfair dismissal. Therefore, although the 1986 Sex Discrimination Act and the 1989 Employment Act afforded women the right to work nights and shifts, to stay in employment until the same age as men and apply for whatever job they wished, such measures have not necessarily produced gains for workers when set against increases in the bargaining power which employers now exercise over employees and wage levels.

Any increases in regulation and central control have been aimed, primarily, at cost reduction. For instance, April 1985 saw the introduction of a limited drug list which banned from NHS prescription nearly 2,000 drugs for which there were cheaper alternatives. Additional savings have been made to public expenditure on the health and social services by asking recipients to bear a greater proportion of costs, for example, for dental consultations, prescription charges, meals-on-wheels and home care services. Birch (1986) calls this "backdoor privatisation". Social Security claimants have been particularly subject to greater controls. In order to

receive benefit, unemployed people are now required to state that they will take any job, however unsuitable, and find childcare immediately. Whilst these subsidies which differentially benefit the poor have been removed, positive measures such as tax relief on private pensions have been introduced which profit the better off (Robinson, 1986).

Overall, the thrust of recent policy towards the social provision of health and welfare can be summed up as follows:

> "Individual decisions in the economic market place, rather than collective decisions in the political market place, should shape the allocation of resources" (Klein, 1984, p.83).

With regard to the general public, the government does not see its role as to do things for people but rather to create an environment in which people can help themselves (Goodin, 1985; McGlone, 1990). Privatisation is held to be conducive to the exercise of individual liberty which is to be prized. The aim has been to break down the 'dependency society' and to concentrate welfare services on those in 'real' and 'deserving' need. In the words of one former Secretary of State for Social Services, Patrick Jenkin:

> "... our statutory services should be a safety-net, not a blanket that smothers initiative and self help" (quoted by Walker, 1984, p.29).

Social security policy has, accordingly, emphasised incentives to work and welfare via gainful employment. Supply-side structures in the NHS are also increasingly based on the assumption that individuals are all capable of helping themselves. Sections 2.3 and 2.4 will now summarise recent changes in order to illustrate this impact of New Right ideologies on the policy and provision of health and social care.

2.3 Health Care Services in the 'Enterprise Culture'

In 1979 the in-coming Conservative government was cautious concerning changes in the NHS. It was aware of the strong sense of public commitment to the principles underlying a universal health service. During the 1983 election campaign Mrs Thatcher was emphatic in her rhetoric that "The NHS is safe with us" (quoted in Russell, 1983, p.184) and it could indeed be argued that national economic decline was enough on its own to dictate the expenditure controls in this part of the public sector. However, the policy of efficiency savings in the NHS continued throughout the 'boom years' as well and it seems clear that the Conservatives brought with them a strong "ideological bias" (Klein, 1984, p.89) which has made its mark on health policy and practice through the 1980s and into the 1990s. The chief emphasis in the NHS arena has been switched away from concerns about equity of provision towards questions of quantity and use of resources (Walker, 1984). Health care policy has been dominated by such issues as overall funding levels, alternative methods of financing the NHS, responsiveness to users and productivity. The term 'efficiency' has come to be equated with 'savings' and cost cutting as opposed to sound planning by management; although more recently the question of effectiveness has become more prominent.

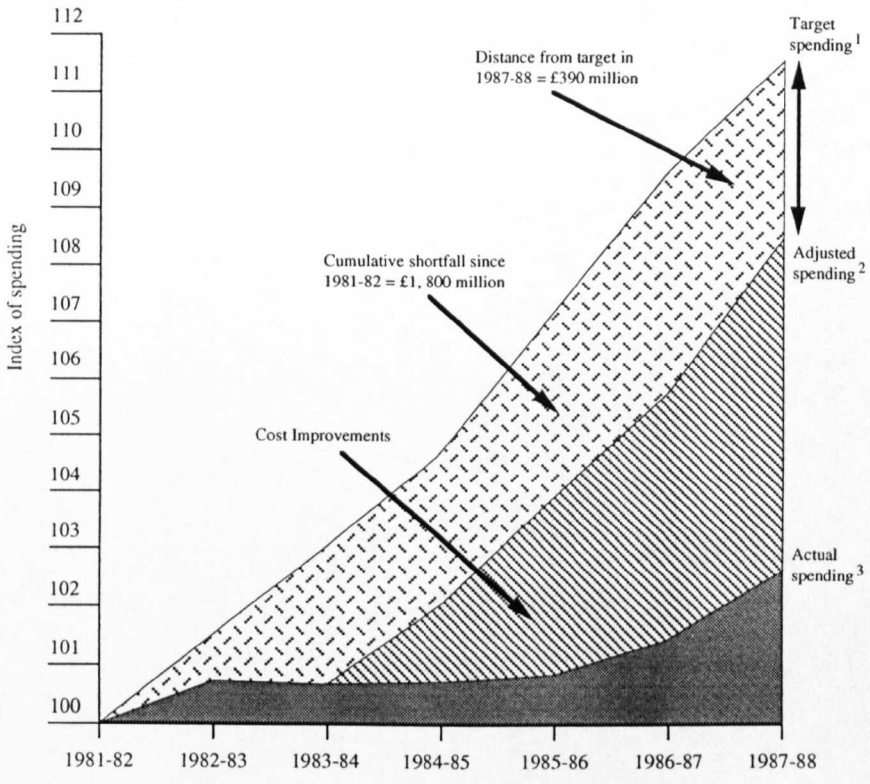
Although the NHS has received more generous funding than the other social services and non cash-limited Family Practitioner Services actually benefitted from increased expenditure allocations in the early 1980s, the Hospital and Community Health Services (HCHS), which accounted for nearly 70 percent of total NHS expenditure, saw a widening shortfall between the level of their government funding

and the resources they actually needed. Pay increases and price inflation at a higher rate than general inflation, meant that HCHS purchasing power did not keep pace with increasing demand. From 1984/85, efficiency savings from Cost Improvement Programmes were relied on more and more as sources of funds for service developments. These were measures aimed at raising productivity by maintaining or improving service output for the same or lower cash and personnel inputs. It was also noticeable that the share of gross expenditure on the HCHS capital programme financed from the sale of land and buildings rose from 2.9 percent in 1980/81 to 14.7 percent in 1985/86 as the NHS estate was rationalised in order to save costs (Robinson and Judge, 1987).

The policy of expenditure constraint came to a head in the highly publicised funding crisis in 1987. Quoting from a survey undertaken that year by the National Association of Health Authorities, Ham, Robinson and Benzeval (1990) describe how, in order to keep spending within its set limits, several health authorities were forced to take urgent action. This included the cancellation of non-urgent hospital admissions, temporary ward closure and the freezing of staff appointments. As Figure 2.1 illustrates:

> "It would appear that the funding crisis of autumn 1987 was the result of cumulative underfunding. Moreover it was becoming increasingly difficult to offset shortfalls in core funding through internally generated savings ... health authorities had already realised significant efficiency savings in the 1980s through cost improvement programmes ... By 1987, however, the clear view expressed by health authorities and key professional groups was that the scope for further savings was narrowing considerably" (ibid, p.13 and p.14).

Figure 2 .1 Hospital and Community Health Services: Trends in Spending, Targets and Shortfalls



Source: Ham et al 1990, p.13.

Notes

1. Increase over base spending necessary for demography, technology and service improvements: 1.3 to 2.3 per cent per year.
2. Actual spending plus cash releasing cost improvements at 1987-88 purchasing power prices.
3. Actual spending at 1987-88 purchasing power prices.

A parallel trend has been the pursuit of consumer choice, market competition and greater efficiency through the expansion of private sector health care provision. Private health insurance schemes have been particularly encouraged. From 1982 those earning less than £8,500 per annum no longer had to pay tax on the value of premiums covered by their employer and companies were allowed to offset health insurance premiums against their liability for corporation tax. The number of

individual subscribers to private health insurance declined during the 1980s but this was more than matched by the growth in cover paid for by companies and professional organisations on behalf of employees and their families. As West (1984) points out, group schemes have increasingly become a standard fringe benefit in higher status jobs. In 1988, 5.7 million people were covered by private health insurance; double the number in 1979 (Johnson, 1990).

The government has also overseen an increase in provision by private hospitals as well as private residential and nursing homes for those, such as the elderly, needing care. From a sample of 183 of the 193 independent hospitals with operating facilities open in 1986, Nicholl et al (1989) found a 77 percent increase since 1981 in the number of residents in England and Wales having elective surgery as private in-patients (287,000). An additional 72,000 day-patients were treated in these private hospitals during the same period. From the 1985 NHS In-Patient Enquiry data, the same authors established that a further 21,000 private day cases and 36,000 elective private in-patient treatments had been dealt with in NHS pay beds. However, the latter figure actually constituted a 38 percent decrease since 1981. This can be explained partly by the government's restructuring of the contractual conditions under which NHS consultants can undertake outside employment. The financial penalties were reduced and this has meant that consultants have been increasingly willing to take on private work in non-NHS hospitals. Another significant trend has been the entry of foreign for-profit providers into the UK market for hospital care. One such provider, American Medical International Health Care, claims that uninsured individuals are increasingly

willing to pay privately for one-off treatments. It anticipates a future expansion in this area of the market (Johnson, 1990).

Overall, a significant reversal has taken place in the supply of private hospital beds. Compared with a figure of 72 percent in 1979, in 1987 just 49 percent of private beds were provided in hospitals run by non-profit making foundations such as Nuffield. Quoting from a survey by the Association of Independent Hospitals, Johnson (1990) states that 98 percent of all new hospital beds in the independent sector between 1983 and 1988 were in for-profit hospitals. By 1989 it was estimated that private and voluntary hospitals and nursing homes supplied 15 percent of all UK hospital based treatment and care by value (Ham, 1992a).

It was against this backdrop of spending controls in the public sector and an increase in private sector provision that Mrs Thatcher initiated a large-scale Ministerial Review of the NHS in 1987. As in the early 1980s, there was support for the view that taxation should remain the principal source of funding for the service. Changes in organisation and service delivery were, therefore, emphasised as the means by which those resources could be used more efficiently. Section 2.4 builds on Ham's (1992) account in order to outline important changes in the structures of supply in the NHS and social care.

2.4 Restructuring the NHS and Social Care

2.4.1 The Introduction of Health Purchasing

One approach to improving resource efficiency has been to encourage Health Authorities to raise funds by various income generating schemes such as leasing space to retail outlets (Ham and Robinson, 1988; King's Fund Institute, 1989). However, the main proposal, originally put forward and developed by Enthoven (1985 and 1988), was for hospitals to compete for resources in an internal market model. To this end, the White Paper *Working for Patients* (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989) aimed to create supply-side competition between hospitals and other service providers by splitting the responsibility for purchasing and providing health care. It set out a funding system in which a District Health Authority (DHA) would receive resources on the basis of the population it serves weighted by factors such as age and sex. Rather than receiving a financial allocation for the provision of care in their own hospitals, health authorities now receive funds to purchase services, within or outside their own districts, on behalf of their resident population. The plan has been for funding not to be adjusted for patient flows across DHA boundaries. Health authorities buy treatment for their residents on the basis of contracts negotiated with providers wherever they may be located. These providers include hospitals and other services which have been able to opt out of health authority control to become self-governing NHS Trusts.

Large GP practices have also been invited to become purchasers of a defined range of hospital services on behalf of their patients. These GP fund-holders

receive a budget from the Regional Health Authority (RHA) for drug prescription and an allocation to spend on diagnostic tests, out-patient treatment and in-patient and day care where a degree of choice can be exercised over the place and timing of such services. The cost of these services is deducted from the budget of the local DHA. The White Paper argued that:

> "Under these arrangements, money would follow patients, thereby rewarding hospitals and GPs able to provide services in demand by patients ... By introducing market principles, the government hoped not only to make services more responsive to patients, but to stimulate greater efficiency in the use of resources. Ministers argued that competition would be carefully managed or regulated to ensure that appropriate services continued to be available in each locality" (Ham, 1992a, p.50).

The role of GP fundholders has since been further expanded with the announcement at the 1994 Conservative Party Conference of a decisive shift in favour of a primary care-led NHS (Department of Health, 1994).

In conjunction with these changes the government has built on the prior introduction of general management to the NHS in an attempt to strengthen the running of the service. The composition of health authorities has been revised along business lines with managers sitting as authority members for the first time. Family Health Services Authorities (FHSA) replaced Family Practitioner Committees and they also appointed general managers. From 1990 onwards DHAs were required to produce purchasing plans alongside the business plans of directly managed units and NHS Trusts. FHSAs also prepare plans concerning their cash limited expenditures and RHAs now lay down consolidated plans concerning their own purchasing and other activities. All the different authorities have been requested to draw up corporate contracts with the authority immediately above them in the

management hierarchy. These contracts set out key tasks and objectives for the year ahead and are assessed annually.

Considerable emphasis has been placed on the involvement of doctors and nurses in hospital management through the extension of the previous resource management initiative. Hospitals are increasingly being organised into clinical directorates led by a doctor and supported by a nurse manager and often also a business manager. Each directorate has a budget to run its own service negotiated with the hospital managers. Doctors in both hospitals and general practice are being encouraged to make savings and are subject to financial audit. Routine medical audits also make them more accountable for their actions in medical practice. By these means the government has begun to strike at established decision structures for resource allocation:

> "In the past decisions about who should (and should not) get what medical treatment have been perceived, and accepted, as matters of clinical judgment constrained but not shaped by national budgetary policies. In future as health authorities move towards buying packages of health care through contracts, so they will increasingly have to make explicit decisions about what they want (and do not want) to buy on behalf of their populations. Political and managerial resource rationing priorities will therefore be visible instead of being largely hidden under the cloak of professional practices" (Klein, 1991, p.1).

The introduction of competition has also contributed to the 'hollowing out' of status levels amongst employees in the NHS (Ham, 1992). That is to say, a large expansion in the numbers of high status managers and, most importantly, low status, secondary workers such as care assistants, has taken place at the expense of the middle ranked professionals. This, together with the decline in union power, has

produced 'flexibility' in the health service labour market but it may yet prove to be at the expense of quality care. The practice of contracting out support services, such as catering, cleaning and laundry, to private firms by competitive tendering was already well established but has escalated under the 'enterprise culture' (Ascher, 1987). Behind the policy of contracting out lay the assumption that the competitive sector of the economy could do the job more efficiently than the NHS itself. In some cases this may have been true, but it is efficiency at the expense of an exploited secondary labour market because private firms often bid for work on the basis of saving costs through lower wages. In the view of Johnson (1990) contracting out constitutes a direct threat to public sector unionised jobs and as such was an explicit ideological assault on the unions by the Conservative government. This is most apparent in cases where the government has opted for the private sector despite clear evidence that public provision was cheaper. These are decisions in which:

> "ideology may override the results of investment appraisal" (Maynard and Williams, 1984, p.109).

In the main, *Working for Patients* was concerned with proposals for hospital services. However, the government has also instigated parallel, radical reforms in the provision of primary and community care. Primary health care includes the services of family doctors, dentists, community pharmacists, opticians and community nurses. Changes to the delivery systems of these services followed the Discussion Document *Primary Health Care: An Agenda for Discussion* (1986) and the White Paper *Promoting Better Health* (Secretaries of State for Social Services,

Wales, Northern Ireland and Scotland, 1987). As the authors stated in their foreword, a major theme of the White Paper was the need to:

> "shift the emphasis in primary care from the treatment of illness to the promotion of health and the prevention of disease" (no page number).

If successful, this is the cheaper option as compared to curative care.

The new GP contract, which was published at the same time as *Promoting Better Health*, came into operation in April 1990 and included provision for health checks for new patients, three-yearly checks for those not otherwise seen by a GP and annual checks for patients aged 75 and over. It included incentive payments to meet targets set for vaccination, immunisation and cervical cancer screening and also encouraged GPs to provide minor surgery and to develop health promotion clinics and child health surveillance. Breast screening became an additional priority in primary care towards the end of the 1980s and a more recent move in health promotion is the GP Banding scheme. Under this programme, doctors are paid actively to encourage healthy lifestyles amongst their patients specifically by appraising them whatever their reason for attendance at the surgery. Doctors are paid to carry out tests, to ask questions and to give out leaflets and advice to the patient concerned.

As far as delivery systems are concerned, there has been an increasing emphasis on the development of primary health care teams. Membership does vary but usually a team includes GPs, health visitors, nurses and social workers. Since the 1960s, the number of GPs who practice in health centres has grown

considerably. These centres provide a range of services from ante-natal and post-natal care to advice on illness prevention all under one roof. As Butland (1993) argues, however, a truly consumer-oriented approach in primary care is hindered by a continued emphasis on contracts with GPs rather than with the whole practice or primary health care team.

2.4.2 Community Care

The government's strategy for community care was formed in response to the Griffiths Report (Griffiths, 1988) and outlined in the White Paper *Caring for People* (Secretaries of State for Health, Social Security, Wales and Scotland, 1989). Building on policy initiated in 1976, the government has continued the shift in spending away from long-stay hospital care. The Audit Commission (1986) had illustrated how care in private sector residential homes, often supported by Supplementary Benefit payments, seemed to be replacing residential hospital provision. In the view of the report this was:

> "missing out more flexible and cost effective forms of community care altogether" (ibid, 1986, p.2).

The term 'community care' has been summarised as:

> "... providing services and support to allow vulnerable people to live as independently as possible in their own homes or in a homely setting in the community" (KPMG Peat Marwick, 1993, p.7).

Policy has, therefore, increased the role of general practitioners, district nurses, home helps and other professionals in the support of care of dependent people by family and friends. The aim has also been to achieve better value for money by increasing the role of informal carers backed up by voluntary and private sector providers where appropriate (Evans, 1990). Therefore, in contrast to internal

market moves in the NHS, a primary objective of the social care reforms has been to develop the market *external* to statutory provision (NHS Executive and SSI, 1994; Wistow et al, 1994). It remains to be seen whether another stated goal of the new legislation, that service users should be able to exercise a greater level of choice and control in their lives, is achieved.

The proposals put forward in *Working for Patients* and *Caring for People* were confirmed in the NHS and Community Care Bill, 1990. Changes in community care were intended to run in parallel with the NHS reforms from April 1990. They were, however, phased in more gradually over a three year period because of problems associated with the introduction of the community charge as the means of local government finance. Since 1992 local authorities have been required to produce community care plans in collaboration with NHS authorities and other agencies such as those in the voluntary sector. In April 1993 they also took primary responsibility for the planning and purchase of community care in local areas whilst continuing to provide some services directly. The key role of the local authority is to assess individual people's need for residential care or for help at home.

One of the current themes, in the debate about the implementation of community care policies, is the need for joint working between health authorities and health and social care authorities (Stockford, 1992). What, for example, is the role of the NHS in long-term care? How do hospital discharges 'tie up' with

support services in the community? A recent survey found several continuing difficulties:

> "... [Local] Authorities said that good collaboration at a strategic level was often found, less often at the care management level ... Responses to the NHS survey suggested that, in many areas, efficient systems for monitoring hospital discharges and admissions had still to be developed: about 20% of health authorities had no arrangements in place. Many respondents expressed concern about this lack of reliable information, particularly in view of the possible impact of earlier discharge on community health services. There was little evidence of the balance of health expenditure changing to reflect new patterns of care" (NHS Executive and SSI, 1994, p.3).

Table 2.2 summarises the present structure of health and social care provision.

2.4.3 The National Strategy for Health

Overall, in terms of health, the national strategy outlined in *The Health of the Nation* (Secretary of State for Health, 1992) has continued to emphasise efficient use of resources by means of preventative health care uptake, the promotion of individual healthy lifestyles and targets for population coverage in screening programmes. The document was significantly influenced by the World Health Organisation's 'Health for All by the Year 2000' policy. It established targets for improving health in a number of 'key areas', including cancers, strokes and heart disease. These conditions were selected on the basis of their large contribution to premature death and avoidable ill health and the fact that effective interventions have been illustrated. Particular emphasis was placed on a healthy diet, exercise and the reduction of smoking levels in the general population. Sections 2.5 and 2.6 will now explore the reasons why some of these policy aims seem mis-guided.

Table 2.2 Structure of Health and Social Care

"THE POLICY-MAKING AND MONITORING COMMUNITY"		
Department of Health & NHS Executive	-	Setting national policy and guidance
Regional Offices of NHS Executive - Former RHAs	-	Increasing role in steering local strategy
"PROFESSIONALS ON THE GROUND"		
LOCAL PURCHASERS/COMMISSIONERS		
i) Local Health Authorities - Former DHAs & FHSAs	-	Purchase health care services on the basis of overall *population* needs in order to meet national targets
ii) Local Authorities	-	Purchase *individual* packages of social care whilst maintaining a general overview of services
LOCAL PROVIDERS DELIVERING SERVICES		
i) Health care professionals	-	Managers and fieldwork staff eg. hospital employees and primary health care teams
ii) Social care professionals	-	Managers and fieldwork staff eg. care managers, home care assistants and residential care workers

Source: Author

2.5 Supply and Demand in Health and Social Care

2.5.1 The Mis-guided Notion of the 'Level Playing Field'

It is evident from the previous section that recent years have seen much emphasis on cost effectiveness in the supply-side restructuring of health and social

care. In the move away from paternalism and medical power, for example, there is less and less mention of real people in decisions concerning the provision of health services. The value decisions of NHS doctors and managers dealing with the allocation of resources are increasingly constrained by the financial considerations imposed (Ham, 1993; Kendall and Moon, 1990; Milne, 1993; Pearson, 1992). Despite the rhetoric, policy which advocates an increased role for non-statutory provision of social care would also seem to be as much about cost reduction as about greater individual choice and responsiveness of services to local needs (Audit Commission, 1986).

In general, the discourse of health and social care has become one where the 'patient' is increasingly seen as the 'consumer' (Klein, 1990; May, 1993). *Promoting Better Health* aimed to offer people a wider choice and more information about primary care and, under the new contract, GPs were requested to produce an annual report and information leaflets for their patients. The procedure through which people change their doctors has also been simplified in order to allow the public a greater degree of choice in this respect. This political rhetoric, which is embodied in *The Patient's Charter* (Department of Health, 1991), has focused on the desirability of people helping themselves rather than looking to government. The individual is increasingly held responsible for his or her own health. *Health of the Nation*, in particular, emphasises this role of individual action in the active maintenance of health. With this policy stance the provision of health care is significantly underlaid by the view that potential service users are autonomous and equal individuals who operate on a 'level playing field' of opportunity. It is

assumed that everyone is equally prepared for and able to make choices to use health services.

Consistent with this and exemplified by *The Health of the Nation*, is the policy view of blaming the individual for what is seen as a lack of response to the opportunities available. Policy attention has particularly been focused on people who 'fail' to attend, for example for screening appointments, with concern especially about poor uptake levels amongst the lower socio-economic groups. Smokers are being increasingly criticised for damaging their own health. Thus, for example, at certain hospitals in Manchester in 1994 smokers were even refused treatment for heart problems on the basis of spending resources more effectively. Policy makers take less and less responsibility for the people who are missed by the health care net. Not everyone is equally able to pay, for example, when prescription and dental treatment charges are raised. Again:

> "One obvious explanation for the regularity with which ill-health has been attributed to ignorance is that such an argument directly serves economic interests. If the problems the working class and the poor experience ... are, to a large extent, of their own making, then ... government need not ... acknowledge any great degree of responsibility for the situation and a policy of minimal intervention in health care is thereby legitimised ... Given the habitual concern of the Treasury to minimize the cost of health provision, any explanation of government rhetoric in terms of economic interest, narrowly conceived, is undoubtedly valid ... This narrow economic interest explanation, moreover, resonates with comments made by Marxist analysts, such as Vincent Navarro (1976; 1978) ... There is a tendency, Navarro argues, for hegemonic class agencies to attempt systematically to obscure the structural and environmental causes of illness by emphasizing individualistic factors, especially moral failings, as the causes of ill-health, thus deflecting attention and blame from the material circumstances of labour" (Smith and Nicholson, 1993, p.236).

Contrary to the view from the 'level playing field', however, a number of key structural factors have been shown to strongly influence health, illness and health care behaviours. These are gender, ethnicity, life-course stage and social class or socio-economic status.

2.5.2 Inequalities on the Demand-side

First, in terms of gender inequalities, there are a number of clear differences which emerge when health patterns among women and men are straightforwardly compared. At first sight, women seem to be at an advantage because they have consistently lower death rates at each stage in the life-course (Macintyre, 1993). They are, however, much more likely to suffer ill health, particularly mental ill health (Turner and Avison, 1989), and to make greater use of health services along the way (Virchow, 1988; Kandrick, Grant and Segall, 1991). Popay, Bartley and Owen (1991) summarise the competing explanations for reported differences. There are those, for example, who ascribe to the biological approach which argues that much of the female excess of minor physical and psychological ill health is associated with menstruation and the menopause. Within the social sciences there are two main explanatory models which focus on: i) the nature of and interactions between gendered social roles; and ii) the argument that women's experience of minor physical morbidity is psychosomatic in origin. Gove and Hughes (1981) and Popay and Bartley (1991) argue that there is little evidence to support the latter view. However, in support of the former model they note that:

> "... where groups of women and men carefully matched along social and economic dimensions have been compared, the female excess [of minor physical and psychological ill health] has disappeared, or in some instances a male excess has been reported" (ibid, 1991, p.3).

It is, of course, equally important to consider differences in health and illness amongst women not just between the genders. Inequalities related to social class[1] were, for example, highlighted by the publication of the Black Report in 1980 (Townsend and Davidson, 1982). The report was received with reservation by the government of the time because of its central findings:

> "... that there were large differentials in mortality and morbidity that favoured the higher social classes and that [these] were not being redressed by health or social services" (Smith, Bartley and Blane 1990, p.373).

The report relied on standardised mortality ratios (SMRs) for 1970-72. Analysis of subsequent SMR data shows that differentials between social classes I and V have continued to widen (Benzeval, 1994; Marmot and McDowall, 1986). Recent work, using alternative measures of mortality such as years of potential life lost, indicates an even larger gradient. This latter measure is a better reflection of the predominance of deaths during the early years of working life amongst manual employees to which accidents and violence are particularly important contributors (Blane et al, 1990). Social class has also been shown to influence morbidity and the experience of ill health (Wilkin et al, 1987). The evidence is that people are less healthy because they are socially and materially deprived, rather than it being the case that they have been socially selected into the lower classes because of ill health (Blane, 1985; Blane, Davey Smith and Bartley, 1993; Fox, Goldblatt and Jones, 1990). This relationship between health and social class is as true for children as it is for adults (Seymour, 1992).

[1]Despite the problems associated with using occupation as the basis for classifications of social class or socio-economic group, this is the measure used in the calculation of social class differences in mortality, morbidity and use of health services.

Much of the analysis of social class differences in women's health has relied on classifying married women by the occupation of their husbands. It shows, for example, that female mortality patterns follow generally similar class gradients to those of men (Virchow, 1988). In the light of greater female labour force participation, however, the need for large-scale examination of the direct impact on health of women's own occupation and socio-economic status is increasingly recognised (Macran et al, 1994; Moser and Goldblatt, 1990; Moser, Goldblatt and Page, 1990). Others point to the fact that studies are constrained by this reliance on analysis which uses the male-dominated occupational classification and argue for future work to employ:

> "... indicators which more sensitively measure women's structural position ... [and] the ways in which women's roles intersect and amplify structural inequalities" (Arber, 1990, p.37).

After all, nearly 40 percent of women are not in *paid* employment. The work of Popay and Bartley (1989 and 1993), for instance, begins to develop an integrated framework by conceptualising the impact on health of conditions in both paid and unpaid work. This link between women's social roles, health and use of health services is discussed in more detail in Chapter Four.

As Johnson (1984) notes, there is a growing literature on the health and relationship to health services of ethnic minority groups in Britain. There are, for example, consistent ethnic differences in the causes of adult and childhood mortality and morbidity (Balarajan et al, 1984; Terry, Condie and Settatree, 1980; Hillier, 1991). Few studies have, however, examined the class distribution of health *within* the ethnic minority groups (Virchow, 1988). What studies there are show an

absence of a social class gradient in mortality among immigrants from Africa, the Caribbean, Europe and the Indian subcontinent. This:

> "... may reflect selection and the insulating effect of their previous culture and environment ... Evidence from other countries shows that these influences tend to diminish with time, and there is evidence that this is already occurring within the Asian community in the UK ..." (Virchow, 1988, p.110).

Despite the importance of biology, heredity and culture, it is clear that the role of social and material disadvantage should not be ignored (Fitzpatrick and Scambler, 1984; Hillier, 1991; Johnson, 1984). For example:

> "... use of general practitioners is heavily affected by social class and any sociological author will discuss the relationship between ethnicity (or 'race') and class. Studies ... which reiterate higher usage by ethnic minorities need to take this factor into account, along with income and need. When these are considered, ethnic minority patients are found to be more like white working class patients in their use of the NHS ... What is required is more studies ... which seek to examine patterns of accessibility, treatment and outcome from the client's perspective ... The solution ... lies not in ignoring the significance of ethnicity, but in realising its relationship to other social factors " (Johnson, 1984, p.229).

Others also point out that:

> "... the debate about inequalities, especially that focusing upon class-based analysis, has largely concentrated upon the population of working age ... This is a significant omission, as 17 percent of the British population ... are now over statutory retirement age ... This apparent neglect of the analysis of social class in the experience of ageing, especially, in terms of health status, reflects the naive assumption upon the part of many gerontologists that the major dimensions of stratification are not important in old age ... Because all the elderly are assumed to be experiencing bad health there is no need to look for inequalities" (Victor, 1989, p.75 and p.76).

Victor (1989) found class and gender differences, for instance, in mortality and limiting long-standing illness in old age. There was no observed relationship between social class and the prevalence of dementia or depression. However,

anxiety was class-related. Having noted the problems of how to measure the social class of retired people, Arber and Ginn (1991) observed similar trends. Blane (1991) also emphasises this diversity amongst the elderly population in relation to health. Section 2.6 will now explore the implications of the demand-side inequalities of gender, age, ethnicity and socio-economic status for health-related experience and behaviours.

2.6 The Role of Structural Inequalities in Health-related Behaviours

2.6.1 Definition of Health-related Behaviours

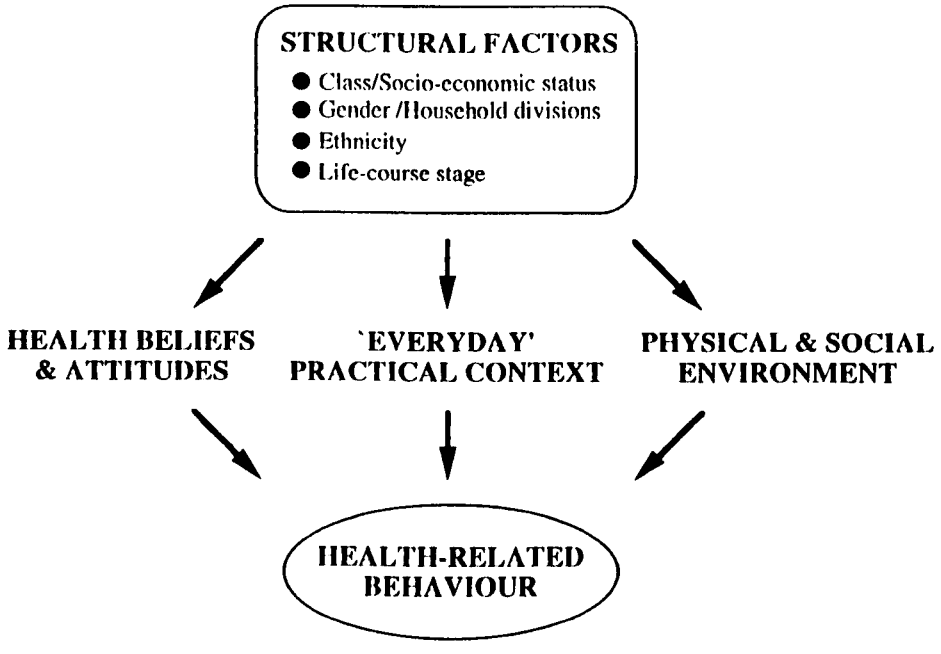
> "The concept of illness or disease refers to limited scientific models for characterizing constellations of symptoms and the conditions underlying them. The concept of *illness behaviour*, in contrast, describes the ways in which people respond to bodily indications and the conditions under which they come to view them as abnormal. Illness behaviour thus involves the manner in which individuals monitor their bodies, define and interpret their symptoms, take remedial action, and utilize sources of help as well as the more formal health care system ..." [original emphasis] (Mechanic, 1986, p.1).

In much of the literature, illness behaviour is distinguished from *health behaviour* which is individual action taken, in the absence of illness, in order to remain healthy and includes factors such as 'healthy' lifestyle behaviours and response to preventative screening programmes. Further, *health care behaviour* has been defined in relation to both of the other categories. Some, for example Kooiker (1992), would, however, argue that such behaviours are not clearly separate and that work should begin to explore the possible mutual influences.

The present section will outline the approaches taken by past researchers looking at the role played in health, illness and health care behaviours by the

structural factors identified earlier. It will also describe the alternative focus adopted for the present research. For the purposes of this part of the discussion, two key themes can be distinguished in the literature[2]: i) the role that structural factors play in behaviour through the construction of health-related beliefs and value systems; and ii) the influence of the physical and social environment. A third theme, that of day-to-day practical constraints can also be identified as an area which requires further exploration (Figure 2.2).

Figure 2.2 Approaches to Research into Health-related Behaviour



Source: Author

2.6.2 Health Beliefs and Attitudes

Much emphasis has been placed in the research literature on the role of lay beliefs in health and health care action; be it lifestyle or response to short or long-

[2]For an overview see Morgan, Calnan and Manning, 1985 and Scambler, 1991.

term symptoms and preventative screening programmes (Calnan and Johnson, 1985; Fitzpatrick, 1884). What 'health' and 'illness' mean to men and women and different groups of the population (Blaxter, 1983 and 1987; Mechanic, 1976; Thorogood, 1990) and level of acceptance of personal responsibility for staying healthy (Pill and Stott, 1982 and 1986) are seen as key factors determining how people respond to their own and their families' health needs. In a further study, Milio (1975) looked at the influence of social class membership on health activities during pregnancy noting that the professionally recommended pattern of activities is influenced by middle class beliefs rather than general, psychologically-based needs.

Friedson (1970) originally noted the important role of the lay referral system, its culture and beliefs, prior to the seeking of all types of professional medical advice. Dingwall (1976) specifically concentrated on ways in which individual illness symptoms are assessed through lay belief networks before any other action is taken by the person concerned. The Health Belief Model derived by Rosenstock (1966) and developed by Becker et al (1977), is based on these sorts of processes and attempts to explain patterns of preventative health service use. The model includes a number of attitude, belief and experience-related factors likely to facilitate acceptance of professionally recommended behaviour. The underlying theory is that people with the 'appropriate' motivations and beliefs will 'comply' with professionally recommended behaviour. Factors associated with 'inappropriate' behaviour could then be targeted in health education programmes.

Much of the literature also places importance on individual physical and psychological tendencies and characteristics in conditioning health and health care responses. As Mechanic (1962) pointed out, individual responses to the same illness condition vary considerably. He attributed this to the level of personal propensity to experience stress and adopt the sick role as a result. Later Mechanic (1968) listed ten factors shown to be associated with medical help seeking. These included visibility, perceived seriousness and frequency of symptoms as well as individual characteristics such as tolerance, anxiety and knowledge about the symptoms. Antonovsky et al (1989), similarly, relate symptom response to personal coping style which they show to be dependent on past experience, motivation to be healthy and anxiety.

In addition, others have noted the significance of the social situation for its construction of illness and the psychological constraints it places on level and type of medical help seeking. Parsons (1951 and 1975), for example, described a deviant 'sick role' in which the individual is only allowed to withdraw from 'normal' social roles and become ill if he or she has the sanction of the other people in the household and social network who are likely to be affected by such a withdrawal. In Parson's view, this puts the symptomatic individual under pressure to seek a professional medical diagnosis and to get better as soon as possible. Zola (1973), similarly, identified five social triggers to seeking help from the doctor and compliance with treatment:

i) an interpersonal crisis such as a death in the family;

ii) symptoms interfering with social/personal relationships;

iii) sanctioning/pressure from other people to consult;

iv) illness interfering with work or physical activity; and

v) attendance if symptoms fail to improve.

From this viewpoint, the individual is regarded as living within a set of social values and expectations which influence response to illness depending on whether legitimation for the 'sick role' is provided (Alonzo, 1980 and 1984; Frankel and Nuttall, 1984; Wolinsky and Wolinsky, 1981). In a further illustration, Nuttbrock (1986) shows how socialisation into the chronic sick role in later life can be seen in terms of conformity to a role cast by others and "improvisation". The latter is defined as portraying sickness to gain social support, legitimated dependency and relief from social strain. Friedson (1970) develops this approach by adding that alternative social groups operate in their own value systems and, consequently, may respond to symptoms in different ways. Alonzo (1985) further describes how the social situation aids understanding of individual recognition of and reaction to illness. Finally, beliefs and attitudes towards 'healthy lifestyle' behaviours, such as not smoking, are also influenced by the social construction of costs and benefits (Waldron, 1991).

2.6.3 The Physical and Social Environment

The effect of the social situation via the impact on health status of environmental factors is a second theme in the research literature (Hannay, 1988). In this context, it seems clear that income is an important determinant of health; if not the major influence as the Black Report (Townsend and Davidson (1982) and Blane (1985) have argued. The impacts of material and social 'deprivation' are felt

through such factors as poor housing, standard of living and lifestyle factors such as smoking, alcohol consumption, diet and physical activity (Virchow, 1988; Townsend, 1987 and 1990; Townsend, Phillimore and Beatie, 1988). In particular, there is strong evidence that the deprivation associated with unemployment is damaging to health (Moser et al, 1990; Virchow, 1988):

> "... After adjusting for the effects of social class and age, the death rates of unemployed men and their wives are at least 20 percent higher than expected ... The two-fold higher death rates from suicide among the unemployed in a given social class, point to the importance of psychosocial factors ... While unemployment undoubtedly damages a person's sense of self-worth, part of the psychosocial impact of unemployment must arise from the material disadvantages it brings" (ibid, p.114).

Amongst elderly men and women, current material circumstances are also associated with self-assessed health and are, therefore of: "critical importance to ... sense of well-being" (Arber and Ginn, 1991, p.127). Finally, material resources clearly influence such factors as the degree of choice a person has over 'opting out' into private medicine (Calnan, Cant and Gabe, 1993; Wiles, 1993).

2.6.4 The 'Everyday' Practical Context

What might be termed the more day-to-day, practical considerations, resulting from an individual's social situation, are also mentioned as barriers to care seeking (Pearson et al, 1993). Mechanic (1968), for example, acknowledges as central such factors as the degree to which symptoms disrupt family, work and other social activities and the extent to which economic concerns and social commitments override illness response. However, he gives relatively little attention to such influences and overlaps them with more psychological factors as shown by the following example of his determinants of help-seeking:

> "... Availability of treatment resources, physical proximity, and psychological and monetary costs for taking action (included are not only physical distance and costs of time, money, and effort, but also such costs as stigma, social distance, and feelings of humiliation)" (ibid, 1968, p. 269).

Indeed, it is a general feature of the research literature that less emphasis has been placed on the role that the social situation and social relations play in health care uptake through more immediate practical considerations such as time-space and resource constraints. These must, however, have a direct impact on the choices and constraints facing people making decisions about health care uptake. As one respondent in a much earlier study said:

> "Sometimes I've felt so bad I could curl up and die, but had to go on because the kids had to be taken care of, and besides, we didn't have the money to spend for the doctor - how could I be sick?" (Koos, 1954, p.30).

Where these issues have been addressed, such as in the work of Grieco and Pearson (1991) and Pearson et al (1993) concerning low-income families on Merseyside, it has been found that inter and intra-household dependencies shape the use of health facilities because they help to alleviate transport and childminding problems. In another Liverpool study, the timing of women's attendance at Well Woman Clinics showed a striking association with employment status (Pearson and Spencer, 1989; Pearson et al, 1990). In her case study of non-attendance at out-patient clinics, Mason (1992) also notes:

> "A host of pragmatic reasons ... given by defaulters, such as working night shifts, or difficulty with transport" (Mason, 1992, p.560).

She concludes that:

> "... non-attenders should not be stereotyped as irresponsible. Suggested measures to alleviate the problem include ... increased negotiation between patients and physicians in order to develop agreed programmes of care and, where possible, a shifting of the onus of responsibility for making and cancelling appointments onto patients" (ibid, 1992, p.554).

Clearly, this is not the 'level playing field' of equal opportunity to access and use health services envisaged by policy makers and outlined in earlier sections.

2.7 Summary

The period since the early 1980s has seen considerable changes in the ideological and policy context for health and social care. A major thrust of policy has been the privatisation of provision and the application of business principles to the public services across the board. For health and social care, this has meant greater emphasis on cost improvement planning and value for money. Efficiency in this respect is to be achieved by the exposure of the NHS and statutory sector providers of social care to the discipline of the market place. This has entailed the creation of an internal market for health purchasing and the requirement on local authorities to develop and manage a mixed economy of social care. It has meant the fostering of supply-side competition and purchaser-provider relationships in both areas. In the context of delivery, these changes have relocated the emphasis of provision away from hospital-based and institutionalised care towards primary care and care in the community. Although some (eg. Le Grand, 1983) have argued that privatisation will not have the negative outcome others have portrayed, there are problems in the structures which have emerged for the market place to function at regional and local level (Ham, 1991; Robinson, 1993). In particular, it would seem that arrangements are being developed by managers using the logic of business with

little consideration of the structural realities for many potential service users (Pearson et al, 1993).

A further fundamental change which has emerged in the philosophical emphasis of health policy would seem similarly mis-guided. With the enhanced focus on health promotion and preventative care embodied in *The Health of the Nation*, the individual has been made increasingly responsible for his or her own health. Those who 'fail' to look after their health needs in this context are regarded as having only themselves to blame. This notion of the 'level playing field' where everyone is equally positioned in terms of health experience and ability to make appropriate choices in the use of health services is an underlying assumption to be challenged from the perspective of this thesis. Individuals do not present themselves to the health care marketplace from equal starting positions. Gender, ethnicity, life-course stage and social class or socio-economic status each have a profound effect on levels of need and ability to access provision. Such factors operate on and through the construction of beliefs and value systems which feed through to influence health, illness and health care behaviours. Finally, real social situations also exert a significant impact through environmental and practical constraints. Levels of income, housing and concrete physical access all bear upon the ability of individuals and families to meet their own health-related needs. The role of the social construction of beliefs and value systems and environmental factors in health, illness and health care behaviours[3] has been well documented. The research

[3]For the purposes of simplification in subsequent chapters, the term 'health-related' behaviour will, unless otherwise stated, be used to cover the range of health, illness and health care behaviours described above.

reported here will, therefore, focus on the influence of structural factors through contingent practical considerations such as resource availability and the time constraints of everyday social role activities. Chapter Three will discuss the research evidence on women's contingent social roles and access to resources both generally and, specifically, in relation to health and social care.

CHAPTER THREE

INEQUALITIES IN SOCIAL ROLES AND RESOURCE DISTRIBUTION

3.1 Introduction

Exponents of New Right philosophies would counter concerns about the effects of class, socio-economic status, race, age and gender differences on health and equitable access to care with the argument that maximum social welfare distribution to overcome such underlying inequalities is only achievable through the liberalisation of markets and not by the adjustment of state interventions. However, the evidence shows that, contrary to the views of their proponents, policies influenced by such thinking have actually increased and complicated the inequalities described (Rentoul, 1987). The wages of lower paid workers have, for instance, been held down by the weakening of trade union powers and a narrowing of the scope of wages councils. Social security policies have begun to move welfare, particularly for the unemployed, towards a US-style workfare where people are required to work, train or actively job search before they can receive benefits. In Johnson's (1990) opinion, unemployment has been used as a tool against inflation in monetarist policies and this has stacked the burden of inequality onto the poorest groups in society.

Further, an analysis of the Budgets since 1985 by the Institute of Fiscal Studies (reported by Elliot and Kelly, 1994) shows that the poor have lost out and the rich have gained as a result of cumulative tax changes (Table 3.1). This is because income tax has been directly reduced at the top of the scale and other

changes, which have switched some of the burden from income to value added tax, have also favoured the rich. The addition of VAT to fuel bills in April 1994, in particular, was bound to have differential effects because the proportion of income spent on fuel by lower income groups is much greater than that spent by higher paid ones (Graham, 1984a).

Table 3.1 Impact of Tax Changes by Weekly Income Group, 1985-95

GROUP BY WEEKLY INCOME	% LOSING	% GAINING	AVGE GAIN/LOSS (£ PER WEEK)	AVGE GAIN/LOSS (% NET INCOME)
1 £0-138	66	7	-3.0	-2.9
2 £139-169	44	13	-1.4	-1.4
3 £170-214	47	23	-1.8	-1.5
4 £215-270	43	40	-1.1	-0.8
5 £271-329	37	50	0.7	0.4
6 £330-390	33	57	1.6	0.7
7 £391-462	29	64	3.1	1.2
8 £463-562	25	69	4.4	1.5
9 £563-719	23	72	6.3	1.8
10 £720 and Above	20	76	31.3	5.8
All Groups	37	47	4.1	1.7

Source: Elliot and Kelly, 1994, p.7.

Overall, in Britain in the 1990s, nearly 12 million people do not have a family income which is adequate to meet their basic needs. This compares to a figure of just 5 million in the early 1980s (Millar and Glendinning, 1992). The period of New Right-style government has, therefore, been one in which the incidence of poverty has greatly increased but state support for the poor has been reduced. In addition, further divisions have become more pronounced which cut across the imbalances in income already described (Graham, 1993; Johnson, 1990). First, divisions in the labour market between the employed and unemployed and

between different segments of the workforce. Second, ethnic minorities are over-represented in the secondary labour market and amongst the unemployed. Third, differences based on gender. Women are predominantly lower paid part-time and secondary sector workers. Hence, the major social divisions of class, race and gender are increasingly associated with different poverty risks.

This chapter will attempt to demonstrate how recent social policies have both exaggerated and built upon the existing social divisions in Britain. It will argue for the existence of powerful ideological forces which, for example, emphasise obligations and responsibilities towards the family at the expense of women's economic freedom. These gender inequalities are outlined in detail in Section 3.2 which illustrates the links between women's economic disadvantage in the paid labour market, in the social welfare system and within the household or family. This is the starting point because, as noted in Chapter One, the thesis stems from an interest in the ways women are managing in the light of increased paid labour market participation and increased household responsibilities for caring.

In addition, the evidence shows that inequities based on class, socio-economic position, race and age also cut across the gender divide (Section 3.3). Therefore, it cannot be assumed that the experience of contingent social relations and circumstances imposed by the social and economic system is uniform amongst women. Finally the argument is developed in an attempt to show how differences in ascribed gender roles appear to be capitalised upon in the fields of health and social care (Section 3.4). This is despite the underlying supply-side proposition that

individuals have equal opportunities to maximise health and access to care. However, it is clear that women who find themselves in one or a combination of the groupings, lower-class, black and older, are the poorest placed to cope in the light of recent changes.

3.2 The Gendered Nature of Social Roles

3.2.1 The Workings of the Economic and Social System

Sayer (1989) provides an overview of basic approaches to explaining the workings of the labour market: the neo-classical and radical political economy approaches. Various authors also review the debates from feminist (Beechey, 1986; Buchele, 1981; Cater and Jones, 1989; Crompton et al, 1990; Dex, 1988; Dutoya and Gauvin, 1987; Kenrick, 1981; Picchio del Maercato 1981; Purcell, 1988) and race perspectives (Aschar, 1989; Bruegel, 1989; Wrench, 1989). The general consensus is that no one theory can fully explain the complex nature of inequalities in the labour market and the economic position of women. Instead, the literature emphasises the complexity and multiplicity of influences on individual situations. The distinct power systems of class, race and patriarchy, which exist within society, are described as are the various types of power relations, for example, amongst waged workers and between employers and employees and men and women. Such social relations are held to be mutually reinforcing to the social division of labour and the social reproduction of labour. In other words, the power systems within society are shown to maintain the social relations of production. It is, for instance, a socially constructed gender division of labour, which assigns women to a primary caring role in the domestic sphere and men to paid employment (Lonsdale, 1992).

Until recent years, the debate concerning the welfare state has privileged the latter's relationship to social class. Critiques have, however, begun to emerge from the social perspectives of the anti-racist and feminist groups. Their arguments are reviewed by Pierson (1991) and constitute alternative viewpoints to the predominantly economic critiques outlined in the previous chapter.

Williams (1989, p.41-86) has developed a classification of feminist approaches which concentrate on the gender-specific consequences of the welfare state and broaden the discussion beyond the 'formal' economy to consider production and reproduction in the domestic sphere. As Pierson (1991) also points out:

> "There is disagreement as to whether the welfare state is primarily to be explained in terms of *patriarchy* (the systemic oppression of women by men) or *capitalism* (the systemic oppression of labour by capital), but generally feminist approaches represent the welfare state as organised in the interests of men and of capital, at the expense of women [original emphasis]" (ibid, 1991, p.70).

The Marxist-Feminist view has been perhaps the most developed feminist account. It represents the welfare state as the combined expression of patriarchal and capitalist oppression, or a set of interventions into the economy which ensure the production and reproduction of labour power in order to maintain capitalism. The state is seen to intervene through its support for the family household based on the male wage and female childrearing and domestic servicing[4]. More recently, radical feminists such as Delphy and Leonard (1992) have reasserted the argument that patriarchy exists independently of capitalism and involves its own system of labour

[4]Feminist concerns to extend Marxist analysis away from its concentration on paid employment gave rise to the domestic labour debate. For a review see Molyneux (1979).

relations. In their view, Marxist-Feminist analyses have subsumed patriarchal relations under those of capitalism.

Consistent evidence does show that, whether women are in full-time, part-time or no paid employment, the division of domestic labour is unequal between the sexes. For example, in the majority of joint households in Henwood's (1987) study, the husband carried out Do-It-Yourself and other tasks defined as 'man's work' and the woman was cast in the housekeeping and caring role. Where the men did take part in domestic labour this was largely regarded as 'helping out'. In relation to childcare, wives tended to carry out the more essential and laborious tasks, such as feeding, washing and dressing, whereas husbands played with children and took them on outings. Brannen and Moss (1988) found this to be the case specifically in dual earner families. Several studies have also found that women predominate as the supporters of elderly dependants (Henwood and Wicks, 1985; Nissel and Bonerjea, 1982; Qureshi, 1990; Qureshi and Walker, 1989; Waerness, 1990) and carers of children and non-elderly adults with mental and physical disabilities (Parker, 1990). Often, men do not increase their participation in domestic and caring tasks even when they are themselves unemployed and have more time available (Morris, 1990). In the view of Qureshi and Walker (1989), this is because male unemployment is seen as a temporary situation and caring would damage a gender identity which is based on paid employment participation.

This provision of services for others in the domestic sphere, can be defined as "care-giving work" (Waerness, 1990) and constitutes a form of labour in the

same way as paid employment outside the home. The domestic division of labour is maintained through state-sanctioned oppression of labour under the wage contract and the oppression of women within the state-supported "dependent-woman family" (Pierson, 1991, p.70). Hence, the profitability of capital is sustained because the costs of the reproduction of labour power are lowered by the fact that female domestic labour is unpaid. This capacity of the welfare state to organise in the interest of capital to the detriment of women relies, it is argued by feminists, on pre-existing forms of female oppression by men which the state can build upon:

> "Both demographic change and the 'restructuring' of the welfare state have been grafted on to a pre-existing situation in which women have been defined as the 'natural' carers and also as the dependants of men. These alleged characteristics of women make them especially attractive as potential providers of unpaid care, in the private domain to which they have been traditionally assigned" (Finch and Groves, 1983, p.5).

Capitalism, in itself too, did not create the patriarchal social structures which underlie the gendered organisation of labour. However, it does exploit and so help to perpetuate the established conditions (Hartmann, 1979). For the purposes of this discussion then, feminist writings bring an awareness that the welfare state is simultaneously "classed" and "gendered" (Shaver, 1989, p.93). It serves the interests both of capital and men, especially those who are white, skilled and working-class.

Social policy has consistently regarded the provision of childcare as 'woman's work' and there is a well-documented lack of statutory services in this area (Moss 1991). Although the nuclear family model of housewife and male breadwinner is no longer most representative, it is a strong stereotype which has

underlain and still does underlie, social organisation (Brannen et al, 1994; Henwood and Wicks, 1985; Land, 1978; Walker, 1983). This stereotype effectively excludes women from full-time working because it assumes that they are responsible for childcare and other non-paid domestic tasks which take up large amounts of time (Elias and Purcell, 1988; Women in Geography Study Group, 1984). Data from the 1992-93 Labour Force Survey, for example, show how nearly half of working age mothers have pre-school children (0-4 years) but only half of these are economically active[5]. Mothers with primary (5-10 years) and secondary (11-15 years) school age children, who need less care than younger ones, exhibit the much higher economic activity rates of 72 and 80 percent respectively (Sly, 1993):

> "The cultural explosion that took place in the 1960s created a powerful feminist challenge to the patriarchal family and to the continued subordination of women throughout society. It brought into question for the first time one of the assumptions of the postwar order - the nature of the family structure ... Faced by this challenge most social democratic parties moved very slowly indeed, but the mere threat that they might act was enough to galvanise a movement in defence of the patriarchal family, focusing upon permissiveness, crime and education" (Gamble, 1988, p.14).

This reassertion of family values, both in rhetoric and policy, by the New Right has led to a reversal of many of those state interventions which did begin to reduce the burden of caring on women (Segal, 1983). For example, as Moss (1991) points out, the policy view that daycare for children is a private issue has become much more explicit under the New Right. The position has been one that statutory requirements on employers should be kept to a minimum and that only where there are 'special needs' should the public sector intervene. Most recently, it has been reported that

[5]For a definition of economic activity see Employment Department, 1990b.

the government has withdrawn its commitment to universal nursery education on the grounds of cost (Judd and Crequer, 1994).

3.2.2 Implications for Women's Participation in Paid Work

On this evidence, it may seem contradictory that such a large increase in female labour force participation has taken place in recent years (Hunt, 1988; McDowell, 1992a; Rimmer, 1988). However, the greatest proportion of this expansion can be attributed to increased economic activity amongst married women who work part-time in order to accommodate domestic commitments and the needs of dependent children while earning income (Beechey and Perkins, 1987; Employment Department, 1990a; Main, 1988a; Martin and Roberts, 1984; Rees and Willox, 1991). These limits are defined by women's own and their family's feelings about what their responsibilities are to the home (Dex, Clark and Taylor, 1995). In turn, employers can take the view that women will exhibit primary loyalty to their family and expect high levels of absenteeism to occur if a dependant is ill and needs care. Since women are perceived as unlikely to be committed to paid work, even those who do not fit the stereotypical role are sometimes not hired to higher status jobs. Their training and promotion prospects can also be limited once they are in work.

In reality, many better paid jobs with greater prospects are full-time and cannot be fitted around domestic responsibilities. For example, the proportion of women who have a full-time job and a child under one, is noticeably greater than the proportion who have a child between two and five years old. This is because

women who take maternity leave often return to their full-time job in order to fulfil the requirements of their leave, but switch to a part-time job as soon as possible (Dex and Puttick, 1988). Amongst home-based workers too, there are gender differences in the number of hours worked (Hakim, 1987a) and in the use of home as the actual workplace as opposed to a base from which to travel (Hakim, 1984). This has implications for the quality of job opportunities and again can be linked to differences in domestic and childcare commitments. Most of the fifty female respondents in Hakim's (1980) study, for instance, expressed a strong commitment to childcare responsibilities as the main reason for taking homework and said that they would prefer to work outside the home in the absence of dependent children. Women caring for pre-school infants are also more likely to take temporary work than those without children or with children over the age of ten (Sly, 1993).

Frequently, women with heavy caring commitments to sick, elderly or disabled dependants are also forced to switch to part-time jobs or to give up work altogether (Corti and Dex, 1995; Corti, Laurie and Dex, 1994; Hirst, 1992; Wright, 1983). This, too, is a consequence of the fact that the male partner is invariably the primary breadwinner (Martin and Roberts, 1984; Morris, 1988). If men have taken on a specifically caring role, they are usually past retirement age and looking after wives rather than other relatives (Ungerson, 1987; Arber and Gilbert, 1989). In these cases, male carers often acknowledge that they have been forced to abandon the gender division of labour in order to keep the marriage tradition alive. It would seem that those men who are carers drift into the role, whereas for women the decision is more likely to be conscious, when they are much younger and have to

juggle many more role responsibilities (Brody, 1981; Parker, 1990). The 1985 General Household Survey, for instance, showed that, although all women under the age of seventy-five are more likely than males to face caring responsibilities towards sick, elderly or disabled dependants, the greatest difference occurs at age forty-five to fifty-nine. Only 16 percent of men in this age-group were carers compared to 24 percent of women (Green, 1988 cited in Glendinning, 1992, p.165). The men were also more likely to play a secondary caring role and women were most likely to be a principal carer. In addition, a clear gender difference existed when care-giving became more intense in terms of hours expended and type of help. Single women, who were divorced, widowed or had never been married, in the 45-64 age-group were even more likely than their married counterparts to have heavy caring responsibilities (29 percent compared to 24 percent). More recent analysis of the 1990-91 General Household Survey shows that, although personal care is shared more equally if the dependant is a spouse or a disabled child, gender differences still exist (Arber and Ginn, 1995).

Each system of asymmetrical gender relations in the labour market and the household reinforces the other (Villeneuve, 1987 cited in Peck, 1988). In particular, the distribution of income within the household impinges upon male and female roles in paid and unpaid work (Garnsey, Rubery and Wilkinson, 1985). As Ungerson (1983) explains:

> "... if there is a need for someone to be looked after at home, it makes sense in material terms and will continue to make sense for the wife to give up her job or reduce her working hours. Thus the ideology of housework and woman's place within it has a material impact on women's paid work which in turn serves to reinforce that very ideology" (ibid, 1983, p.38).

The ideologies of the male breadwinner and the family wage also support the labour market realities which mean that men can command higher wages. Interpreted simply, this means that a vicious circle has developed in which women can only gain low-status, low-paid employment for which job commitment is not a priority in hiring and these factors serve to determine the 'rationale' by which they perceive the opportunity costs of domestic and paid labour (Henwood 1987; Graham, 1983a; Land, 1978; Wicks, 1987).

Hence, the employment of women has been consistently concentrated in particular industries and occupational groups where part-time and other forms of 'non-standard' work are readily available (Beechey, 1986; Crompton and Sanderson, 1990; Employment Department 1990a and 1991; Hakim, 1979; Rees and Willox, 1991). In the 1992-93 Labour Force Survey, for example, 83 percent of women worked in service industries compared to just 56 percent of men (Sly, 1993). Whereas men dominate the professions, managerial, supervisory and, what are generally termed, 'skilled' manual jobs, the largest groups of women are found in 'semi- and unskilled' jobs in both white and blue collar occupations. Women are typically employed as health, education and welfare professionals and associate professionals, clerical workers, shop assistants and personal service workers in areas such as catering, cleaning, hairdressing, waitressing and bar work (Martin and Roberts, 1984). Part-time paid-working women are much more likely than full-timers to be in the latter sorts of low-status manual jobs (Employment Department, 1990a; Elias, 1988). Only 5 percent of part-timers were managers or administrators in the 1992-93 Labour Force Survey as compared to 11 percent of women overall

and 19 percent of men (Sly, 1993). The growth of part-time employment opportunities at the lower-status end of many jobs since 1979 has, therefore, helped to increase the already considerable gender segregation and inequality in the paid workforce (Elias and Purcell, 1988; Garnsey, 1987).

The types of employment associated with women are found in what has been termed the secondary sector of the labour market. This consists of low-status, low-paid, unstable jobs and is peripheral to the core or primary sector of high-status, stable and well-paid occupations. As Peck (1988) explains, the disadvantaged groups which find employment in the secondary sector are those which also commonly possess some alternative economic role outside the wage labour market. They are also those groups which have traditionally not been able to mobilise significant political or social power. The negotiation of skill levels and the family wage by predominantly male trade unions, for example, has helped to maintain gender inequalities:

> "There are, however, important feedback processes in operation here ... Work in the secondary sector very often does require skill to be practised and discretion to be exercised ... while the secondary workforce may also exhibit stability and loyalty to an employer ... However, by the very participation of low status groups in these jobs, their skill content and associated social status becomes undervalued ... It must also be acknowledged that the power differentials which emerge between groups of worker, through collective activity in the primary labour market, is also an important means by which the labour market is segmented and the supply of labour structured" (ibid, 1988, pp.72-73).

3.2.3 Women as 'Flexible' Paid Workers

The discussion has so far shown that the occurrence of 'non-standard' forms of employment is inextricably linked to the supply of labour as influenced by the role of women in the household division of labour. However, it is also possible to view such employment opportunities as a demand side feature of the labour market, or a product of the desire of employers to increase workplace flexibility (Atkinson and Gregory, 1986; Leek, 1985):

> "A feature of the alternative roles possessed by many of those workers confined to the secondary sector is their role as a structural 'safety valve' for the labour market as a whole, facilitating the relatively unproblematic mobilisation or demobilisation of this group of workers in line with short-term labour demand requirements ... Such flexibility ... is not nearly so readily available in the primary, organised sector of the labour market ... Thus, the actions of both employers and organised sectors of the working class act to heap the burden of economic downturn upon those workers consigned to the secondary sector" (Peck, 1988, p.80).

Homeworkers, for example, are used by employers as a buffer against fluctuations in trade and to keep down costs (Hakim, 1980) and part-timers, too, are cheaper and more amenable to fluctuating orders than full-time workers. Over the 1980s, part-timers, the self-employed and those working in temporary jobs have emerged as the three most important categories of 'flexible worker' with homeworkers or outworkers cutting across all these groups (Hakim, 1987a).

The 13 percent expansion of the flexible workforce, over a three year period alone, to constitute one third of the total workforce in 1986 (Hakim 1987b) is set against the steady decline in traditional, full-time jobs which has occurred since the 1950s. This is part of a general restructuring of the British economy in the light of new technology and the changing international division of labour. The post-1979

fall in total employment has been caused entirely by a reduction in full-time jobs with the numbers working part-time actually on the increase. Since the numbers of women working part-time are far higher than men, the economic activity rate of working-age females (16-59) has increased considerably from 63 percent to 71 percent between 1979 and 1993 and that of men (16-64) has fallen from 91 to 86 percent (Sly, 1993). As women also constitute the majority of homeworkers (Hakim, 1987a) and temporary employees (King, 1988), it follows that just one quarter of men were employed in the flexible part of the workforce as compared to half of women in 1986. This means that, at the height of the economic boom in the late 1980s, women contributed two-thirds of the total flexible workforce and only one-third of the traditional workforce (Hakim, 1987a).

Labour market flexibility can be achieved by a variety of means outlined by Hakim (1987b):

i) *Wage flexibility* or the adjustment of labour costs;

ii) *Labour mobility* or the movement of workers between jobs, industries and regions in response to employment availability;

iii) *Functional flexibility* which consists of reduced demarcations between categories of worker and more adaptable job descriptions;

iv) *Changes in the pattern and organisation of work* which has meant an altered balance between the 'traditional' system of full-time, stable, permanent work and other, less rigid forms of employment.

The type of flexibility described already is the last category or that based on the changing nature of work organisation. As Lonsdale (1992) points out, these kinds of flexible work practices are not necessarily as beneficial for the workers as they

are for employers. For example, part-time employment is often shift or night work and homeworking can frequently be to tight deadlines with long slack periods in between times:

> "It is notable that the 1985 White Paper *Employment: The Challenge for the Nation* gave particular emphasis to this [iv) above] type of flexibility. Changing patterns of work were taken to include *inter alia* flexible hours, earlier retirement, job-sharing, part-time working, homeworking and self-employment" (Hakim, 1987b, p.550).

Again, it would seem that recent social policies have emphasised economic expediency at the expense of the people who have to cope with such changes in society. In order to create a cheaper and more 'flexible' workforce in response to long-term structural changes in the economy (Beatson, 1995), it appears that social and economic policies have, particularly, capitalised upon the female caring role and the growth in part-time, temporary and homeworking employment.

It has been claimed that, because women are often employed in periods of economic boom and laid off in recession they constitute a 'reserve army of labour' in the Marxian sense[6]. However, it is evident that, as a group, women do not have the kind of strength that the use of this term implies (Peck, 1988). As secondary sector workers, they have been less able to mobilise against government policies of labour market de-regulation which might adversely affect their position. Since women are predominantly secondary sector workers they have been disproportionately affected by the general worsening of job security and employment conditions which such changes have brought. Lonsdale (1992), for instance, points

[6]Rubery and Tarling (1981) and Humpheries and Rubery (1984) cited by Peck (1988) provide useful reviews of this debate.

to the estimate by the Equal Opportunities Commission that women constitute three quarters of all workers covered by wages councils. Hence, they have been affected more than men by reductions in the influence of such organisations.

Significantly for later arguments in this thesis, there are, however, large differences between segments of the female labour force in their susceptibility to the inequalities imposed by the social and economic structure (Crompton et al, 1990; Pratt and Hanson, 1993; Spencer and Taylor, 1994). Hakim's (1991) article directly addresses these contrasts. Those women, in her study, who had consistently planned a career had thirty percent higher wage levels than those who never planned, but had been forced by necessity, to work. In her view, women who make realistic plans and acquire the necessary skills fare best in the labour market. She concluded that there are at least two types of working women. Those in the first group exhibit work commitment similar to that of men. They have almost continuous, full-time work histories, often in jobs with higher status and earnings than are typical for women. The second group has very low commitment to paid employment which is a secondary activity, usually undertaken to earn a supplementary wage rather than as primary breadwinner. This is low-skilled, low-paid, part-time, casual and temporary work more often than skilled, permanent and full-time. Women do switch between groups over time. They are human actors who can and do make career choices not totally constrained by past gender-role stereotyping and economic activity. There are "careerist", "adaptive" and "homecentred" work orientations to be chosen between. However, some women are better placed to make choices and to adapt that others (Corti, Laurie and Dex,

1995). Dex and Puttick (1988), for example, show that education is the factor that has the strongest influence on a woman's age at first childbirth. It may be that better educated women are more free to chose the career option and, once in their higher paid jobs, have more economic opportunity to consider the childcare options. To summarise:

> "The most 'privileged' group of women are those who work with men in full time higher non-manual jobs. They are more likely to have better pay and conditions and job opportunities than all other women, and can be seen as forming a primary sector of the female workforce. All other groups of women in varying degrees have the pay and employment conditions and labour market position associated with secondary sector workers" (Martin and Roberts, 1984, p.189).

One of the clearest indicators of the gendered structure of inequalities in the labour market is the greater vulnerability of certain groups of women to poverty. As Glendinning and Millar (1991) point out, until the emergence of feminist accounts this had gone relatively unnoticed in official statistics and social policy analysis. In the UK:

> "... four percent of all households are headed by a single parent of which 89 percent are women. At the other end of the life-cycle, 14 percent of all households are single adults over the age of retirement and 80 percent of these are women. Statistics for household income show that single pensioners are the lowest income group, the next lowest being single parents. Women, therefore, make up a higher proportion of low income households" (Pierson, 1991, p.75).

The discussion now turns to an illustration of how little the system of social welfare does to alleviate this situation because it too has been consistently based on assumptions about who should care for the family and the financial dependency of women.

3.3 Gender Inequality and Women's Economic Positions

3.3.1 The Caring Role - Implications for Income

The fact that women's earnings are much less than those of men is less significant in a dual earner family where the woman is not the sole breadwinner than it is to a lone mother. As a group, lone mothers make a particularly glaring example of the economic consequences of inequalities in gender roles (Chandler, 1991; Joseph Rowntree Foundation, 1994a, McDowell, 1992a). Of the one million lone mothers in Britain, two thirds live in poverty and:

> "... it is precisely because lone mothers are women that they have a very high risk of poverty. The situation of lone mothers - their position in the labour market and their treatment in the social security system - reflects particular assumptions about women and their roles. Analyzing the economic position of lone mothers in the context of the economic position of women in general is therefore the only way to understand the causes of their poverty" (Millar, 1992, p.149).

As Rimmer (1988) points out, lone mothers face all the same inequalities as other women in the labour market but also have the added burden of sole domestic and childcare responsibility. They miss out, for example, on the opportunity which some women have to fit their own employment around the times when a partner is at home (Hardey and Glover, 1991). Also, when income support replaced supplementary benefit in April 1988:

> "... work expenses, including childcare, could no longer be offset against part-time earnings before these counted against benefit entitlement. The evidence suggests that this change has hit lone mothers particularly hard. As a result of their childcare costs, they can be worse off as a result of taking part-time work" (Graham, 1993, p.135).

Lone mothers, therefore, find it particularly difficult to earn substantially more than they would receive on benefit unless they are very well qualified or work extremely

long hours which are incompatible with available childcare (Popay et al, 1982). Hence their very high unemployment rate and the fact that they are actually less able to work than married women in two parent families. Many lone mothers do have to rely on the state for income support which provides a very low income indeed. 85 percent of the women in the Bradshaw and Millar (1991 cited in Millar, 1992, p.154) study had been in receipt of income support at some time since becoming a lone parent with 72 percent still in receipt at the time of interview. During the 1980s, the method of uprating income support was altered to follow increases in prices rather than earnings. The outcome has been a widening gap between the incomes of claimants and the national average (Graham, 1993).

The social security system is structured such that means-tested benefits are reduced and removed as earnings increase so the combination of part-time work and claiming benefit is not a sensible option for lone mothers to raise overall income (Garnsey, 1987). Those who do work are, therefore, much more likely than married women to try to combine the pressures of a full-time job with rearing very young children (Joshi, 1984). Lone mothers as a whole are far more often in full-time jobs than their married counterparts (Martin and Roberts, 1984). However, a national survey carried out in 1989 found that 65 percent of lone mothers working 24 hours or more per week were low paid. This meant that they were earning less than two-thirds of the median male hourly earnings cited (Bradshaw and Millar, 1991 cited in Millar, 1992. p.151). The gendered nature of the labour market also means that lone fathers are much more likely to be able to get a full-time job which pays them enough to cover childcare. The number of one parent families has risen

dramatically from about 750,000 in 1976 to 1,150,000 in 1989 and the number of single (never married) mothers has increased from 130,000 to 360,000 over the same period (Millar, 1992). Further, a study carried out by the European Commission and reported by Carvel (1993), shows that Britain now has the highest proportion of lone-parent families of any country in the European Union. Despite this, recent social policy has consistently done little to alter the balance of economic inequality away from such groups. The new childcare allowance, announced in the November 1993 Budget to start in 1994, for example:

> "... rules out help for the majority of families who at present ... use informal childcare arrangements ... [and] According to research carried out in 1991 by the Department of Employment, ... only 22 percent of lone mothers use professional care" (Brindle, 1993, p.16).

Benefit arrangements have not been geared to meet women's specific needs in other ways too (Millar and Glendinning, 1992). For example, only six in ten women workers qualify for maternity leave and subsequent reinstatement. The event which affects many women's, but no man's, employment is inadequately covered by employment legislation or income replacement provision. Although social security payments for unemployment and sickness are now generally available to women on the same conditions as men, the fact that they are often tied to full-time work means that many women again fail to qualify. Also, as Graham (1993) notes, the monetary values of both child benefit and maternity payment have declined in recent years because they have not been uprated on an annual basis as previously. Child benefit is most often paid to mothers rather than fathers and maternity payment is designed to help mothers on income support with the expense of a new baby.

In terms of state pensions, men are further advantaged because entitlement depends on prior contributions. Such an arrangement rewards continuous attachment to the labour force and high wages. Since women often have shorter and more irregular work histories as a result of childbirth, they are less well placed than men to obtain full benefits. Many lose access to a pension through their partner because of divorce and there is also no compensation for this (Joshi and Davies, 1991 cited in Millar, 1991, p.159). Occupational and private pension schemes do not take adequate account of women's caring responsibilities over the life-course either (Groves, 1992). There are substantial differences between the pensions accrued by women with a continuous employment record and those who have a caring role (Joshi, 1992). In general, far more employed men are members of occupational pension schemes than women, a statistic again associated with the distribution of full-time, primary sector jobs.

The economic and social experience of old age, therefore, differs markedly by gender. In 1987, the most recent year for which information was available to Walker (1992), only 23 percent of older men but 35 percent of older women were living on incomes on or below the poverty line. This is defined as up to 40 percent above the appropriate social assistance level, supplementary benefit before 1986 and income support thereafter. Almost half of lone older women compared to just under 40 percent of single older men had income on or below the poverty line. More than three out of five older women were living in or on the margins of poverty in total and the position of widows was particularly acute. The gender difference in the distribution of poverty in old age is, in part, due to the greater longevity of women.

However, it is also a function of the socially constructed relationship between gender and the labour market and women's consequent lower access to resources before retirement. The fact that many women do have to reduce or give up their paid employment in order to meet caring responsibilities causes them to suffer a considerable reduction on their potential earnings over the lifetime (Joshi, 1992). When combined with the economic and social effects of a life lived in a low social class, it is evident that the severest deprivation is imposed on very elderly, working-class women.

Pensions are yet another area in which gender inequalities have increased under recent social policy initiatives. The 1986 Social Security Act, which came into force in April 1988, reversed the main attempts of the 1975 State Earnings Related Pension (SERP) Scheme to adjust state pensions to the economic experiences of women (Walker, 1992). The calculation of earnings related pension has been changed to be based on 20 percent of a lifetime's earnings (40 years) as opposed to 25 percent of the best twenty years. The original allowance was considered too generous to those people, especially women, who have shorter than average periods of employment or non-incremental earnings. Since the SERP Scheme provides the basis for the guaranteed minimum pension within occupational pension schemes, this alteration causes the same inequality for women in the private sector. The proportion of SERP which can be inherited from a husband was also reduced to half their entitlement rather than the full amount. This has reversed the likely improvements to widows' incomes in old age. The state retirement pension is increasingly viewed as a residual foundation on which individuals have the

responsibility to base more adequate provision through other means. This individualistic policy exacerbates the difficulties women already experience in providing for themselves in old age because it fails to take account of the continuing importance of female caring and the nature of women's paid employment (Ginn and Arber, 1993; Groves, 1991).

Invalid Care Allowance (ICA), introduced in 1975, was intended to replace the earnings lost or forgone by a working-age carer who provides full-time, or at least thirty-five hours' of care per week, to a disabled person. Until a successful appeal in the European Court in 1986, it represented one of the most explicit examples of the assumption in social policy that married women should be financially dependent upon their husbands. These women were ineligible for the benefit on the grounds that "they might be at home in any event" (DHSS, 1974 para 60 quoted by Glendinning, 1992. p.172). Despite the court ruling, ICA is still received by less than one-tenth of all carers who are providing thirty-five hours' help a week. This restricted coverage is largely the result of the complex criteria governing eligibility:

> "Perhaps most crucially, ICA, as a non-contributory benefit is very low - in 1991/2 less than 80 percent of the basic minimum income support payable to a single adult ... The low level of ICA means that many carers will still have to 'top up' the benefit by means-tested income support ... However, carers with savings above the limit for means-tested benefits have to rely entirely on ICA plus income from their savings, a strategy which is likely to increase their risk of poverty in the longer term ... The limit on the amount which can be earned while receiving ICA effectively discourages carers from retaining contact with the labour market ..." (ibid, 1992, pp.172-173).

When the ICA was introduced, recipients had their rights protected to the basic state pension and unemployment benefit when they ceased caring. The October 1988 change of benefit rules ended this protection and, at the same time, made eligibility to unemployment benefit dependent on sufficient *paid* contributions in the previous two tax years as opposed to just one (Land, 1991). In all these ways benefit policy has contributed to the likelihood that many female carers will experience poverty.

3.3.2 The Nature of Widening Income Inequalities in Society

There has also been a widening of income inequalities between women in families with children. The evidence shows that the deterioration in the relative economic position of households with children, which started in the 1970s, sharpened in the 1980s:

> "As a result, families represent an increasing proportion of households with the lowest standards of living. In the late 1980s, only a third of households contained children ... However, households with children made up nearly 60 percent of households with incomes in the lowest 10 percent of the income distribution" (Graham, 1992, p.213).

This is largely associated with the incidence of unemployment which:

> "... means a significant drop in living standards, which fall further as the duration of unemployment increases ... But for families with dependent children where the father is unemployed, the risk of poverty increases significantly ... Thus a rise in the two earner household in combination with an increase in unemployment is leading to a polarisation of families in terms of income ..." (Rimmer, 1988, p.77).

Data for 1987, employed by Oppenheim (1993), suggest that nearly 80 percent of families where the head of household is unemployed have incomes below 50 percent of the national average. Again, the social security system is a disincentive for

wives' working whilst husbands are claiming benefit (Joseph Rowntree Foundation, 1994a and 1994b; Joshi, 1984; Morris, 1988).

The 1986 Social Security Act has also worked against families with children by reducing their access to additional finance to meet expenses that cannot be covered from regular benefit. Families were major beneficiaries of the previous system of single, one-off payments to claimants in financial difficulties who qualified. The replacement Social Fund only gives limited help through grants and most families now have to seek discretionary loans for emergencies or to pay for single large items of expenditure. Although it is interest free, those who do have access to a Social Fund loan are often faced with weekly repayments set well above what they can really afford. Studies show that, rather than increasing the financial independence of social security claimants, recent changes have actually led to greater debt and increasing dependence on relatives (Graham, 1992). Further, the type of family to lose most from cumulative tax changes are the unemployed couples with children followed by the single unemployed and single parent families (Table 3.2).

As Graham (1992) points out, Labour Force Survey data for the late 1980s show that approximately 50 percent of Afro-Caribbean and 70 percent of Pakistani households contain children compared to just one-third of white households. The age and composition of these ethnic minority households means that, proportionately, they have been more affected by the decline in the relative income

Table 3.2 Proportions Gaining/Losing by Family Type After Tax Changes, 1985-95

FAMILY TYPE	% LOSING	% GAINING	AVGE GAIN/LOSS (£ PER WEEK)	AVGE GAIN/LOSS (% NET INCOME)
Single unemployed	58	21	-1.1	-1.1
Single employed	16	76	8.0	3.9
Single parent family	64	13	-1.6	-1.0
Unemployed couple, no children	53	31	0.1	0.1
Unemployed couple with children	78	8	-4.4	-2.7
One earner couple, no children	44	46	5.3	2.1
One earner couple with children	62	28	6.0	2.0
Two earner couple, no children	28	65	6.0	1.7
Two earner couple with children	46	47	4.7	1.3
Single pensioner	16	48	3.8	3.3
Pensioner couple	29	51	4.0	1.7
All family types	37	47	4.0	1.71

Source: Elliot and Kelly, 1994, p.7.

position of households with children in the 1970s and 1980s. They have also been more affected by the changes to the social security system described above.

Additional inequality is experienced by ethnic minority women because the economic system and the welfare state not only favour the interests of men but also those of the majority white community. The take-up rate for state benefits, for example, is lower in black than white communities due to factors such as language, lack of information, the complexity of eligibility criteria and indirect and direct discrimination in the benefit system. As Cook and Watt (1992) point out women living with black men also have less access to resources via a partner's income

because black men tend to be employed more marginally than white men and are disproportionately affected by unemployment.

Black women themselves are more likely than their white counterparts to experience unemployment and have their labour market access restricted to low-status "caring" or "servicing" occupations (Williams, 1989). These are the lowest-paid jobs in the most highly segregated occupations. Only two percent of women of West Indian ethnic origin as opposed to 17 percent of white women and 20 percent of Asians were employed in professional and managerial jobs in Brown's (1984 cited in Beechey, 1986) study. Asian women were more likely to be in manual manufacturing work than the other ethnic groups especially textiles and clothing in areas such as Yorkshire and the East Midlands. Afro-Caribbean, Non-Muslim Asian and many other Asian women are also low-paid homeworkers. Black women in the National Health Service very often carry out domestic work such as cleaning and catering, and are nurses on lower grades rather than ward sisters and doctors.

In addition, as Bruegel (1989) notes, whereas for white women low-income jobs are usually part-time, for black women they are very often full-time. The view that part-time employment is the major determinant of the differential treatment of men and women in the labour market is very much an ethnocentric one. However, there is also differential access by race to scarce formal childcare provision. So working-age women from the ethnic minorities are affected not only in terms of the feminist arguments described but also the anti-racist critique of social provision.

The evidence for the economic position of black women above retirement age is not calculable from official statistics but they too suffer as a result of patriarchy and racism (Walker, 1992).

3.3.3 Summary - Women's Social and Economic Roles

Sections 3.2 and 3.3 have argued that the welfare state is substantially underpinned by women as low-waged employees in the public sector and unpaid workers in the domestic sphere. They have also attempted to show how social welfare is largely consumed by women because they are poorer than men, usually live longer and do not have as much access to services provided by the private sector which depend on substantial resources. Recent changes in the provision of health and social care would, therefore, seem misguided in the underlying assumption that all individuals are equally placed to take advantage of the opportunities available in society. The evidence reveals that, not only are males and females unequally placed, there are also large differences in the circumstances of individual women. The lives and roles of women have been altered substantially in recent years with the 'double burden' of paid and unpaid work an increasingly common experience. Women's ability to cope with the demands of their gendered social roles depends, to a large extent, on their class and socio-economic group, their ethnicity, and their stage in the life-course. Health and social care policies, which have shifted the balance of public and private provision do not take account of these gender inequalities and the social differences amongst women. Such policies, which have exploited gender differences in ascribed social roles have had particularly detrimental effects for women at the lower end of the economic scale

who are already under-resourced. The rest of this chapter will attempt to illustrate these circumstances specifically against the context of recent changes in the policy and provision of health and social care.

3.4 The Place of Women in Health and Social Care

3.4.1 Income and the Management of Health within Families

Although welcome, the increased emphasis on healthy lifestyles, health checks and preventative screening has meant extra responsibility for women because their culturally defined role includes responsibility for family and individual welfare (Graham, 1988; Pearson et al, 1993). Women are the primary health managers in the majority of households. They are most often responsible for buying and preparing food (Brannen et al, 1994; Graham, 1984a) and, regardless of class or ethnic group, are primarily responsible for the use of health care by children (Anderson and Elfert, 1989; Graham 1992; Mayall, 1986; Pheonix, 1991). Research also shows that, at least amongst white low-income households, this responsibility for family welfare goes together with financial management (Bradshaw and Holmes cited in Graham, 1992 p.216). However, money management does not necessarily mean control or economic freedom (Morris, 1988; Pahl, 1980; Rimmer, 1987) even in the light of increased female labour market participation (Volger and Pahl, 1993):

> "Male control over money tends to be reinforced by labour market position, with studies reporting that women exercise less control in homes where the man is the sole earner ... It is mothers with young children who are most likely to live with men on whom they are financially dependent, leaving paid work in order to take on full-time caring" (Graham, 1993, p.83).

For a significant minority of women, then, movement into lone motherhood actually means that they can exercise greater control over spending. However, instead of being poor within marriage, they are now poor within the system of social security (Graham, 1993). It follows that, particularly for women living in poverty, their own health is an integral and prominent part of the difficult daily trade-off required to meet the basic needs of and maintain the well-being of family members.

Graham (1992 and 1993) describes the complex budgeting strategies which women in households on benefit use in this context of the struggle to balance individual health and household economic survival. Often women afford low priority to their own health needs against those of a partner and dependants. The first set of strategies attempts to meet health and other family needs within the household income. Credit and debt commitments taken on in the past to ensure basic health resources such as housing, fuel and children's clothes are usually given priority. They are deducted straight from benefit at source or paid early in the week. The residual income then has to cover basic necessities which relate directly to caring tasks. Cutting back on these items, of which food is the major expenditure, is the best way to control overall out-goings. Many women restrict their own food consumption or miss out on meals completely in order to protect the diet of their children and partners. Some mothers also save on fuel costs by heating the home only when their children are home from school and are not in bed. A study by the Food Commission (reported by Brindle, 1994b) showed that inadequate provision is made in income support payments to cover the costs of a healthy diet

for children. It follows that mothers on benefit have to make the kinds of sacrifices described on a routine basis.

The second set of budgeting strategies described by Graham (1992 and 1993) resorts to sources of support outside the household. Small additions to financial income including child benefit can be disproportionately significant and, again, the value of such benefits has fallen in real terms in the last decade. Families and friends play an important part in the informal economy of care providing practical help as well as material support such as food items, meals at the weekend, hand-me-down children's clothes, toys and financial help in emergencies. This day-to-day system of exchange usually takes place between female relatives and friends:

> "... reflecting and reinforcing the gendered organisation of care within the families" (Graham, 1992, p.221).

Borrowing from outside agencies, including mail-order catalogues and local shops on 'tick', has also become the norm for low-income families and mothers on benefit. In Bradshaw and Holmes' (1989 cited by Graham, 1992) study, 96 percent of claimant households with children had debts averaging £441, and with an average weekly repayment which represented 12 percent of their weekly income:

> "High income households use credit to purchase items such as cars, televisions and videos, while low-income households use credit to cover the costs of surviving ... High-income households spend most on credit; low-income households spend least. However, it is low-income households who devote the highest proportion of their disposable income to servicing credit commitments. They do so, too, on a household income where most of their money is already devoted to meeting basic household costs, such as food, fuel and housing. As a result, those on the lowest incomes have credit commitments that exceed their available income" (Graham, 1993, p.145).

The financial commitments, particularly credit repayments, of low-income households to outside agencies have increased in the 1980s and 1990s and the evidence suggests that, once in debt, families find it very hard to get out. Many women are, therefore, experiencing increasing pressure on spending even for everyday necessities for health and this has important implications for family health management.

In the mid-1980s research had already shown that, although women across the class groups set out into motherhood with similar ideas and objectives for their children's health, differences in practices do emerge and these can be linked to problems of material resources. Controlling the intake of sugary and fatty snacks is, for example, difficult as children grow up into a social world where such foods are the norm and also more affordable than 'healthy' alternatives (Mayall, 1986). These potentially 'health threatening' behaviours can also be the means by which people cope with the high levels of stress experienced as a result of living on a low-income (Graham, 1987, 1988 and 1993). Mothers often identify sweets, crisps and biscuits for children and cigarettes for themselves as necessities which help them to 'keep the peace' and alleviate stress in pressurised situations. They also identify such items as luxuries which provide a temporary respite from the experience of poverty:

> "Set within this context of everyday life, questions of individual choice and control become more complex. Looking at one particular context - that of caring in poverty - we can begin to sense that behaviours deemed 'irresponsible' by outsiders may be the means by which health responsibilities are met. In such circumstances, health choices - junk foods, sweets and smoking - are more accurately seen as health compromises which, repeated day after day, become the routines which keep the family going" (Graham, 1988, p.7).

3.4.2 Implications of the Changes in Health and Social Care

The implementation of *Caring for People* has also meant a greater role for family care of disabled and elderly dependants and shorter stays in hospital have meant more aftercare in people's own homes. Public expenditure restraints in the 1980s have required reductions in a number of support services including home-helps, district nurses and meals-on-wheels. In the view of Glendinning (1992), the 1993 reorganisation is likely to further intensify this shift from public to private provision. The statutory services are intended to become 'enabling authorities' purchasing services and supporting *informal* carers as the primary care-givers. There has been a:

> "... subtle shift in official notions of 'community care' which has been evident in policy documents of recent years. Original intentions to replace large-scale institutions with statutory services *in* the community have increasingly been modified with a growing emphasis being placed instead on the role of families, friends and neighbours as the main providers of 'community care'. This care *in* the community has increasingly become care *by* the community ..." [original emphasis] (ibid, 1992, p.163).

Critics have shown that, in practice, family and neighbourhood care means care by *women* (Finch and Groves, 1980).

Much of the explanation for the unequal share of informal caring again lies in the way in which the family has been socially constructed into society as the basic unit of self support (Baldwin and Twigg, 1991). Policies of Care in the Community build upon this situation because they carry an explicit, ideological statement about which family members should care for and support dependants (West et al, 1984; Wicks, 1987). This has consistently translated into a lack of formal support from

the health and social services for female carers compared to males and for disabled and elderly people who live with female, non-elderly, married relatives compared to those who live alone or with other relatives (Arber and Gilbert, 1989; Henwood, 1987; Nissel and Bonnerjea, 1982). A recent analysis of the large-scale data from the 1985 General Household Survey has confirmed this poor situation in which many middle-aged, married, female carers find themselves (Parker and Lawton, 1994).

As Land (1991) explains, skills obtained through informal caring have been devalued by the development of mechanisms formally to acquire knowledge as in nursing. She argues that the proliferation of professionals in the formal sector will cause systems of care to become less flexible and more fragmented. Home helps have, for example, become 'home care assistants' who may no longer dust or wash up and the result is:

> "... less personal and comprehensive care requiring more patching and piecing together by the carer at home" (ibid, 1991, p.17).

As local authorities have been required to manage rather than provide packages of care, social workers have become professional 'care managers'. The question arises as to whether:

> "... these care managers concentrate their attention on those for whom there is no informal carer, as some of the groups representing disabled and elderly people fear? This will leave families struggling with inadequate services and support, as before. It will also avoid the awkward question of identifying the client on behalf of whom these packages are being managed - the carer or the person being cared for? Their needs and preferences may well conflict. Either way, this new development may enhance the value of certain skills in social workers and their assistants but will do little to recognise *and* value the informal care manager's skills and time. It will certainly not be experienced as having more 'choice', which purports

to be one of the great virtues of increasing private sector influence" [original emphasis] (ibid, 1991, p.17).

There are also direct financial consequences for the women on whom the policy of Community Care increasingly depends (Glendinning, 1992). Not only can they experience a disproportionate reduction in their current and future income, pension entitlement and living standards, they often have to absorb extra care-related expenses by restricting their own personal expenditure. These extra costs might include bedding, heating, food, laundry and substitute care if the carer herself is working. Many of these women experience greater financial dependency on a male partner and sometimes even the person for whom they are caring because the dependant's circumstances help to govern a carer's entitlement to benefits. Research also shows that people with physical illness and disabilities, that is to say those who need help with everyday health tasks, are concentrated in low-income households (Blaxter, 1990). There are also considerable class differences in the receipt of formal support services (Ungerson, 1987). Community Care, therefore, represents another area in which social policies have intensified the inequalities experienced by the poorer socio-economic groups.

In addition, changes in health care provision which focus on the cost efficiency of the service are likely proportionately to shift costs onto the service user who cannot necessarily afford them (Pearson, 1992; Pearson et al, 1993). Rationalisation of services, for example, will produce costs in terms of transport to and extra time needed to reach more dispersed facilities. It may create the expense of substitute cover for caring responsibilities for the longer periods required to

access care and also, perhaps, additional emotional stresses as a result of these added expenditures. Women in the secondary labour market, who have a lower income and lower entitlement to welfare benefits than men and women in the primary sector, also have lower access to private transport and often have to rely on time-consuming public transport. These women are often the people who incur the additional costs described and yet they are the ones least likely to be in a position to offset the strain. They are experiencing the increasing caring responsibilities but may not have time free or be able to afford health care attendance themselves.

Moves towards privatisation have also altered the distributional inequality of health care. For example, having an occupation per se is an important pre-condition for access to private insurance and, amongst the employed, the growth of private health care has chiefly benefited the middle classes. Papadakis and Taylor-Gooby (1987) argue that privatisation has augmented the complexity of, rather than simply added to inequalities which existed before. They point out, that private health insurance paid for by companies depends on status, income and gender within the occupational structure. Professionals and managers are far more likely than semi-skilled and unskilled workers to be covered and amongst the higher status jobs men greatly outnumber women. Women in paid employment are much more likely to be covered by the policy of their partner than by one of their own. Men who work part-time are almost as likely as those in full-time employment to be insured whereas full-time women workers are very much advantaged as compared to their part-time counterparts:

> "There is no intrinsic reason why the development of private welfare should have any preordained distributional effect ... However, the experience of recent measures taken together with the pattern of state interventions into and delineations of the market sphere over the post-war period indicates the direction of probable changes. The core functions of welfare will be sustained while the structure of class [, ethnic] and gender advantage will continue" (ibid, 1987, p.38).

3.5 Summary

Far from reproducing and operating on a 'level playing field' of opportunity, recent social policy appears to have contributed to a deepening of the very inequalities which render the concept mis-guided. Women find themselves at the sharp edge of these systems of inequality because they continue to be assigned to the primary caring role in the domestic sphere and, at the same time, are being increasingly drawn into the 'flexible' labour market. The restructuring of the welfare state has served to produce and reproduce conditions damaging to women over the long as well as the short term. A causal relationship exists between women's roles in the household and family context and those in the evolving 'flexible' labour market which re-cycles and re-constructs gender inequalities in general.

However, although women as a whole are disadvantaged by the way their social roles are constructed within society, there are also extreme inequalities which exist within the group itself. Class, socio-economic status, ethnicity and stage in the life-course all modify the nature of gendered social roles and income differentials are reinforced as a result. Many are confined to conditions of life stress which can only impact negatively on their own health and well-being. In

addition, instead of providing universal benefit, the turn towards healthy lifestyles, health checks and preventative screening has produced extra responsibilities for women by virtue of their socially constructed domestic and caring role. The shift in the locus of care to the 'community' is also a weight to be shared unequally. Women have become the bearers of the policy in ways which have served to intensify the inequalities experienced by the poorest socio-economic groups.

In the complex budgeting strategies of the most deprived, women's own health needs are often afforded low priority in the trade-off they operate to manage their assumed and assigned responsibilities. This thesis attempts to examine such issues of how women are managing the extra household work created in the light of the changing structures of health and social care provision. In order to facilitate the analysis, Chapter Four will build on the theme of diversity amongst women and so develop a decision-making framework for health as household activity. The framework will be used to further illustrate how groups of women are differentially placed to respond to the demands being asked of them.

CHAPTER FOUR

DECISION-MAKING FRAMEWORK FOR HEALTH AS HOUSEHOLD ACTIVITY

4.1 Introduction

As discussed in previous chapters, recent social policy has increased considerably the health responsibilities of individual households at the same time as:

> "Financial necessity is driving more mothers to search for jobs at a time when economic restructuring is tying women's employment more firmly into the lower paid marginal sectors of the labour market" (Graham, 1993, p.125).

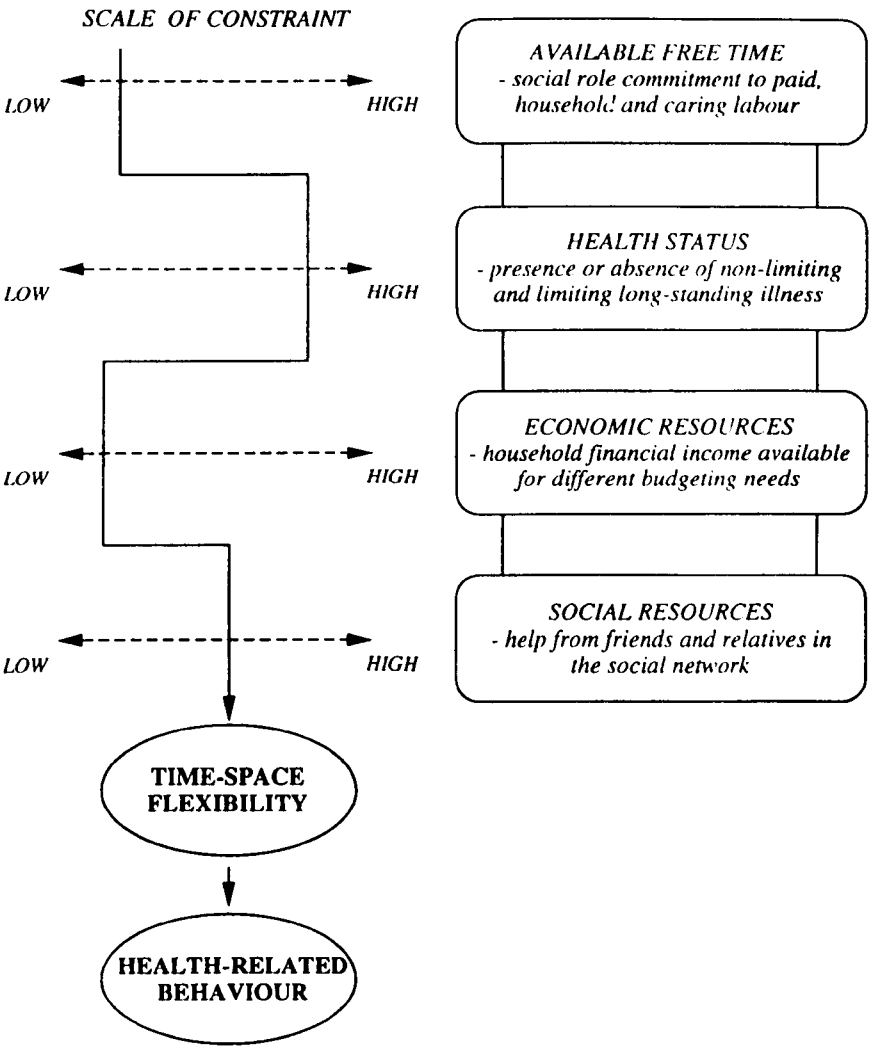
This makes it vitally important to look at health-related behaviours in the context of day-to-day activities. Significantly for the women who form the subject of this thesis, recent years have also seen extensive rationalisation of transport, shopping and other facilities as well as the concentration of primary and secondary health services on fewer locations than in the past. Collectively, the processes described have expanded the number of everyday tasks which must be accomplished within particular households at the same time as increasing the spatial range which must be covered in order do so. As a direct consequence, many women are experiencing greater difficulties when attempting to schedule their competing tasks, not least health care use (Pearson et al, 1993). A philosophy of service provision which is underpinned by the assumption that people are equally able to attend fails to take account of the difficulties that some may have in scheduling health care into their other activities. As the simplest of examples, not everyone is in the position to travel to centralised hospital services, or easily able to attend the particular hospital

where their GP fund-holder can obtain the least expensive care or the shortest waiting time.

This chapter explores the kinds of considerations which women face in their everyday activity scheduling decisions. It points to the variety of ways in which health-related behaviours are underpinned by time-space mobility and outlines how that mobility depends on interactions between the demands of social roles, the constraints of health status and the availability of economic and social resources. The notion of the differential apportionment of constraints between women, a theme advanced in the previous chapter, is continued and developed further. Emphasis is again placed on the fact that women in higher-status positions in the social structure are better able than others to overcome the restrictions of social roles and health status. The converse point, that position in the social structure affects the experience of both health and social roles, is also explored as is the view that the two are mutually reinforcing.

It should not be forgotten that there is also a distinct spatial dimension to the experience both of mobility constraint and health. This involves the position of the individual and household in relation to, for example, the geographical distribution of health care facilities and other services, the shape and form of public transport networks, local labour market opportunities and environmental triggers to ill health (Pahl, 1984; Rose, 1993). However, choice of living location is, in turn, affected by position in the social structure (Dicken and Lloyd, 1981). The geographical context for this study will be outlined in Chapter Six.

Figure 4.1 Decision-making Framework for Health as Household Activity



The interacting factors which are viewed here as the main constrainers of women's relative freedom of choice in their role as household health managers will be discussed in Section 4.3 and applied in the context of health-related behaviours in Section 4.4. For the present, they are illustrated in Figure 4.1. The factors are:

i) amount of free time available after social role commitments to paid, domestic and caring labour;

ii) constraint as a result of individual health status;

iii) availability of economic resources for different budgeting needs; and

iv) social network resources.

None of these are factors, however, which pertain to the individual solely in isolation. The shape of each depends not only on the circumstances in which individual women must operate within their respective households but also on the situation of the household within its wider family network and society as a whole (Anderson, Bechhofer and Kendrick, 1994). This includes, for instance, the type of labour demands as they are influenced by gender relations and the level of emotional involvement and obligation to care (Pahl and Wallace, 1985; McKee and Bell, 1985; Morris, 1985). This is not to treat the household as the primary unit of study as this has been shown to be mis-guided (Abbott and Wallace, 1990; Tivers, 1978); it is simply to define the 'household' as the principal context in which these factors are confronted and outcomes are negotiated between individuals (Morris, 1990). Section 4.2 follows the analytical divisions adopted within the sociological and political-economic literature. It examines the ways in which women within families and households are linked to the wider economy and society and located within the capitalist social structure.

4.2 The Household as the Context for Health-related Behaviours

4.2.1 Household Diversity

In Western industrial societies the term 'the family' has been used most often to describe a unit consisting of parents and their children:

> "This unit is widely thought of as a group based on marriage and biological parenthood, as sharing a common residence and as united by ties of affection, obligations of care and support and a sense of a common identity. This taken-for-granted conception of what the family *is* clearly reflects traditional beliefs as to the way in which sexual and parental relationships *ought* to be ordered ... However this way of delimiting the family is problematic. Ball (1974) points out that it conflates two logically distinct categories, 'the household' and 'the family'. The household, he says, is a spatial concept and refers to a group of persons (or a person) bound to a *place* whereas families are groups of persons bound together by ties of blood and marriage ... The family (a kin group) must therefore be differentiated from the household (a spatial group)" [original emphasis] (Elliot, 1986, p.4).

It is now generally accepted that attempts to define 'the family' actually obscure the great diversity of living arrangements which really exist (Abbott and Wallace, 1990).

For instance, households which contain people who regard themselves as family actually vary in size, composition and character. A household is commonly regarded as belonging to the 'nuclear family' type if it comprises a married couple and their dependent children. However, many couples live together and have children without legally getting married and consider themselves a family. Biological and social parenthood do not necessarily coincide as in the case of adoptive and foster families (Aldgate, 1982). Households may consist of families reconstituted along the lines of a nuclear family following divorce and remarriage or cohabitation. In this situation, one or other parent may already have children and

the couple may or may not have children of their own (Burgoyne and Clark, 1982). 'One-parent family' households may be headed by single mothers who have always cared for their children alone. They might equally be headed by widowed parents or parents of either sex given custody following divorce (Jackson, 1982). There also exist collective or communal households where children are defined as children of a particular nuclear family or children of the commune respectively. Parenting is also carried out by homosexual couples who may have adopted or have children by a previous relationship (Elliot, 1986; McCulloch, 1982). Brothers and sisters can form a household and many people also live alone.

> "Common to all these specifications of various types of families is a conception of 'the familial' as referring to social units based on biological reproduction and blood relationships (or simulated blood relationships, as in the adoptive family)" (Elliot, 1986, p.7).

However, the range of blood relationships used to form familial ties can also vary considerably. At one end of the scale, a married couple and their dependent children:

> "... may form a more or less independent unit and only a limited range of blood ties may be given social recognition" (ibid. 1986, p.5).

This 'conjugal family' arrangement is contrasted with that of the 'extended family' system where the nuclear family members are tied into a larger kin group linked by descent, marriage or adoption. In other words, just as variations exist in 'family type' as described above, there are also different kinds of 'family form'. This is a term which describes the family in its social context. It is the:

> "... overall shape or outward appearance in relation to the rest of society" (Close, 1985, p.10).

Thus, it refers to the degree of openness to external kin as already described, a relationship to the economy which depends on wage-labour or social security and so on. Different types of family may exhibit the same characteristics of family form.

As Gittins (1993) points out, the family has generally been treated as a single unit by sociologists and historians. Implicit in this is the view that individuals within the unit are all living in the same situation and sharing the same resources. Feminist research has, however, shown that:

> "There are inequalities *within* families just as there are inequalities *between* families. Assuming one identical family form denies important differences in terms of class, gender, ethnicity and age" [original emphasis] (ibid, 1993, p.2).

Each of these dimensions cuts across the different types of family and household and the shape of each is embedded in culture and locality. Dual-worker families vary from those in which both partners have a 'professional' career to those where the man's job is higher status and takes precedence (Gowler and Legge, 1982). Not all single parent families live in poverty. Instead such families can be found across the social classes. Children also vary in age from pre-schoolers to teenagers (Jackson, 1982). In fact:

> "Age is an important factor to consider in trying to understand the organisation of kinship and households ... As individuals age, so the composition and structure of the unit in which they live change. Consider the ways in which the household composition and resources of a couple change as, first, aged 20, they marry and both work; second, aged 25, they have had two children and the wife has left the labour market for a few years to rear the children until they attend school; third, at 30, one partner leaves or dies and one parent is left with total care of the children; fourth, at 35, one or both may remarry someone who perhaps has three children from an earlier marriage, or may take in an elderly parent to care for, and so on.

> The number of wage earners and dependants changes over the household's cycle, just as it changes for the individuals within the household" (Gittins, 1993, p.69).

Ethnic differences also add variety to the picture of what can be meant by the term 'the family'. For example, if we consider South Asian families:

> "The problem of just what should be identified as constituting a family can be illustrated by considering the disjunctions which often arise during the process of migration. The most concrete kinship aggregations that can be observed in Britain are households, that is groups of people who live together and who make common domestic arrangements amongst themselves. Yet among South Asians the members of such households often regard these arrangements as a matter of temporary convenience ... Thus an empirically observable household in Britain may often be no more than a local facet of a much wider network of familial relationships around the world. It is these networks of binding relationships which are very often the most appropriate focus for an analysis of the family" (Ballard, 1982, pp.180-181).

There are also great variations in family configuration both within and between ethnic minority communities. Not only are there differences in terms of cultural inheritance but the process of adjustment to the UK situation also influences outcomes (Barrow, 1982; Driver, 1982; Oakley, 1982).

Most authors believe that there is now such a diversity of family types in Britain that no single one can be dominant at a particular point in time (Laslett, 1982; Gittins, 1993; Rapoport and Rapoport, 1982). Close (1985), however, would argue that if a life-course perspective is taken, the majority of households are either of the nuclear family type at present or likely to be moving into or emerging from that type. The latter category might include divorced or widowed single parents and

pensioner couples. In his view, evidence of diversity is also no argument against the point that:

> "... the *conjugal family form* is culturally prescribed and in this sense 'dominant'" [original emphasis] (ibid, 1985, p.17).

The evidence certainly shows that, despite the increasing number of households headed by single mothers, elderly widows and middle class professional women who choose to live alone:

> "... the total proportion of women who are heads of households is still small -only about one in ten in the active population (that is, aged between 16 and 60) ... Even among African Caribbean women in Britain less than half head households; and among Asian women in Britain there is a notably lower-than-average rate of woman-headed, single-parent and lone adult households; and conversely, quite a high rate of male-headed, patrinatal, extended family households" (Delphy and Leonard, 1992, p.114).

It is clear that family *type* and family *form* both have implications for the negotiation of responsibilities between household members. The workings of the household also vary as individuals and families progress along the life-course. Gowler and Legge (1982), for example, note that dual-worker families often revert to more 'traditional' roles in response to the birth of a disabled child, chronic illness, the need to care for elderly relatives or unemployment. It is also clear that considerable social divisions and inequalities exist between family households and, as Harris (1983) argues:

> "... family forms must be understood in terms of the part they play in a system of production" (ibid, 1983, p.117).

4.2.2 Households in their Social Context

Elliot (1986, p.8-14) provides a summary of the main sociological approaches to the analysis of the changing configuration of the family and household within the wider social and economic structure. These are functionalism, Marxism and feminism. Functionalist analyses focus on the relationship between families and other social institutions whereas Marxist approaches emphasise their role in economic production and the reproduction of labour. Many of these accounts have been 'gender-blind' and, as argued in Chapter Three, it has been left to feminist theorists to examine specifically the position and role of women in families within the social and economic structure. The present sub-section will explore the ways in which the family household and its relationship to wider society provide the context for women's decision-making.

For many years, sociologists argued that the family had gradually lost its functions and become less important in social life with industrialisation. Complementing this was the view that the kinship relationships of large extended families had given way to the more restricted ones of the nuclear unit. However, later writers have argued that family households are still vital to the functioning of society even though their roles may have been modified. Allen (1985), for example, outlines the work of an earlier writer in order to argue that the family and the social organisations which emerged with industrialisation are complementary:

> "Litwak's formulation ... recognizes that the family is not becoming functionless in the sense of having its social importance limited to one or two residual activities - tension management and socialization, say. Rather the family and the help and assistance its members offer one another is central to society, for its actions as a primary group help many of the more formal organizations and institutions to fulfil

> their goals. Far from being peripheral, the family is involved in quite a wide range of activities, including health care, education, social welfare and economic provision. 'However', as Litwak argues, 'in each of these areas it contributes only part to the achievement of goals. The other part is contributed by the formal organization' (ibid, 1985, p.12).

As Close and Collins (1985) note, various authors single out for discussion:

> "... the substantial contribution families make to the operation of economic mechanisms, not only by way of their members' participation in industrial or 'public' production but also by way of their constituent activities, roles and relationships" (ibid, 1985, p.1).

Broadbent (1977), for example, argues that geographical outcomes within an urban system and the relationship of that system to the wider economy, are both underpinned by the day-to-day activities of households and the people within them in their combined roles as producers and consumers. Essentially, the urban area is perceived as a 'pool of labour' and the local labour market is defined in terms of the daily system of home-paid work movements by employees. This line of thinking:

> "... helps to focus the attention on the way production is organised in the market economy and especially on the separation between 'home' and 'work' ..." (ibid, 1977, p.91).

This is acknowledged as one of the most fundamental divisions within society and the household is regarded as a 'small factory':

> "... producing a commodity (labour) for the market by employing other inputs (such as consumer goods) like any other production activity" (ibid, 1977, p.111).

Hence, home and work are considered to be two aspects of the same single activity which is overall economic production.

Of course, different types of household have particular combinations of consumption inputs and production outputs (Gershuny, 1983; Pahl, 1984). Consumption patterns vary depending on the income, number and age of people in a household. Broadbent (1977) believes that the wide range of social differences which exist between households emerge as distinct social areas within cities. Even though all households can be regarded as production units, the saleability of the labour they supply to the market will depend on the inputs they utilise. Taking this economistic view, it seems likely that a high household income would reinforce itself by the ability to purchase 'quality' inputs such as a good education and thereby produce labour which is in turn able to command a high wage on the market. Finally, there must be a circle effect in operation whereby characteristics of the local area, such as income opportunities through availability of employment, also influence consumption input opportunities.

Broadbent (1977) argues that, just as in industry, it is the expenditure of human time, effort and skill in labour which converts household inputs into an output product. He also acknowledges that much of this labour activity within the household is performed by women and is unwaged. This line of thinking has been developed substantially by various feminist authors, such as Molyneux (1979), who maintain that, essentially, the family and economic production are linked because of the role domestic labour plays in sustaining the ability of household members to work. This is achieved through regular fulfilling of workers' physical, cultural and emotional requirements. Broadbent's (1977) 'social variability' argument outlined above can also be developed further here to illustrate how the activities women

carry out in order to turn consumption into production vary across household types. The stage the household has reached along the domestic life-course of labour production, for example, affects the type of activity demands on women. Amongst other things, older and younger children require different amounts of time and attention. In addition, grandparents often contribute to the creation of a second generation of workers through the help that they provide to sustain the separate households of their children. Their activities in this context are likely to be of a different order to those needed when they raised their own children.

More recently, Delphy and Leonard (1992) have correctly argued for a more in-depth analysis of domestic labour divisions:

> "To talk of the 'structural characteristics' or the 'political economy' of housework while continuing to define it as a list of tasks, is a contradiction in terms. The inadequate definition of housework (or rather the constant confusion between its common definition and the more formal study of the relations of production within which these tasks are typically done) has greatly hindered our understanding of house*wives*" [original emphasis] (ibid, 1992, pp.98-99).

They propose that the term housework be applied broadly to:

> "... the composite of regular day-to-day tasks which are judged necessary to maintain the home in contemporary western society" (ibid, p.99).

The term "household work" is used: "to cover all the work done within family household units" (ibid, p.100). It includes not just housework but also emotional and sexual servicing, procreative work and any production of goods and services which are intended for exchange on the market rather than self-consumption. Finally, "family work" is distinguished as "all the unpaid work done by dependants" in order:

> "... to emphasise that the relations within which the work is done are those of dependency and that people are recruited (obliged) to do this work by kinship and marital relations" (ibid, 1992, p.100).

In other words, family labour is regarded as an economic system based as much on hierarchical power and status within the household as it is on external capitalist relations. Gender inequalities are seen to be reproduced within, and regarded as part of, the structure of family households because of their need to accommodate the inequalities inherent in outside institutions. Delphy and Leonard's (1992) terminology allows much more detailed distinctions to be made between family members as regards the benefits and disbenefits of production, consumption and property accumulation each of which are areas in which the family household has often been regarded as a single undifferentiated unit:

> "For example, when the husband and children consume meals served by the wife, she provides the services, so she cannot consume them in the same way as they do: as work done by somebody else. She cannot both wait and be waited on. Hence there are real problems in treating the family as a 'unit of consumption' in any analysis" (ibid, 1992, p.108).

Gender and generational differences in household divisions of labour and consumption have already been noted in Chapter Three and will be further elaborated in the next section of this chapter.

What this part of the discussion has illustrated is the need to combine approaches to the analysis of the family household. Delphy and Leonard (1992) demonstrate that households are not homogeneous units and show the importance of patriarchal in addition to capitalist power relations. They argue that family households cannot be likened to factory businesses because the work carried out

within them is not subject to the laws of the market and is not paid a wage in exchange. The work of other authors, shows, however, that although unpaid labour is not *subject* to economic circumstances it is certainly heavily *conditioned* by them (Anderson, Bechhofer and Gershuny, 1994; Morris, 1990).

The internal differentiation of roles, responsibilities and spheres of activity between men and women inside households emphasises the need for a specialised primary carer and domestic servicer. As Allen (1985) points out, this pattern is historically specific to social and economic forces of industrialisation which include the development of social institutions for collective provision. The family has to be flexible, for example, to cope with the priority demands of the education system for a child's attendance at particular times. These include a short working day, long holidays and the closing of schools for in-service teacher training days. There has been a tendency to see the family household as an integral unit whereas, in fact, there are large divisions in the tasks and responsibilities which take place within the home which both shape and are shaped by wider divisions and inequalities outside. The demands made on households by external agencies, such as health, production, welfare and education, are largely met by women in their roles as partners and mothers. This arrangement is central to contemporary family organisation. Although material changes, such as improvements in housing standards and the development of technologies which have altered the content of housework:

> "... have fostered an image of the home as a place of relaxation and self-fulfilment in contrast to the harsh realities of the work place [,] ... in reality their separation is not so clear-cut ... At its most obvious, the hours that people are employed, the time they spend travelling or away from home, the shift system in operation, and the character of work - its mental and physical arduousness - weave a

> pattern that imprints itself on the daily routine that is family life ... The working week is the dominant component and domestic organization clearly reflects this in such areas as the timing of meals, the periods the family spends together and the general rhythm of family life. Far from being unrelated to production, the family, and especially the housewife, arrange their schedules around the requirements of employment" (ibid, 1985, p.19).

Clearly, economic co-operation occurs between members of different households as well as between individuals within households (Gittins, 1993). As Allen (1985) points out:

> "... the family operates as a network in which a range of services are exchanged between the individual members. The family in this view is not seen as a fixed group, be it residentially, economically or politically defined, but as a collection of individuals who can draw on one another and use each other as resources in a co-ordinated fashion as and when the occasion demands" (ibid, 1985, p.12).

He would, however, argue that the modern family is relatively restricted in extent and that:

> "... the individual's overriding obligation is to his or her conjugal family" (ibid, p.13).

The kin group does operate as a network in the sense that its constituent conjugal family units exchange services depending on need and resources available. However, those units are well adapted to cope with the majority of contingencies. It is not normally necessary to call on help from the outside network. When help is given it is usually to immediate family members or primary kin:

> "Adult children normally turn to their parents for help before their siblings, and of course it is adult children who cater and care for elderly parents ... Occasionally too particular siblings may regard one another as best friends and consequently rely on each other a good deal for a variety of purposes ..." (ibid, 1985, p.15).

Kinship, then:

> "... is a way of identifying others as in some way special from the rest, people to whom the individual or collectivity feel responsible in certain ways. It is a method of demarcating obligations and responsibility between individuals and groups" (Gittins, 1993, p.65).

Those individuals feel more or less obligated to others in the family depending on the type and strength of the relationship and it has, of course, been shown that responsibilities within the kin group are also gendered (Finch, 1989; Qureshi and Walker, 1989). Variations in kinship networks have also been associated with social class (Wilson, 1987).

Households are, therefore, complex units of social action and interaction with their own external and internal dynamics. In particular:

> "... they entail the distribution of resources. Resources include food, drink, material goods, but also service, care skills, time and space ... All resources are finite and some may be extremely scarce; some form of allocation therefore has to occur, and this presupposes power relationships. Food, work and space are rarely distributed equally between co-residing individuals, just as they differ between households and social sectors. Rather than using Murdock's definition of 'economic co-operation', it is thus more useful to understand families in terms of the ways in which gender and age define, and are defined by, the division or labour within, and beyond, households" (Gittins, 1993, p.62).

The obligation to do work within the family household and wider network is very much contingent on gender and marital status and based on systems of dependency. Gender and inter-generational relations are worked out and responsibilities are negotiated within and between households. The family, whether as a conjugal unit or a wider kin network, is integrated with all the other institutions which constitute society. Different households relate to the wider economic and social system in different ways and the tasks carried out and the rewards received for labour will

vary greatly from one to another. Women's traditional caring role is equally functional to the system as men's in paid employment and the demands of external organisations which rely on the participation of the family help to maintain this situation. As in Chapter Three, it is clear that socio-economic, age and ethnic minority dimensions are important; they all cut across the different types of family and household and the shape of each is embedded in concepts of culture and locality.

In addition, as Gittins (1993) points out, the environment and conditions in which the household is situated are all open to change and these changes often have important repercussions for those households and the individuals within them. Patterns of interaction between individuals and households may alter, for example, in times of male unemployment. There are also consequences for the access of households to resources in an increasingly divided society (Burchell, 1992). Increasing socio-spatial inequalities are emerging, for example, between the deprived outer estates and the affluent suburbs (Green, 1994). To summarise the overall argument, therefore:

> "... the family is a unit with a hierarchy. Its members are not all of the same status doing the same sort of work and getting the same rewards. Rather the family in space (the household) and in time (the line) are sets of gendered and generational statuses regarding both the division of labour and the distribution of resources. And families are in turn located within wider societies in which there are other age and gender inequalities, and the various sets of inequalities feed into one another" (Delphy and Leonard, 1992, p.158).

The next section will outline this differential apportionment of labour demands and resources between women using the framework of time, health, economic and social resource constraints shown in Figure 4.1.

4.3 Decision-making Framework for Scheduling of Activities

The aim of the last section was to highlight the household as the appropriate context for exploring women's activity scheduling decisions. As Gittins (1993) argues:

> "Problematic though it may be, it is necessary to retain the notion of co-residence, because most people have lived, and do live, with others for much of their lives. Thus 'household' is useful as a defining characteristic, while bearing in mind that it does not necessarily imply sexual or intimate relationships, and that, moreover, relationships *between* households are a crucial aspect of social interaction. 'Household' [also] should not be interpreted as a homogeneous and undivided unit ..." [original emphasis] (ibid, 1993, p.71).

Indeed, as the last section illustrated, complexity and diversity should both be important features of any analysis of 'the household'. Accepting this view, therefore, that the household context for women's decision-making is complex, it is necessary to provide a conceptual framework with which to approach the rest of the thesis. The present section aims to do that. It describes the interacting factors which are viewed here as the main constrainers of women's relative freedom of choice in relation to activity scheduling in time-space.

4.3.1 Amount of Time Available after Social Role Commitments

For the purposes of this discussion, the time constraints and freedoms under which a woman operates are considered to result, primarily, from the fulfilment of her social role responsibilities to the household in which she lives and the wider family outside (Seymour, 1992). These responsibilities might be economic and met through participation in the paid labour market and/or they might be the commitment to provide unpaid domestic and caring labour. Whatever her marital

status, a woman is required to fulfil some or, in many cases, all of these roles. She can be partner, mother, waged employee and unwaged domestic worker in the home. Each type of commitment to the household absorbs time from the day and affects the freedom a woman has to choose between options because of the necessity to schedule numerous and competing activities (Horrell, 1994).

Overall, the many possibilities which exist for hours to be given to paid and domestic workloads make for great variation in the pressures on women's time. Both length and pattern of the working day and week have been shown to vary enormously with level of domestic demand (Dex and Puttick, 1988; Martin and Roberts, 1984). Not only does family size affect the amount of domestic labour necessary, distinct forms of caring responsibility also require different types of task to be carried out and, consequently, impose differing pressures on time. Commitments can range from the care of normally healthy children and partners to looking after those relatives who are, as a consequence of disability, unable to look after themselves. The latter includes physically and mentally handicapped children and adults and the physically frail and confused elderly. As Land (1978) points out, the care of a sick or elderly person is especially time-consuming because it demands differing amounts of attention, spaced at varying intervals across the day, depending on the dependant's level of infirmity and ability to care for him or herself. In the most challenging cases, caring for the old involves dealing with sleep disturbance and night wandering, an inability to dress unaided as well as wash and/or shave, an inability to manage stairs and feed without help and the necessity not to leave the person unattended (Sanford, 1975). Elderly men often expect a far greater level of

servicing than carers are accustomed to provide for their own household (Qureshi and Walker, 1989). Equally, women may demand hours of attention in return for the support they gave daughters in the past (Ungerson, 1987).

As has been demonstrated, the relative restriction imposed by the different social roles described is strongly influenced by gender relations within the household. Some men, for example, have particularly strong views about whether their partners should work part-time, full-time or not at all following childbirth (Joshi, 1984) and divisions of domestic labour generally have been shown to vary with women's employment status (Martin and Roberts, 1984). To be fair, fathers of young children often have little time for domestic tasks because they work longer hours than childless men in order to cover the extra financial demands of having a family (Rimmer, 1988) and the present lack of any paternity leave provision also places limits on men who would otherwise chose to be more involved in childcare (Dex and Puttick, 1988). Whatever their origin, however, variations in household divisions of labour mean that some women do have to schedule more domestic activities into their daily routine than others. The fact is that the forty-one percent of full-time working women in the Women and Employment Survey (Martin and Roberts, 1984), who replied that they carry out most of the domestic tasks and the thirteen per cent who said that this was solely their responsibility, are under more strain than the women whose partners share the load more equitably.

Those who do combine some form of paid work with a high degree of domestic commitment, not surprisingly, report difficulties in scheduling conflicting

activity demands. Mothers of young children who also hold down a full-time job are especially likely to express difficulties but many part-timers also have problems. Without a partner to provide substitute childcare, however, it is non-married mothers who report the most complications (Focas, 1989; Martin and Roberts, 1984; Jones, 1989). Many of those whose social role is exclusively one of care giver, also experience activity scheduling difficulties and can find choices difficult between the needs of different family members. Women caring for a parent, often feel that they are 'neglecting' their children and partner and those looking after in-laws can also experience guilt about not 'being there' for their own parents (Ungerson, 1987). The women who combine a paid job and looking after school-age children with the additional responsibility of an elderly dependant face even greater pressures.

Clearly, current position in the life-course is also an important cause of difference amongst women (Pratt and Hanson, 1993). Finch (1987a and 1989) utilises this approach as one which recognises that variations exist in individual and family experience and responsibilities. These are also specific to contemporary time; to the chronological age of the woman concerned and the normative rules, economic and social structures present at a particular historical time period. The inter-relations between these factors as well as marital and parental status and the ages of any children are such that women do not experience time-space constraints consistently over a lifetime (Burgoyne, 1987; Katz and Monk, 1993). In addition, older women are likely to have experienced paid labour participation and household gender relations in very different ways as compared to their daughters (Dale, 1987).

Gershuny (1982 quoted in Rimmer, 1988) and Jones (1989) note particularly specialised divisions between routine and non-routine household tasks, amongst the older age-groups, in line with traditional views of gender appropriateness. Not surprisingly, Main (1988a) found, in a cohort analysis of the Women and Employment Survey, that the 'stereotypical housewife pattern' has declined in recent years. Many older women never entered the labour force at all. It may be that women in the older age groups, who do have commitments to a disabled child or elderly parents, are more constrained by the gender role than younger women with heavy caring responsibilities. Middle-aged women also are particularly likely to be under pressure from multiple social role demands (Brody, 1981; Davis, 1981; West, 1984).

4.3.2 Health-related Constraint

Health-related constraint is the presence or absence of limiting and non-limiting long-standing illness. This is a complex, mutually-reinforcing (Adelmann, et al, 1990), relationship in which:

i) pre-existing health status influences paid labour participation, ability to cope with domestic tasks and choices in health-related behaviours;

ii) social roles and obligations impact on health experience including physical, psychological and stress-related psychosomatic problems.

In terms of the former premise, it is well recognised that severe limiting long-term illness or disability, and poorer health generally, will limit scope for participation in paid labour (Beral, 1987; Waldron et al, 1982). The term 'healthy worker effect' is used to describe this selection on the basis of health (Carpenter, 1987; McMichael, 1979). In addition to the effects which it has on both paid labour participation and amount of domestic and caring tasks that the woman is capable of carrying out, health status also has direct implications for mobility in time and space.

However, theories relating to social roles and women's health, particularly mental health, have tended to focus on the second question of whether paid employment is beneficial or a source of role strain (Arber, Gilbert and Dale, 1985; Fowlkes, 1987). There is a substantial literature with argues that, in comparison to the economic invisibility and social isolation of 'only being a homemaker' (Miles, 1988; Parry, 1987), paid work protects health because it facilitates social participation and is perceived as economically productive (Anson and Anson, 1987; Brown and Harris, 1978; Cochrane and Stopes-Roe, 1981; Kessler and McRae, 1982). A further question relates to how the *dual role* of waged worker and unpaid domestic labourer impacts upon a woman's physical and mental health (Arber, 1991; Hibbard and Pope, 1991; Nathanson, 1975 and 1980; Popay and Bartley, 1992; Verbrugge, 1983). Some argue that multiple roles create distress and feelings of a lack of personal control (Rosenfield, 1989; Ross and Bird, 1994). Others point to the greater control which a job and a personal income brings to women (Downey and Moen, 1987; Lennon and Rosenfield, 1992). A further argument still is that

employment or role overload per se are not as important as actual and perceived levels of equity in task sharing between the genders (Glass and Fujimoto, 1994; Woods, 1985). Lone mothers, in particular, have been shown to be under strain (Scott and Corti, 1991).

Overall, the complexity of linkages discussed clearly illustrates that understanding causative mechanisms is not a straightforward exercise (Arber, Gilbert and Dale, 1985; Jougla et al, 1983; Joshi and Macran, 1991; Passannante and Nathanson, 1985; La Rosa, 1988). What it is important to note, however, is the fact that, just as the paid work environment can be hazardous to health (Chamberlain, 1991), so too can the context for domestic labour (Popay and Bartley, 1987/88). For example, those who have to give up paid work to care for an elderly dependant can often experience severe economic stresses. The tasks involved, such as lifting, bathing and washing clothes and linen, are also labour intensive and tiring. As Ungerson (1987) points out, a number of women in their fifties experience bad health in their own right and may leave paid work as a result. Such participants in her study were often under extra strain due to the strenuous physical nature of caring. Several carers interviewed by Sanford (1975) also cited their own physical health as a problem caused or exacerbated by the necessity to provide tending services.

The main point overall is that experience of health both in relation to paid work and caring is socially constructed. There is, for example:

> "... overwhelming evidence that the majority of additional pressures at work experienced by female managers are stress factors beyond their control and based largely on prejudice and discrimination from both corporate policy and other people at work" (Clark, 1991, p.10).

Finch and Groves (1983) and Graham (1983a) term caring the 'labour of love' as it involves both feelings of affection and the provision of services through labour. They use this concept to illustrate that women's experience of caring is simultaneously influenced by normative psychological structures (Chodorow, 1978) and wider social relations (Ungerson, 1983). The same analysis can be utilised in order to understand the likely health effects of care-giving work.

It has been shown that the psychological need 'to care' is very important to some women. A number of Ungerson's (1987) interviewees, for example, deliberately took on an elderly dependant when their children left home in order to prevent 'empty nest' feelings. For those women there can be great satisfaction in fulfilling their identity in-built from childhood (Chodorow, 1978). Others, however, find tending a "distressing, depressing and disturbing experience" and associate it with feelings of inadequacy (Ungerson, 1987, p.45). Stress is also associated with the necessary adjustment to changes in a relationship brought about by the increased dependency of a formerly healthy person. Problems of emotional conflict are often caused by adverse behaviour and personality changes in the elderly person as well as generational differences in views about gender appropriate roles (Mullender, 1983; Qureshi and Walker, 1989). Since many women carers are perceived as central to the continued successful running of the household, they can experience feelings of sole responsibility and failure when things go wrong.

It was a similarly long-held assumption that childrearing promotes well-being among women because it is a mother's 'natural job'. Until recently, therefore, research rarely explored the relationship, specifically, between maternal participation and women's psychological functioning. The few studies available show, however, that women's caring for children is as much a socially constructed experience as is responsibility for an elderly dependant. For example:

> "It is striking that both the employed and the nonemployed mothers in the study expressed few complaints overall. They reported little role strain and presented a picture of high well-being. Both the employed and the nonemployed women carried the major portion of childcare, yet neither seemed to experience the situation as burdensome. Perhaps an expectation of inequity means adaptation to it" (Barnett and Baruch, 1987, p.101).

4.3.3 Access to Economic Resources

Economic resources depend on the overall level of household financial income and its real availability to individual women for different budgeting needs (Davies and Joshi, 1994; Pahl, 1989; Vogler, 1994). Typically associated with low-income couples is what Morris (1988) and Rimmer (1987) term the 'whole-wage' system of household financial management. Under this system, the man keeps a proportion of his wages for his own 'spending money' and the responsibility for managing day-to-day needs with the residue is most often left to the woman. However, this does not necessarily mean that she can exercise overall control in financial decision-making. The amount retained by the man is often, for example, his decision. The system whereby the woman is only given an 'allowance' to cover her spending on behalf of the household affords her even less to manage with. Both systems for the management of household income are associated with women's part-

time working. In each case, women have been shown to use their wages to augment the money available for spending on collective household needs, such as food, clothing and accommodation. Again, it is higher socio-economic position and women's full-time working which is associated with the greatest female control over resource distribution in a system of 'joint financial management'. This is because women tend to have higher or lower levels of power and control in the household by virtue of contributing or not contributing to the domestic income (Pahl, 1989).

Thirty-seven percent of all working women in the Women and Employment Survey (Martin and Roberts, 1984) said that they needed their job 'to earn money of my own', highlighting the point that spending is an issue of control in many households. Although full-timers most often said that they worked to cover basic needs, whereas part-timers said 'extras', twenty-eight percent of part-time workers also needed their wages for essentials. Unskilled and semi-skilled factory employees were by far the most likely to be working for 'basics' and unmarried women, particularly those with dependent children, were also meeting essential expenditures from their wages:

> "The general indications are that an income for women is not sufficient to overcome issues of gender role and identity in the management of household finance, but that inadequate housekeeping together with the woman's traditional responsibility for the domestic sphere may ironically drive her to seek paid employment" (Morris, 1988, p.395).

Those women who do have heavy domestic responsibilities and cannot, therefore, obtain better paid work contribute too little financially to insist that a share of household income be spent in a way which increases their own time and space resources. Ironically, despite an overall drop in income, mothers often report

having more money available following divorce because they no longer have to prioritise a partner's spending decisions (Chandler, 1991).

Income benefits from length of service and additional training are also associated with higher-status, full-time jobs (Employment Department, 1990a and 1991). Women caring at home, in particular, find it difficult to fit skills training around domestic arrangements because so few Further and Higher Education courses provided the time flexibility required (Rees and Willox, 1991). The differential experience of income loss as a result of downward occupational mobility after childbirth is another way in which advantage accumulates with certain groups and not others[7]. The longer a new mother takes off work, the greater the likelihood that she will return to a part-time, lower-paying job than the one she left (Dex and Shaw, 1988; Joshi, 1984). This has been associated with loss of 'human capital' due to depreciation of individual productivity and past training (Main, 1988b) and with the loss of promotion prospects which go with length of service in an internal labour market (Buchele, 1981; Garnsey, 1987). Thirty-seven percent of returners in the Women and Employment Survey (Martin and Roberts, 1984) experienced downward mobility. However, women in professional and managerial occupations are much less likely to be affected because higher-status returns are associated with the differential availability of maternity leave (Dex and Shaw, 1988).

Where finances and transport availability are tight, some women combine domestic commitments with paid work in ways other than the 'standard' job. Often

[7]Elias (1988) provides a review of the main literature concerning occupational down-grading.

this is temporary work, carried out from the home and involving few and irregular hours. A particular example of this kind of employee would be the mail-order agent (Employment Department, 1990a). Another would be the outworker, or homeworker, found predominantly in manufacturing, needlework, office and clerical work, and packing and maintenance (Beechey, 1986; Rubery and Wilkinson, 1981). Women employed in this way face different pressures as compared with those solely looking after the home. Since wages in these jobs are also usually very low and spent on essential household items, they are unlikely to produce major improvements in time-space freedom. They might, however, provide the vitally needed boost to a single mother's state benefit or give greater bargaining power to a wife in negotiations for household resources. Homeworking is only available to higher-status workers in certain jobs including, for instance, editing and sales promotion (Cragg and Dawson, 1981 in Beechey, 1986), personnel and management (Dawliffe Hall Educational Foundation, 1991) and academia. For these women homeworking will provide much greater scope to overcome time-space constraints through income mechanisms than for their less well-off counterparts. On an everyday level, homeworking may be more flexible than paid employment in the formal sector because the labour process is unsupervised and, as long as they fulfil overall production deadlines, women can arrange work around other commitments. Higher-status homeworkers certainly enjoy greater time flexibility. For the majority, however, there is often little choice but to work long hours as and when required.

4.3.4 Access to Social Resources

Social Resources depend on the amount of help and support from family and friends in a woman's social network. Phoenix (1991) notes, for example, the role of social networks in providing emotional, practical and material support to mothers bringing up young children. Pahl (1984) described the 'self-provisioning' which takes place between households in employment and Morris and Irwin (1992) point to reciprocal arrangements of support across households of the unemployed. Dowswell and Hewison (1992) and Rees and Willox (1991), in particular, argue the importance of network relationships for mothers' access to paid work. However, those women who do have to fit employment around the availability of husbands or grandparents are often forced to work evenings and shifts (Dex and Shaw, 1988; Martin and Roberts, 1984; Pickup, 1989). In practice, this arrangement probably allows them very little overall time free from social role commitments. In addition, such inter-household exchanges may be more reliable and take place more often, between immediate family members than between friends and neighbours living close by (Pearson et al, 1993). As Wilson (1987) argues:

> "... assistance is structured by gender, income level, household financial organisation, residential proximity, need and ideology. In terms of the provision of continuing support to households with young children, grandparents are important but grandmothers give more assistance than grandfathers and they direct it where it is most needed ... The ideology of assistance is differentiated by class. In professional families the married couple is the unit of transfer but for working class families the solidarity of female relatives, in particular, of daughters and mothers and mothers-in-law, is more important" (ibid, 1987, p.703).

Finally, kinship and friendship networks are also important to perceptions of health problems generally (Scambler, Scambler and Craig, 1981). Stark (1987), for

instance, demonstrated that although the effect on psycho-social health is stronger than that upon minor physical symptoms, both are more frequently reported by individuals who feel themselves to be socially isolated and unsupported. Especially amongst women, perceptions of a lack of social support seemed more important than objective indicators of social contact. In particular, both material and emotional support serve to buffer an individual from the effects of economic and social stress (Parry, 1986; Hobfoll, 1986; Whelan, 1993).

4.3.5 Summary - Women's Activity Scheduling

For ease of illustration, the factors which constitute the decision-making framework shown in Figure 4.1 have been discussed as if discrete. However, whilst each of the component factors do exhibit their own variability amongst women, it is the ways in which the elements combine and interact in time and in real places which produce the relevant outcomes for health-related behaviours. The aim of this research is, therefore, to explore actual decision-making processes in the household context for it is here, and in the wider family, that strategies for managing are negotiated between people. A woman's ability to find her way through the net of opportunities and constraints is not simply a function of her own characteristics, such as health status, but her working out of systems for managing within the social and spatial context of her everyday life. As noted in Chapter One, the specific route taken in this research into understanding women's positions in processes of household health management is through an examination of the nature and workings of time-space constraints. The next section, therefore, takes these issues forward to consider the possible influence of social roles, health status and economic and

social resources on women's time-space flexibility and, hence, their health-related behaviours.

4.4 The Decision-making Framework and Health-related Behaviours

4.4.1 Everyday Activities and Time-space Constraints

As a conceptual frame of reference, women can be individually located along the scale of constraint for each of the four factors described. Seen at its simplest, each woman must negotiate a pathway, as indicated by the line in Figure 4.1, through the combination of constraints which she faces given her household context. A broad typology of groups of women can now be envisaged where each group would appear to start from a different position in the decision-making framework. For example, some women are located at the high end both of the scale of time commitment to paid labour and degree of dependency by other people for caring. Groups can be defined by the type of resource, economic, social or both, which they seem likely to substitute in the attempt to fulfil their responsibilities. There are other groups of women with a high commitment to paid work but few caring responsibilities and vice versa. These women too have different levels of economic and social resources at their disposal. Thus, a woman's combined flexibility in time and over physical distance and her experience of time-space are perceived to depend on the individual and combined impact of the four differentially constraining and liberating factors described.

Such flexibility is important, for example to an understanding of women's management of household health needs, because timing of journeys and choice of

destination in the public sphere are set in what Hägerstrand (1970) termed a 'time-space prism'. This prism is the maximum time-space range over which a person is able to operate daily outside the home (Figure 4.2). The concept has been developed to show how such individual behaviour is set within its societal context (Pred, 1981a and 1981b; Thrift and Pred, 1981). There is a clear limit to the number of locations which people can reach in the public sphere given the practical and perceptual constraints with which they must manage:

> "An individual, bound by his [sic] homebase, can participate only in bundles [of activities] which have both ends inside his daily prism and which are so located in space that he has time to move from the end of one to the beginning of the following one. This means, for example, that if a doctor holds his clinic during the working hours of a patient, the latter cannot see the doctor except by obtaining permission to be absent from work" (Hägerstrand, 1970, p.15).

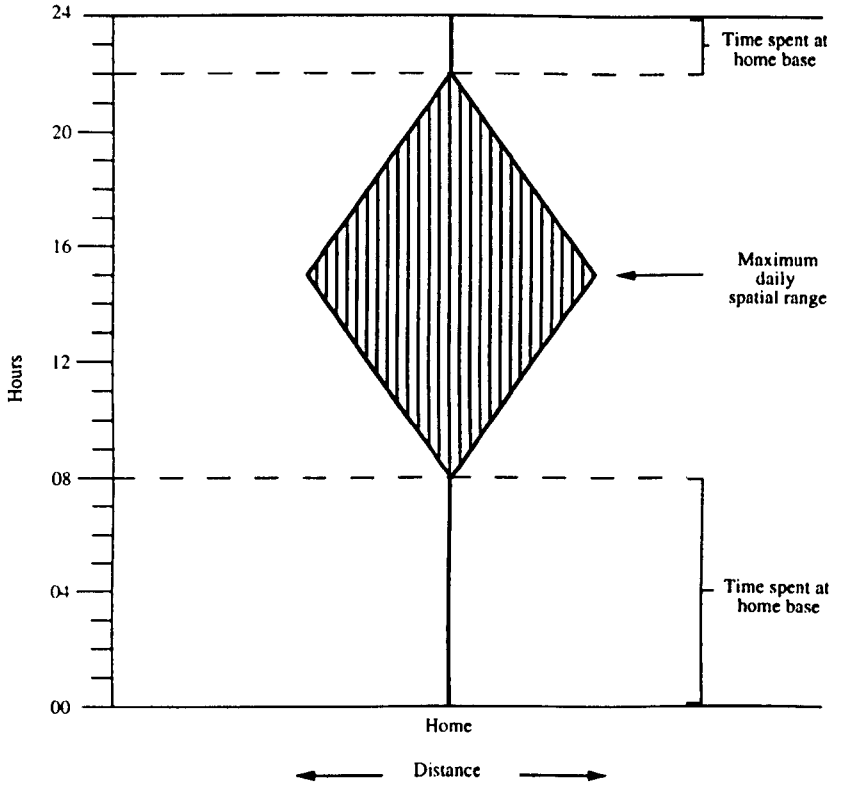


Figure 4.2 Individual Daily Range in Time-space

Source: Dicken and Lloyd, 1981.

It has been shown that, to a large extent, male-female variations in access to facilities in the public sphere depend on the contrasts in amount of time committed to the domestic sphere (eg. Tivers, 1978 and 1986). The requirement on many women to be at home at certain times during the day not only restricts the number of places to which they perceive it possible to travel in the public sphere but also the amount of time they can spend where they do go. Men travel further by virtue of their labour market participation and it follows that a mother with young children and no paid job will spend more time at home than her professional paid-working counterpart who is single and has no dependants.

For instance, there are four periods during the day when the woman shown in Figure 4.3 is at home. She does not have a paid job and her home-based activity is interrupted by the need to shop, to take her young children to and from school and to provide their lunches. The latter, especially, are activities which are fixed in time and space. In addition, since her partner has taken the family car to work, the larger supermarket is outside her daily range unless she goes in the evening when he returns home. Similarly, health care facilities may be beyond her daily reach if opening times and locations are not compatible with her other activities and lack of access to a private car. The afternoon opening of GP surgeries often coincides, for example, with times when children will be returning from school. Hamilton and Jenkins (1989) note also the inconvenience of taking young children on buses with one-person operation, high step height and inadequate luggage space especially when carrying heavy shopping. This may discourage women who do not

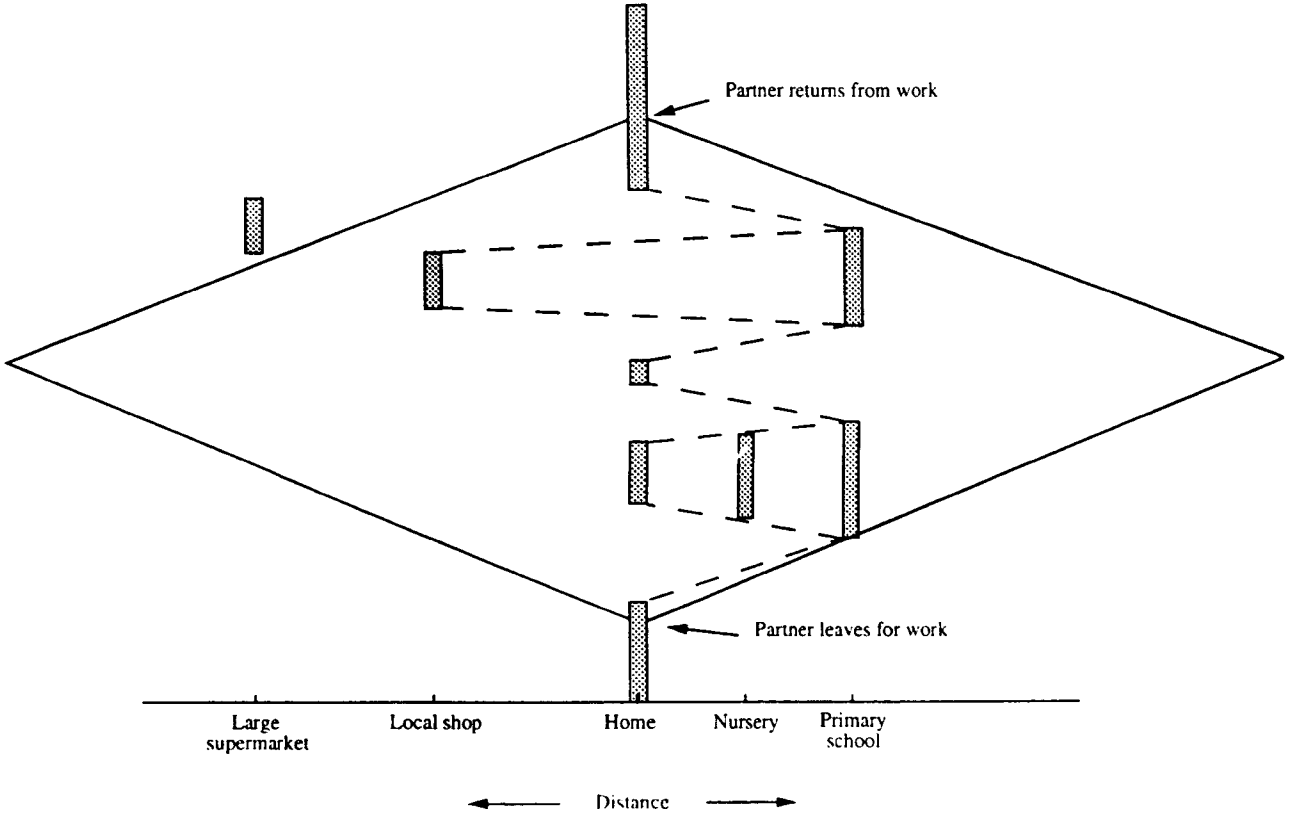


Figure 4.3 Daily Time-space Range of Mother with Young Children

Source: Dicken and Lloyd, 1981.

have the use of a car from combining routine health care attendance with other activities. In addition, problems when attending centralised hospital services:

> "... not only involve travel costs and the amount of time consumed but also the increased problems of scheduling of activities to gain access to more dispersed facilities ... problems in rescheduling activities can lead to additional anxiety and stress" (Pickup 1989, p.201).

The constraints are different and, possibly, greater, for a divorced or unmarried mother of young children who has to take paid employment outside the home in order to support her family. Both the variety of employment opportunities and access to facilities are limited by constraints of available childcare, school times and holidays. Studies have consistently illustrated the tendency for women who do combine work and caring responsibilities to do so close to home in order to accommodate childcare and domestic tasks (Hanson and Pratt, 1995; Jones, 1989; Rees and Willox, 1991). Focas (1989) found that proximity of workplace to place of residence was particularly important for some women of Asian origin and those with a disability. The limits on the time-space range of these women in the public sphere are almost as great as for those committed totally to the home:

> "Women with young children, in particular, show especially clearly the impact of time-space constraints on accessibility to sources of well-being. In most families in Western urban-industrial society [and elsewhere] the socially derived role of the woman is essentially child-centred. She has the primary responsibility for bringing up, and caring for, the children. Tivers (1977) coined the term 'gender-role constraint' to describe this role. Operating through the triad of time-space constraints it produces very limited spatial mobility ..." (Dicken and Lloyd, 1981, p.343).

The emotional and practical responsibilities of motherhood have been used as the main example in this sub-section because they so dramatically illustrate the constraints of caring on women's time-space flexibility whether in the domestic or public sphere. As noted in Chapter One, however, the mother role is not the only source of possible constraint. Pred and Palm (1978) provide several more cases to illustrate the different situations of various groups of women. They show how women can still be limited in their choices when children are older or they do not have children at all. New caring commitments to a parent or other relative may emerge as women age and the time constraints of not, for example, being able to leave an elderly person without company are obvious. Pensioners too face different constraints on their mobility and time-space flexibility as compared with younger people (Hillman, Henderson and Whalley, 1976).

4.4.2 Economic Resources and Choice in the Use of Time

By employing economic resources in particular, women are seen as being able to ameliorate the various time-space constraints imposed by social roles and health status. Women with a higher disposable income have greater scope to substitute paid cleaning, childcare and eldercare services in place of their own time input. They are also more likely to be able to afford the extra costs which can result from dependency, such as heating, dietary requirements, disability aids and household adaptations (Henwood and Wicks, 1985), without making cutbacks on other items. Compounding this is the fact that, amongst women in paid employment, work practices which help people to combine paid employment and caring responsibilities such as taking children to the GP are more available to those

in higher status clerical, personnel and managerial jobs (Christensen, 1993). A survey of flexible work practices by the Dawliffe Hall Educational Foundation (1991) found that major employers such as Boots Co and Rank Xerox UK only introduce schemes to help their employee carers when loss of individual employees comes to be seen as an issue of training and recruitment costs. Part-time hours in the retail trade have, on the other hand, to be fixed to coincide with peak business (Dombois and Osterland, 1987) and continuous flow production processes require synchronised operation on a daily and weekly routine such that flexitime could be accommodated only with difficulty. In a number of manufacturing sectors, there are even industry-wide regulations based on collective bargaining agreements which bar flexitime. This has come about because unions have often failed effectively to represent those people, usually women, who benefit most from innovations in working patterns (Garnsey, 1987).

Differences in sick pay provision may also be important to the health-related behaviours of paid-working women since they affect ready ability to take time off for illness or to match health facility opening hours. In all occupational groups except semi-skilled factory workers, fewer part-timers than full-timers are entitled to receive sick pay because of differences in the number of hours worked and length of service (Martin and Roberts, 1984). Amongst full-time workers, those in factory jobs are particularly poorly provided for and, amongst part-timers, sales and other semi-skilled workers are the most disadvantaged. Ninety percent of mothers, in the Martin and Roberts (1984) survey, said that they could easily take time off work in order to cope with a child's illness or attendance at the doctor, dentist or other

specialist. However, they were more likely to use annual leave or their own sick leave in order to do this without losing money. Thirty-four percent of part-time workers lost pay in these situations and only twenty-eight percent could make the time up. It seems reasonable to assume that a similar situation applies for women's own health care needs. However, most would probably be less willing to lose pay or holidays on their own behalf, particularly for non-urgent health care such as a preventative check-up (Pearson et al, 1993). Part-timers usually have fewer paid holidays than full-time workers. If they work shorter hours but not fewer days than full-timers and clinic opening times do not correspond to their hours away from work, they may not be able to take the time to attend. Since they do not usually have any employment rights such as sick pay or holiday leave, homeworkers generally lose money if they take time off to go to the doctor or for illness. As a result, these women may be deterred from anything other than vital health care use on their own behalf. Clearly, the part-time and casual nature of women's increasing participation in paid employment could have serious implications for their use of health services.

4.4.3 Economic Resources and Physical Mobility

Another way in which financial resources can ease decision-making constraints is by reducing the fear of unsafe areas (Pain 1991; Valentine, 1989 and 1990) and by easing the difficulty of scheduling spatially disparate activities (Jones, 1989). Access to a private car, for instance, provides security as well as the opportunity to save time by combining tasks in a single journey and using more efficient routes than when walking or taking public transport (Holzapfel, 1986).

Possession of a driving licence and access to a private car again vary amongst women depending on age group, whether or not they live in one or two parent families, employment status and position on the occupational hierarchy (Focas, 1989; Pickup, 1989; Rosenbloom, 1993). A telephone also allows people to interact without loss of time in transportation (Hillman, Henderson and Whalley, 1976). Doctors can often be consulted over the telephone if a family member has illness symptoms and most appointments to see a GP are made in this way. It has been shown already that women who cannot afford their own telephone at home are often deterred from contacting a doctor by the need to go out to a public pay-phone (Pearson et al, 1993). The fact that men often claim priority access to the family car by virtue of their need to drive to a job which is higher in status than the occupation, paid or unpaid, of their female partner (Hamilton and Jenkins, 1989; Whipp and Grieco, 1989) contributes to a circle effect of time-space restriction for these women. This is because locational constraints are placed on the woman's employment to within walking distance of home or an easy journey on public transport and her job choice is, therefore, limited to whatever is available (Women in Geography Study Group, 1984).

Women confined to the local area in this way are limited in their choice of types of health care. For instance, independent advice organisations, such as the Brook Advisory Service, are often situated in city-centre locations away from many residential areas. For women in paid employment, the location and timing of work would seem to be particularly important determinants of ability to overcome scheduling difficulties by chaining or linking trips. That is the combination of travel

to and from work with other household tasks such as shopping. This releases time for other activities not least health service use and lifestyle options such as exercise. In addition, some women are better placed to link health care attendance itself with work journeys. The timing of attendance at Well Woman Clinics in Liverpool shows a striking association with employment status (Pearson and Spencer, 1989; Pearson et al, 1990) as does use of preventative health services generally (Lutz, 1989). Others have speculated that the greater use of over-the-counter medication by employed women, as compared with 'housewives', may be a substitute for trips to the GP (Zadoroznyj and Svarstad, 1990). There were also specific differences in trip linking behaviour between single and married mothers in Rosenbloom's (1989) study. It follows that household situation may also affect ability to combine regular travel with health care use.

4.4.4 Social Networks and Time-space Flexibility

In the absence of available income as a means of managing constraints, social networks within the wider kinship structure and neighbourhood may be accessible to some but not to all women (Hosking, 1989). Grieco and Pearson (1991) found that one-parent and other low income households, often swop 'favours' as a means of releasing additional time resources through substitute care and transport provision. However, research amongst low income families on Merseyside (Pearson, 1991) shows that favours are considered reciprocal and, as a consequence, they are often saved for emergencies (Pearson et al, 1993). This places women in the awkward role of moral arbiter deciding the merits of competing health needs within the family. In certain social situations it seems that women afford low

priority to their own health needs in order to keep favours for use on behalf of children and other dependants. For instance, personal use of preventative health services was not seen as a legitimate reason to ask for help. It follows that the time-space constraints attached to a wider range of health-related behaviours may be perceived differently depending on which family member is involved. In households with acute scheduling problems, particularly those heavily dependent upon favours from the social network, the perceived benefits of health care may be outweighed by the social and financial costs incurred in its utilisation. The monetary, emotional and health costs paid by women on low incomes without kin networks may be even higher.

4.4.5 Implications for Household Health Needs

It is clear that scope for choice in time-space and ability to overcome temporal and spatial distance in the public sphere are largely dependent on flexibility to schedule competing everyday activities (Jones, 1989). The distance which women can cover to reach differentially provided health services, for example, will depend on the shape and amount of time and the combination of resources they have available. In general terms, the more easily a woman can fulfil her social role commitments, the freer she is to prioritise her own needs in general and specifically health-related needs. In particular, this would include healthy lifestyle behaviours and utilisation of preventative screening and non-emergency services. Scheduling choices must, however, be judged against the time-space frame of reference set by a woman's own health status and the division of resources, labour market participation and caring responsibilities in her household. Women are faced with

physical and perceptual access barriers to care seeking and other health-related behaviours as a result of such considerations and these may vary depending on whether their own or the health needs of a family member are at stake. For example, low-income women who lack access to private transport may chose to ignore symptoms in themselves. Faced with the same symptoms in a child and still unable easily to travel to the GP surgery they may overcome time-space constraints by calling the doctor out to the home.

The last point illustrates the extent to which it would be untrue to claim that all variation in time-space constraints and accessibility, for example to health care, is caused by straight-forward problems of physical mobility. As Rose (1993) argues, emotions and feelings of relation or attachment to others are vitally important in the social construction of time-space. In addition, there are other barriers to the use of space or facilities in the public sphere which stem from social and racial discrimination. This 'social distance' is particularly important in the context of health-related behaviours. People from ethnic minority backgrounds, the old, the less well-educated and those in the lower social classes may be prevented from accessing local health care. They can experience barriers of language or simply lack the confidence to communicate and assert their needs to the professional 'gate-keeper' of services.

It is vital to take on board these issues in order to build on the concept of time-geography or activity analysis in the context of women's management of household health-related behaviours. As noted in Chapter One, outcomes in time-

space can only be understood as specific articulations of contingent social and spatial relations and circumstances. Time-space is very much negotiated with attached and changing differential meaning. It is perceived differently by particular groups of women and by the same women in different situations. The level of priority which women afford to their own health needs must, therefore, be understood within the complex overall dynamic.

4.5 Summary and Questions Addressed by the Research

Given the central and increasing role of the family in responsibility for health and health care and given that 'family' very often means the female members, it is essential to examine the impact of household conditions and social relations on women's activities in order to unravel decisions about priority in health needs. What this chapter has aimed to highlight is the complex and diverse nature of the household as the context for such an exploration of choices in health management. It is clearly vital to set individual mechanisms for managing within the context of the wider social structures. Accepting this view that the household context for women's decision-making is complex, the chapter has provided a conceptual framework with which to approach the analysis. This is based on the framework of time, health, economic and social resource constraints shown in Figure 4.1 and the differential apportionment of labour demands and resources between women is what has been emphasised. Women's experiences of the, apparently, 'same' social role have been shown to differ across groups and across time and space. It is particularly clear that economic resources afford greater flexibility to overcome the constraints of time and health status in comparison with help from the social

network. The potential impact of these factors for time-space flexibility and, hence, health-related behaviours has been illustrated in the last section which pointed to the importance of subjectivity in decision-making.

A number of questions emerge from this discussion of women's management of household health needs in the context of everyday practical constraints. They can be summarised as follows:

i) Do women living with the associated time-space constraints of alternative social roles make different use of primary and secondary health services, whether for preventative, curative or emergency purposes, in response to their own health needs?

ii) Is there an order of priority for meeting the health needs of family members within the context of household processes surrounding health management?

iii) Are women in certain social situations free to make their own health needs more of a priority than others? For instance, can paid-working women with older children give greater attention to their own health needs than those with pre-school children to look after. Does having a partner in the same household make a difference to the health-related behaviour of carers?

iv) How, when and for whom are economic and social resources employed in order to reconcile conflicting social role demands and health needs?

v) How do decision-making processes vary around primary, secondary and emergency health service use?

This research aims to address these questions by bridging the approach of those who largely analyze health and social care as a set of supply and demand relationships and the more theoretically informed approaches which explore the complex causalities of social relations surrounding health-related behaviours. The aim is to develop an understanding of women's responses to symptoms and uptake of the various types of health care by exploring their decision-making using the contextual and conceptual framework provided. This framework is, therefore, reflected in the structure of the household-level interview analysis which is to follow. Chapter Seven will expand on the nature and interaction of social role and health constraints and Chapter Eight will deal with economic and social resources. Chapter Nine will outline the links between the general framework and health-related behaviours. Before moving to the household-level analysis, however, the next chapter will set out the methods adopted for the empirical phase of the research.

CHAPTER FIVE

RESEARCH METHODS

5.1 Introduction

As explained in Chapter One, the purpose of this research has been to examine processes of household health management in the context of contingent social relationships and circumstances in real time-space. Chapters Two-Four have examined those issues conceptually using existing literature. The rest of the thesis will address the same issues empirically through the lens of the everyday lives of women living in Liverpool. This chapter will, therefore, expand on the research tools employed for the empirical portion of the research:

i) the means for selection of the study areas (Section 5.2);

ii) methods for establishing the context of health care provision (Section 5.3);

iii) the design and analysis of the first-stage postal survey of women (Section 5.4);

iv) the selection of in-depth interview participants; and the intensive research techniques employed in those interviews (Section 5.5).

5.2 The Study Areas

The electoral wards of Netherley and Woolton in south west Liverpool were the areas selected for the empirical study. There were two key principles in the research design which led to this choice:

i) the necessity to include as wide a range as possible of women in the socio-economic circumstances typical of Liverpool; and

ii) adequacy of the localities chosen to control for difference in health service provision.

Housing-income/social areas based on the 1981 Census of Population (City Planning Department, 1984) were used as the means of selection in terms of the first criteria[8]. Four out of the city's five Social Area types are represented in the study areas (Figure 5.1). In Netherley, there are areas of Mixed Low Income Council/Low Income Terraced, Poorest Council and Medium Income Owner-Occupied Housing. In Woolton, Medium Income and Higher Income Owner-Occupied are the social types represented. Since the two wards are adjacent, the picture of health and social care provision was also geographically consistent. It was hoped that this would allow an effective assessment of the influence of social circumstances on health service use.

[8]Data from the 1991 Census of Population were unavailable at this stage. Subsequently, analysis has shown that social variety within and contrasts between Netherley and Woolton wards have changed little over the decade between Censuses (City Planning Department, 1993).

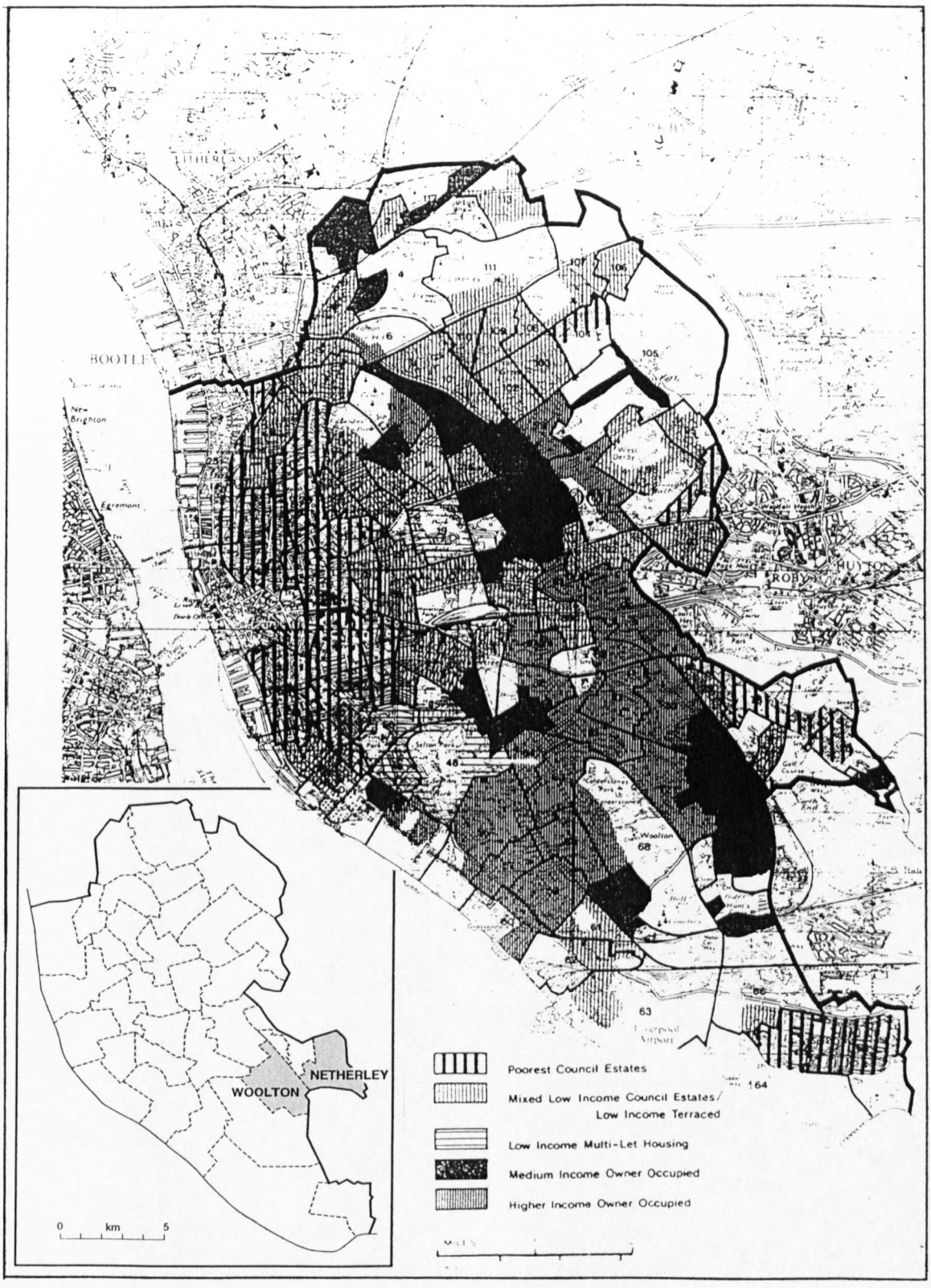


Figure 5.1 Liverpool Social Areas: April 1981

Source: City Planning Department, 1984.

It was decided not to include an area where respondents were likely to come from ethnic minority groups for a number of reasons. First, the relatively small black population in Liverpool is geographically concentrated in the Granby and Toxteth districts near the city centre (Table 5.1). If these localities had been selected, geographical consistency in service provision would have been lost because the medium and higher income areas are in the suburbs. Second, the Chinese, Asian and other ethnic minority communities make up even smaller proportions of the city's total population and are more widely spread geographically. It would have been difficult to select specific study areas in order to locate women from these groups. Third, it was difficult within the time and cost limits of a PhD project to translate and produce the postal questionnaire in languages other than English and to employ interpreters or substitute interviewers for follow-up interviews with those women for whom this was applicable. However, the approach taken here which considers the combined influence of social roles, income, social networks and health should be repeated and extended in this manner given appropriate resources.

Table 5.1 Ethnic Origin of Residents - 1991 Census of Population

ETHNIC GROUP	LIVERPOOL %	WOOLTON %	NETHERLEY %
White	96.2	96.3	97.9
Black	1.6		
Chinese	0.7		
		3.7	2.1
Asian	0.7		
Other	0.8		

Source: Shepton, 1994

5.3 Methods for Establishing the Context of Health Care Provision

The task in the initial stages of the research was to establish the picture of primary and secondary health care provision in and for the study areas. This involved interviews with health care professionals and managers from Liverpool Family Health Services Authority (FHSA), Liverpool District Health Authority (DHA), including the Public Health Department, and North Mersey Community (NHS) Trust. In the latter case, interviews were conducted with the overall Director of Services, the Women's Services Manager and the Locality Manager for Netherley and Woolton. The secretary of the Local Medical Committee, the representative body for general practitioners, was also contacted at this time.

Following the initial interview, Liverpool FHSA provided an up-to-date list of local GPs and their health promotion clinics. A brief outline detailing the research was sent to the main partner at the one health centre in Netherley and each of the four surgeries in Woolton together with a one-page questionnaire (Appendix 1). The questionnaire asked for details of the days and times of the general surgery as well as the system for appointments. It provided a list of the type and times of health promotion clinics and asked that this be amended where necessary. A practice leaflet was also requested. The aim was to undertake follow-up interviews either with GPs themselves or with practice managers. However, as is by no means unusual (see, for example, Murphy, 1992), just three surgeries returned the questionnaire and only two were willing to take part in an interview. These were Netherley Health Centre and Woolton Medical Centre. The latter is one of the first wave of five fund-holding practices in Liverpool. Interviews were carried out with

the practice managers in both cases and issues relevant to health care uptake in the local areas were discussed. Problems were encountered in gaining access to the other surgeries as the GPs were unwilling to participate prior to approval for the research being granted by the Local Medical Ethics Committee. It has to be recognised, therefore, that the picture of local provision of primary care was partial to say the least.

It had also been intended to negotiate access to the patient records of participating surgeries in order to expand the background picture of health care use by local women and raise issues for the subsequent in-depth interviews. Given that the original intention was only to complement the interviews, the decision not to proceed had little effect on the research as a whole. There is, however, an important lesson to be taken from this experience. Researchers should be fully aware of the role of Local Medical Ethics Committees (Abrams, 1991; Moodie, 1992) and should carefully plan and timetable their proposed project appropriately. In my case, the committee took ten months to agree the protocol. This meant that it was no longer feasible to contact more surgeries or examine patient records if the research was to remain on overall schedule.

5.4 Methods for Locating an Interview Group

5.4.1 The Postal-questionnaire - Design and Sampling

The next stage of the research involved locating women who represented the broad spectrum of social circumstances in the study areas. A short postal questionnaire was employed for this purpose (Appendix 2A) the format of which

was based on the General Household Survey (OPCS, 1973, 1986, 1987 and 1989), the Health and Lifestyles Survey (Cox, 1987), a smaller-scale survey of health service uptake on the Isle of Man (Pearson and Dawson, 1991) and other sources (Fitzpatrick, 1991). The questionnaire was conceptually informed by the issues which emerged from the review of literature outlined in Chapters Two-Four. It aimed, therefore, to establish the following characteristics and contingent circumstances of respondents:

i) labour market position and caring responsibilities;

ii) marital status, household structure, age and ethnic origin;

iii) economic and social resources;

iv) short and long-term health and recalled use of health care.

The 516 women to whom the questionnaire was mailed constituted five percent of the total female population of Netherley and Woolton. They were selected randomly from the electoral register[1] and the sample was proportioned on the basis of the percentage of the female population of the two wards living in the various social areas outlined in Section 5.2. It was possible to establish the number of women electors in each social area by matching Figure 5.1 to electoral divisions as shown in Figure 5.2. Where electoral divisions crossed social area boundaries, which occurred in two out of ten cases, an ordnance survey map was used to determine the appropriate split.

[1]The electoral register was chosen as the means of contact despite the potential bias introduced by non-registration related to the Community Charge. This was in order to counter likely objections from the Local Medical Ethics Committee to the alternative which was to contact people by virtue of their NHS registration.

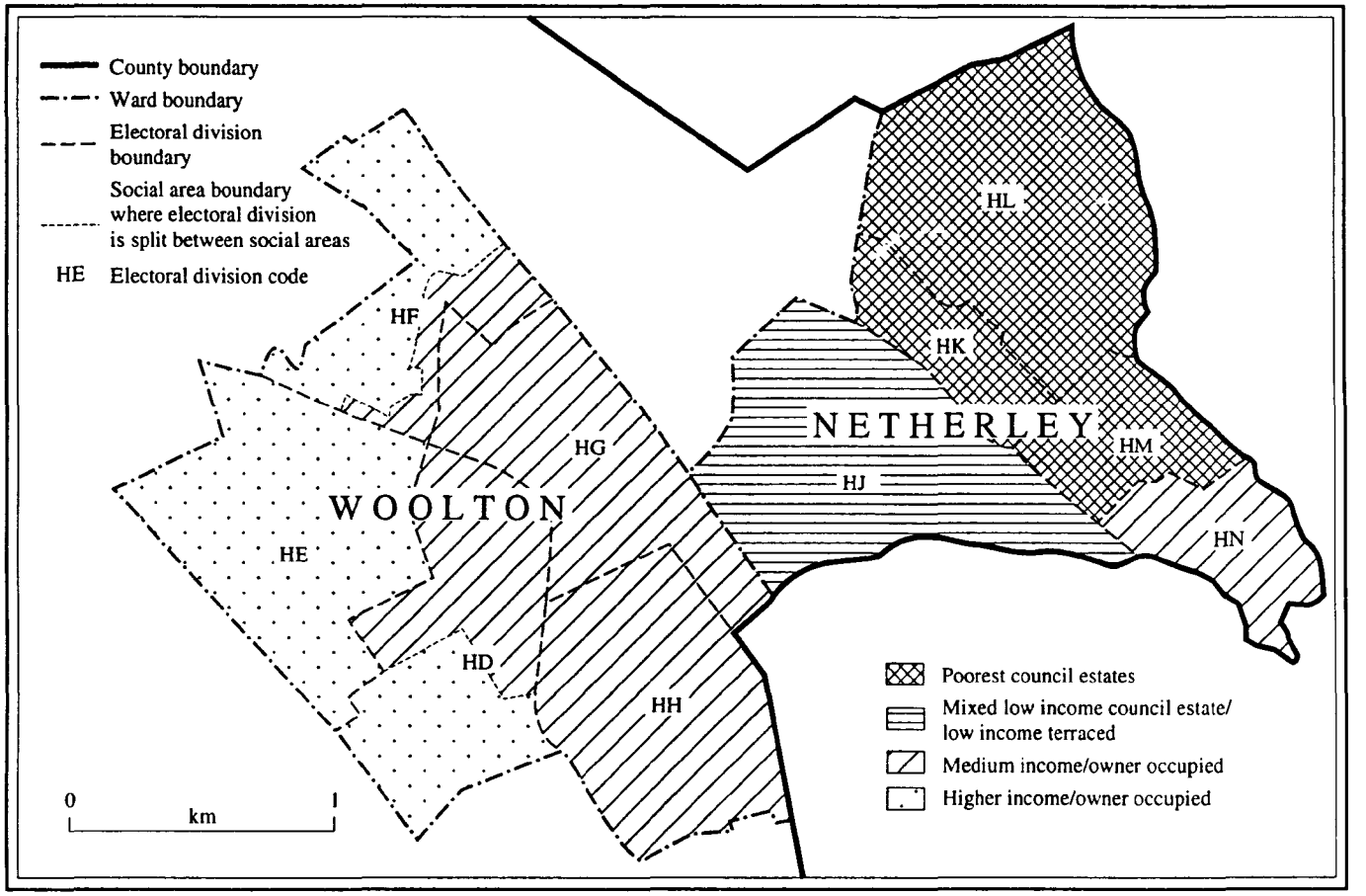


Figure 5.2 Key to Stratification of Postal Questionnaire

A stratified sampling design was chosen because sub-groups of the overall population defined by social area were expected to differ from each other in ways important to the study. These included the number of young children being cared for, age of the population, employment characteristics, income and car ownership and health status. Simple random sampling is more likely to locate a respondent group clustered into one or two sections of the population only, whereas stratified sampling ensures that respondents cover the range of social characteristics. Systematic sampling had the disadvantage that, once the first individual is chosen, all the others are fixed. The list of names on the electoral register are arranged in order corresponding to position along the street and, as Dixon and Leach (1978) point out:

> "... taking a sampling interval with an even number might produce a sample consisting entirely of the left-hand pair of semi-detached houses, which might be different in size and other important features" (ibid, 1978, p.14).

For the purposes of selection, random numbers were generated and the corresponding name taken from the electoral register. If this did not belong to a woman then the name above was taken consistently. Rest and retirement homes are listed separately on the register. These were excluded from the population eligible for sampling because their residents are predominantly over retirement age and the eventual aim of the research was to locate women of working-age. Older women have been shown to experience very different health problems and make different use of health services as compared to their younger counterparts (Arber and Ginn, 1991). There was simply not enough scope in the timescale of the research to examine the different range of constraints facing older women. The areas of Mixed

Low Income Terraced/Council Estates and Medium Income Owner Occupied housing in Netherley were 'over-sampled' because their populations were so small. It was hoped that contacting more women than the stratified sampling design strictly required would raise the chances of the respondent groups being proportionate to the share of the overall ward population living in those areas.

5.4.2 The Social Exchange Context for the Postal Questionnaire

> "The process of sending a questionnaire to prospective respondents, getting them to complete the questionnaire in an honest [sic] manner and return it can be viewed as a special case of social exchange ... The theory of social exchange ... asserts that the actions of individuals are motivated by the return these actions are expected to bring and, in fact, usually do bring from others ... It is assumed that people engage in any activity because of the rewards they hope to reap, that all activities they perform incur certain costs, and that people attempt to keep their costs below the rewards they expect to receive ... Thus there are three things that must be done to maximise survey response: minimise the costs of responding, maximise the rewards of doing so, and establish trust that those rewards will be delivered" (Dillman, 1978, p.12).

It is feminist scholars who have most often expressed the need to 'give something back' and not to exploit 'the researched' (Reinharz, 1983). The language used by Dillman (1978) and other influential proponents of mailed surveys (Roeher, 1963) almost suggests, however, that costs to respondents should be considered solely in relation to the appropriation of completed questionnaires. For the purposes of this research, the methods proposed by Dillman (1978) were utilised but they were modified and some were omitted in order to show as much regard as possible for the women concerned. As Maynard and Purvis (1994) have argued:

> "... much effort has been expended by feminists in adapting the traditional interview format to comply with feminist research practice. Perhaps it is now time to consider transforming questionnaire and survey methods, making them sensitive to feminist

> principles concerning how to treat participants and how to use the information to which their testimonies give rise" (ibid, 1994, p.4).

It is hoped that the objections of feminists and others to exploitative research techniques were in some way addressed in the mail survey employed here.

Measures taken included phrasing questions in a way that was accessible to respondents with possibly varying reading skills. The questionnaire was designed using MacDraw II for easy-read appearance and went through several draft stages in order to make it as short and 'friendly' as possible. It was piloted with mothers of children who attend the University of Liverpool Creche as well as a second nursery in the city. These women were asked to add comments on the ease of filling out the answers, wording of questions and overall layout and to state any issues for inclusion at the interview stage. Changes were made which included layout modification and the addition of a question which asked about use of other health services such as well woman clinics. Answer categories which appeared ambiguous and open to different interpretations were altered. For example, different people may give alternative meanings to the terms 'unemployed' and 'registered unemployed'. The latter was the category used in the final questionnaire in order to locate women actually receiving social security payments. Questions directly related to income level were considered by the pilot respondents to be too personal and likely to deter a response. They were, therefore, omitted from the final version of the questionnaire.

Other measures aimed at showing positive regard for respondents included fully explaining the study (Sobal, 1984), thanking in anticipation for help received,

assuring confidentiality and using personalised greetings and an individual signature on the covering letter (Appendix 2B). It was explained that because the women asked to participate were part of a small, carefully selected group their response was vital to the success of the study. The University of Liverpool logo was used in the hope that this would establish the 'legitimacy' of the project. In order to avoid any sense of depersonalisation, the envelopes were addressed by hand and sent using a First Class postage stamp as opposed to a franking machine. A stamped addressed return envelope was also provided.

5.4.3 Response Rates to the Postal Questionnaire

Reminders were sent out at two-week intervals to non-returners in the hope of raising the response rate. The first took the form of a postcard and the second was a further letter and copy of the questionnaire (Appendices 2C and 2D). On these occasions address labels and the university franking machine were used as it was felt that any benefits of personalisation would only be gained at the first mailing. The fourth and final mailing by certified mail suggested by Dillman (1978) was omitted because, as Nederhof (1988) points out:

> "... the use of certified mail has some important drawbacks. The requirement of signing for receipt is a coercive element, and the costs for the respondent will be even larger if he or she has to go to the post office in order to get the questionnaire. In addition to the costs of time and money which this involves, anxiety may have been created on the part of the respondent ..." (ibid, 1988).

Although Dillman and Makela (1984) suggest that omitting the fourth reminder will substantially reduce the overall response rate, this did not appear to be the case in the present study. Table 5.2 shows the percentage of the original mailing returned as completed questionnaires which it was possible to use in the subsequent analysis

for each of the social areas in Netherley and Woolton. The figures were relatively consistent across the social areas ranging from 60 percent in the Higher Income area of Woolton to 66 percent in the Medium Income area of Netherley.

Table 5.2 Response to Postal Questionnaire by Social Area

AREA	NUMBER MAILED	% INCLUDED IN ANALYSIS
Netherley - Mixed Low Income Council Estates/ Low Income Terraced	50	64 (N=32)
Netherley - Poorest Council Estates	80	60 (N=48)
Netherley - Medium Income Owner Occupied	50	66 (N=33)
Woolton - Medium Income Owner Occupied	211	65 (N=137)
Woolton - Higher Income Owner Occupied	124	60 (N=74)
TOTAL	516	324

Reminders were important because, as Evans (1991) points out, non-response is one of the main sources of bias in a sample:

> "Using available resources to take a random sample and then pursuing these chosen subjects intensively with repeat letters, telephone calls and so on to obtain a high response rate is preferable to dissipating resources in mass mailings ... Small random samples with high response rates are more valuable than large non-random samples or those with low response rates" (ibid, 1991, p.303).

The women were asked at both the first and second mailings to confirm if they did not want to take part in the study by sending back the blank questionnaire. Ninety-five (18 percent of the original mailing) took this opportunity to avoid receiving

reminders. Table 5.3 shows the overall distribution of questionnaire response categories. If the categories such as 'Returned Blank' were used in the calculations, therefore, the response rates in the social areas would be even higher than those shown in Table 5.2. Overall there were 9922 women on the electoral register in Netherley and Woolton. Questionnaires were mailed to 5 percent of these women and replies included in the analysis represented 3 percent. It is hoped that, by sending reminders, as wide a sample as possible of social variety across the two wards was obtained. Finally, all of the respondents who returned a completed questionnaire, whether or not it was included in the analysis, were sent a postcard thanking them for their help (Appendix 2E).

Table 5.3 How the Postal Questionnaires were Accounted

RESPONSE CATEGORY	% QUESTIONNAIRES MAILED
Included in Analysis	62.8 (N=324)
Completed - Not Analyzed*	2.9 (N=15)
Returned Blank	18.4 (N=95)
Returned as 'Moved Away'	3.9 (N=20)
Deceased	1.2 (N=6)
Unaccounted	10.9 (N=56)
TOTAL	100.0 (N=516)

* Questionnaires not included in analysis because completed by women who had moved away from the area.

5.4.4 Respondent Groups and Interview Participants

As noted in Chapter One and in line with the realist position, it was never the intention to test relationships statistically across the data generated by the postal

questionnaire respondents. Instead the aim was to locate households in meaningful causal groups and contingent circumstances in order appropriately to select a cross-section of participants for the second-stage intensive interviews which examined the real everyday processes of health management. The survey was intended only as a preliminary examination of the patterns of health and characteristics of social roles and key resources facing women in the study areas. The point was to identify groups of respondents located at different positions across the contingent framework of time-space constraints and freedoms conceptualised in Chapter Four (Figure 4.1). Interview participants could then be sampled theoretically (Finch, 1987b) or selectively (Schatzman and Strauss, 1973 quoted in Strauss, 1987) on the basis of the characteristics of the respondent group rather than their statistical representativeness of a wider population.

5.4.5 Correspondence and Hand Analysis of the Postal Survey

In order to identify such theoretically-informed groups for subsequent intensive research, the data set generated by the postal survey was analyzed simultaneously by hand and using the technique of Detrended Correspondence Analysis (DCA) on computer (Greenacre, 1984; Hill, 1973; Gauch, Whittacker and Wentworth, 1977). Both methods were employed in order that one might verify the other and the schema used is set out in Figure 5.3. Correspondence Analysis is a technique not out of character with realist philosophy because it privileges difference rather than similarity and relation rather than association (Phillips, 1994). The aim is to summarise and reveal mutual relationships between variables of different kinds in an exploratory and descriptive rather than predictive manner. Attention is

focused on inter-relationships between all the variables without regard to such distinctions as dependent and independent variables (Weller and Kimball Rouney, 1990). The technique describes deviation from independence whether or not that deviation is statistically significant.

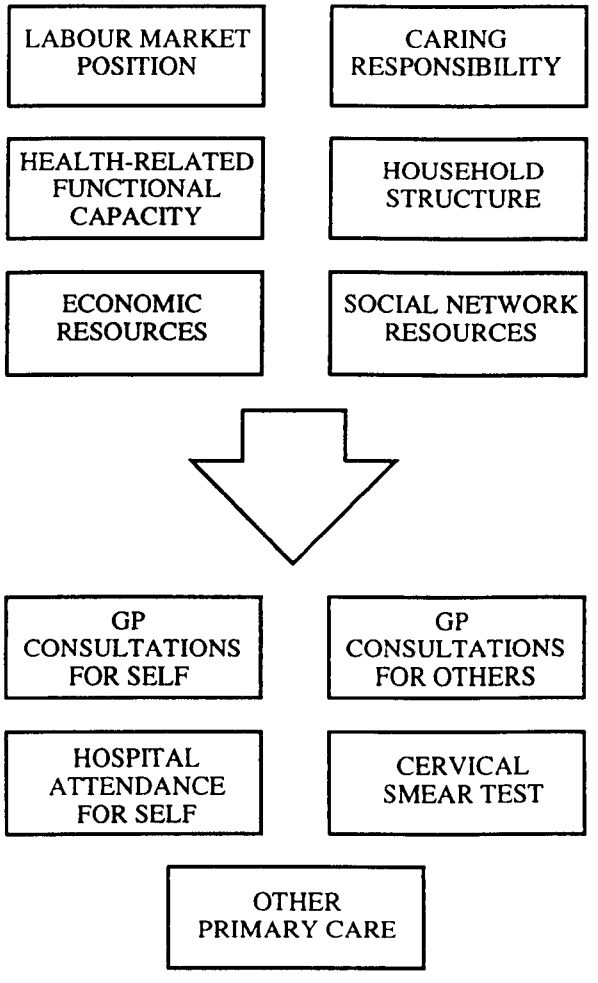


Figure 5.3 Schema for Postal Questionnaire Analysis

Correspondence Analysis has the advantage over similar statistical techniques such as Principal Components Analysis because it produces a three-dimensional point representation of cases and attributes (column and row variables of a two-way contingency table) located in the *same* relational (or eigen) space[10].

> "It can be thought of as trying to plot a cloud of data points (the cloud having height, width and thickness) on a single plane to give a reasonable summary of the relationships and variation within them" (Phillips, 1994, p.2).

The eigendistance between points represents the degree of correspondence between their characteristics. Individual variables, specific cases or variables and cases will exhibit correspondence if their representative points are close together. Points will be further apart if they correspond less closely. Women who are 'ordinated' or located neighbouring each other will, therefore, exhibit correspondence in terms of their characteristics as identified by the postal questionnaire.

The variables used in the Correspondence and hand analyses are shown in Appendix 3. The majority were coded directly as they appeared on the questionnaire. A number were, however, derived separately. The job description given by respondents in paid work was, for instance, assigned a Standard Occupational Classification code (Employment Department and OPCS, 1990) in order to obtain their Socio-economic Group (SEG). SEGs were chosen because they have been shown to reflect women's employment more accurately than classifications of Social Class although they are still inadequate (Moser and Goldblatt, 1990). The ages of children living in respondents' households were

[10]Detrended Correspondence Analysis has been further developed from the original technique in order to overcome difficulties identified in the plotting procedure (Hill and Gauch, 1980).

classified by school-age as it was felt that this would be a major cause of variation in shape of time constraints. Responses to the questions about social network resources and car ownership and usage were also combined respectively to reflect levels of support and access.

For the 'hand' analysis, a 'characteristics card' was written out for each respondent. These were then sorted into smaller and smaller groups based on the differential nature of the women's labour market and caring responsibilities, their health status and so on. The number in each of the final groups is indicated in brackets at the bottom of Figures 5.4a and 5.4b which summarise the process. In the Correspondence Analysis, the responses of all 324 respondents were examined together initially. From this first set of ordinations, two initial distinct groupings of women were identifiable by their code labels (not shown on diagrams). Those with paid jobs, part-time or full-time, constitute the smaller group and those without jobs constitute the larger group in Figure 5.5. The latter were also primarily ordinated in terms of their 'relationship to the labour market' in categories such as 'Income Support', 'Looking after home' or 'Retired'. This confirmed the clear split based on employment status identified in the hand analysis.

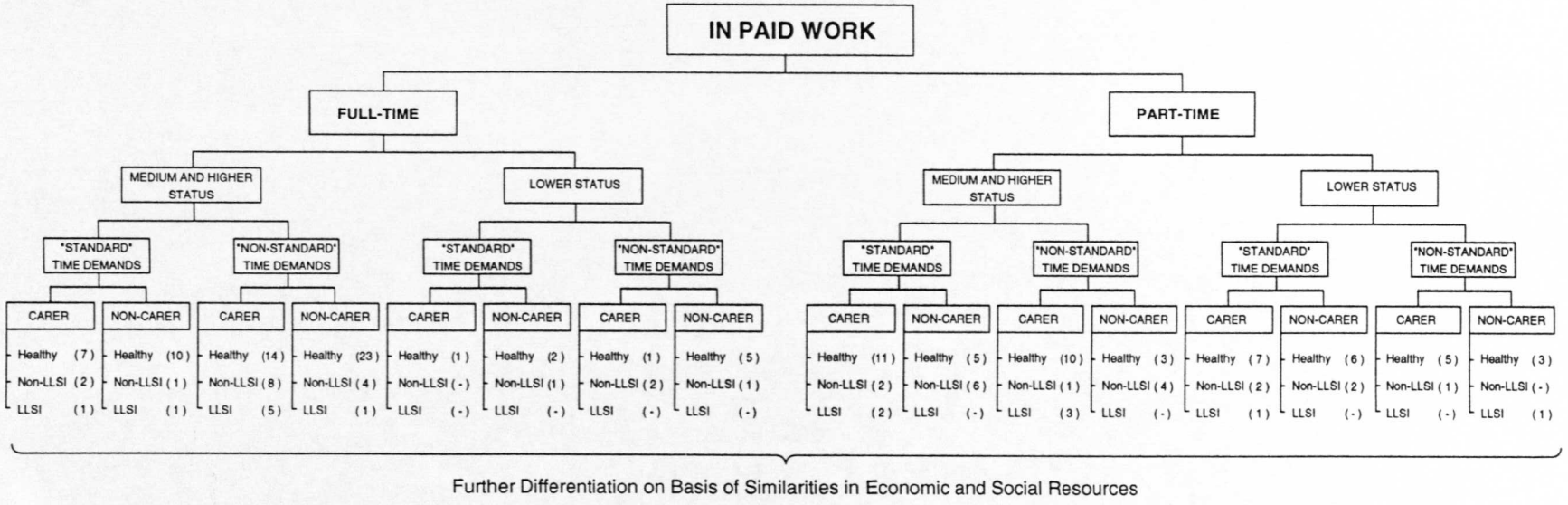


Figure 5.4a Postal Questionnaire Analysis - Women in Paid Work

Notes:

Medium and Higher Status categories include women whose jobs are in SEGs 1, 2, 3, 4, 5 and 6. Lower Status categories include women whose jobs are in SEGs 7, 10 and 11.

"Non-Standard" Time Demands include one or more of the following: overtime, shift work, working at home and being on call. Jobs with "Standard" Time Demands do not involve these types of working.

Carers are those with responsibility for any combination of the following: pre-school, primary or secondary school-age children and a sick, elderly or disabled dependant at home or living in another household.

LLSI = Limiting long-standing illness. Non-LLSI = Long-standing illness which does not limit activities. Healthy women are those who do not have a long-standing health problem.

Economic resources refers to housing tenure and car and telephone ownership. Social resources refers to whether a woman receives help from friends and relatives ocasionally, regularly or not at all.

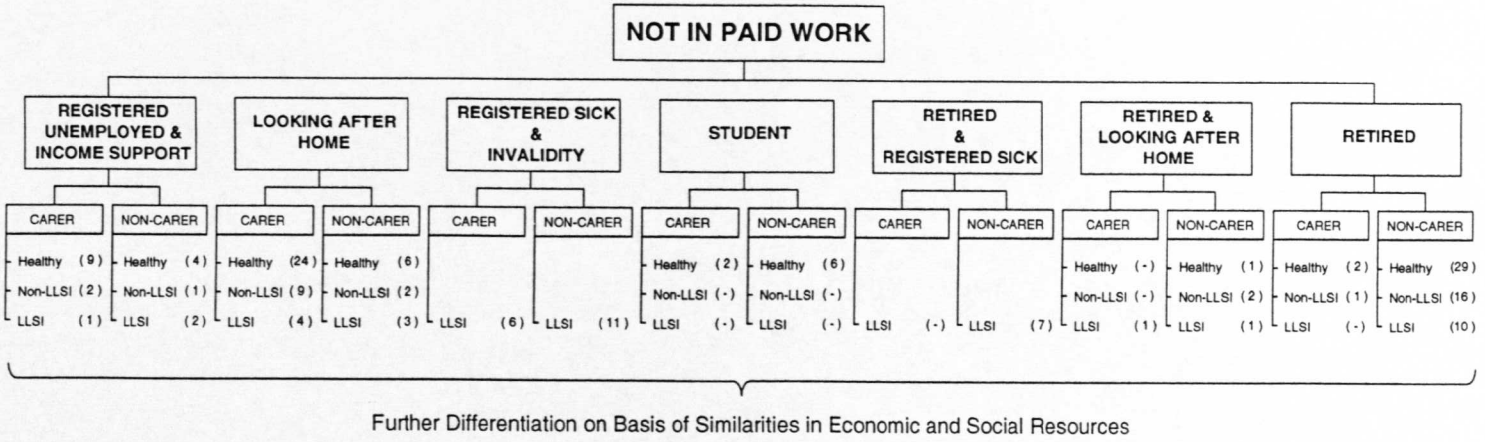


Figure 5.4b Postal Questionnaire Analysis - Women not in Paid Work

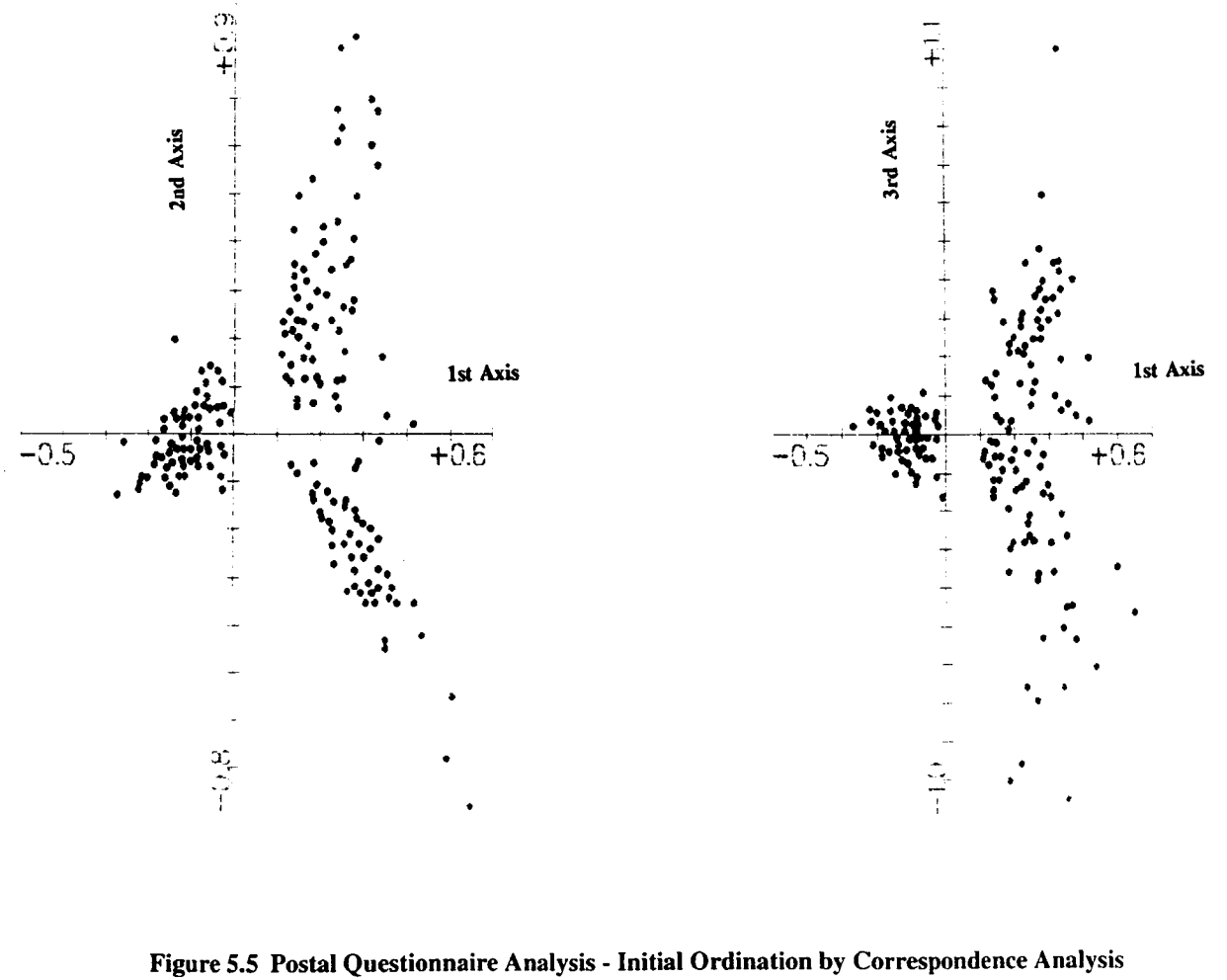


Figure 5.5 Postal Questionnaire Analysis - Initial Ordination by Correspondence Analysis

Because the computer graphics package (CANODRAW) was not designed to handle such a large number of cases it was impossible to differentiate further at this stage. Subsequent analysis was, therefore, carried out on the two 'labour market groups' separately. This:

> "... collapsing of tables is a frequently recommended procedure resulting in clearer results and little loss of information" (Weller and Kimball Rourney, 1990, p.59).

Once again, the results confirmed the distinctions based on type of caring responsibility, employment and health status and resources shown in the hand analysis. Figures 5.6a and 5.6b show the variables with their code labels in addition to points which represent the women themselves. Several women were less tightly associated with the group cores especially when the ordinations were viewed on different planes simultaneously. Even though DCA is vulnerable to 'outliers' in the data sets, Aldenderfer and Blashfield (1984) emphasise the point that outliers:

> "... may in fact be representative of poorly sampled subgroups of cases" (ibid, 1984, p.61).

Overall 241 respondents were under sixty years of age. The 83 who were sixty or more were excluded at this stage of the research. This group included the 6 who were above retirement age but still in paid employment. As explained earlier, it was always the intention to locate women of 'working-age'. If those above retirement age in paid employment had been asked for an interview, then the other older women would have had to be included too. The interview participants were, therefore, selected from women under the age of sixty.

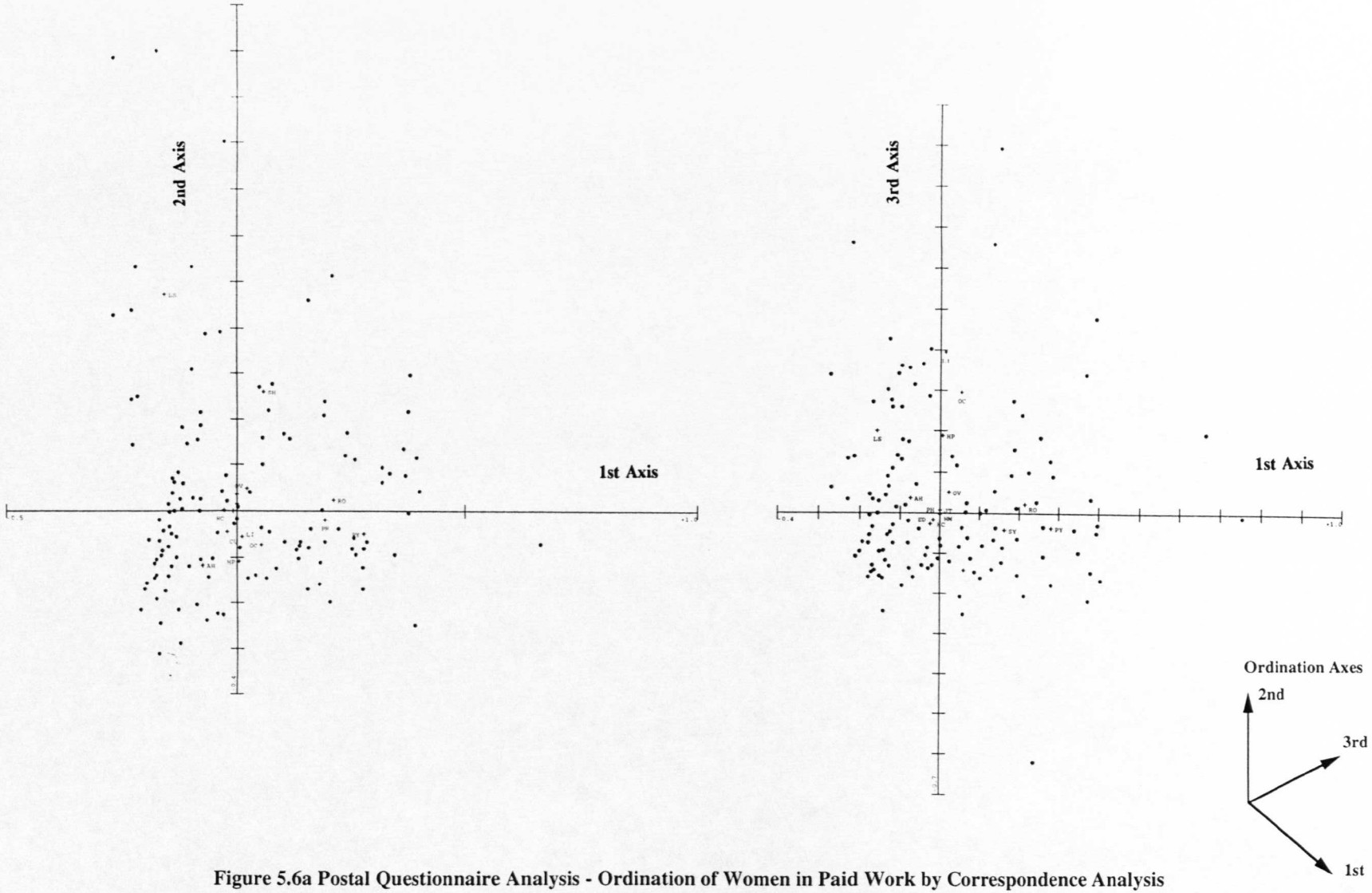


Figure 5.6a Postal Questionnaire Analysis - Ordination of Women in Paid Work by Correspondence Analysis

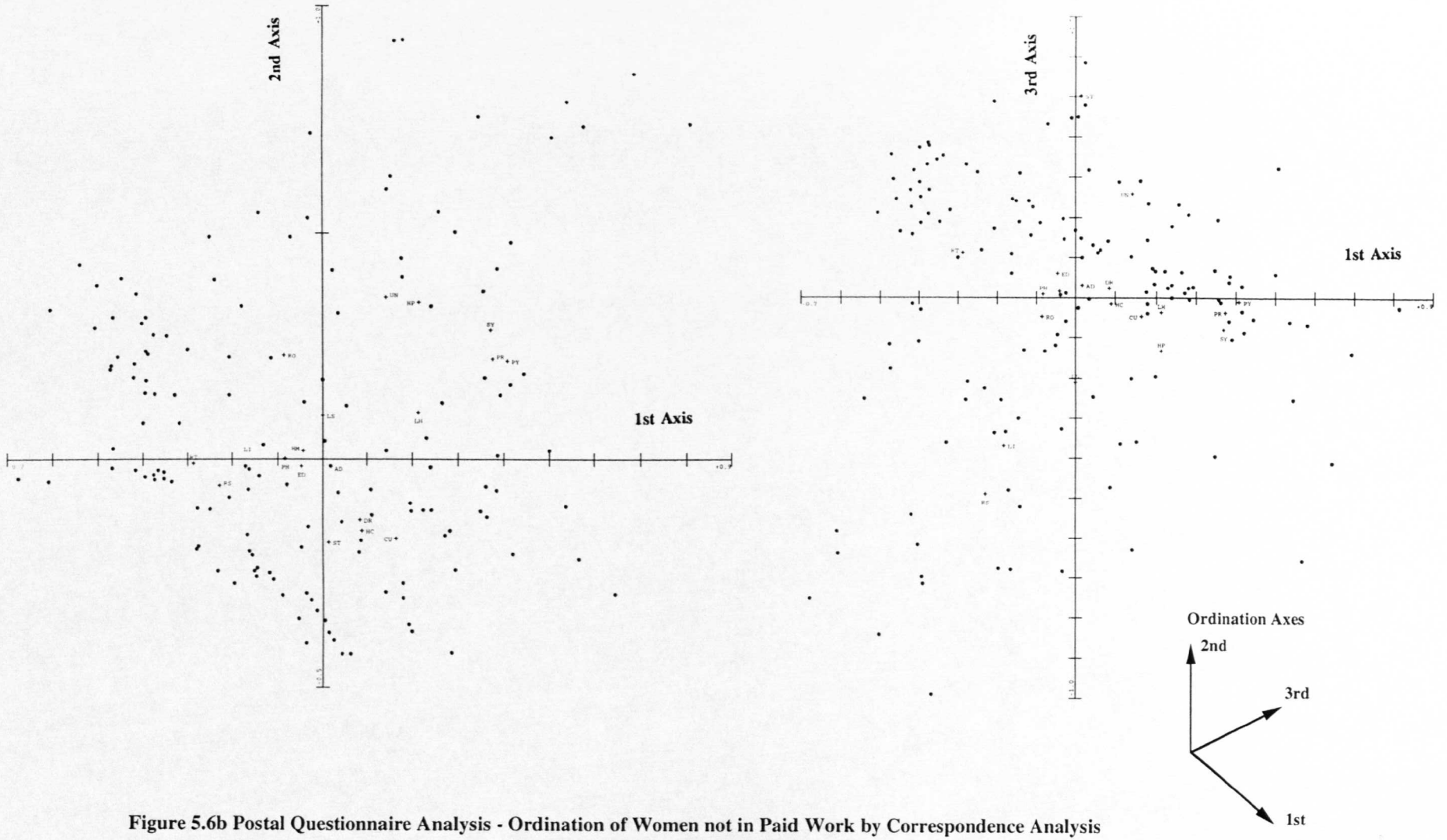


Figure 5.6b Postal Questionnaire Analysis - Ordination of Women not in Paid Work by Correspondence Analysis

5.5 Methods for Exploring Individual Health Management Strategies

5.5.1 Issues Raised by the Postal Survey for the Intensive Research

The postal questionnaire responses were also examined for issues which could be followed up in the in-depth interviews. As Figure 5.3 indicated and in keeping with the realist position, this initial work explored only the apparent patterns between the identified groups and the following types of health care use: i) number of GP consultations in the last six months concerning personal heath; ii) number of GP consultations in last six months concerning the health a person living in the same or another household; iii) hospital attendance by the woman in the last twelve months; iv) length of time since last cervical smear test (< 3 years, 3-5 years, 6-10 years or > 10 years); v) use of any other type of health care such as chiropody, physiotherapy, breast screening and well woman clinics.

The patterns revealed were interesting from a number of viewpoints. One group identified comprised 27 full-time paid workers in medium and higher status employment which involved extra or non-standard working hours. They also had caring responsibilities. Five of these women had a long-standing illness which limited their activities and an additional eight had a non-limiting long-term health problem (Table 5.4). In each case, the condition could have been stress-related (high-blood pressure, migraine and asthma) or work-related physical strain (back and neck problems). Carers in medium and higher status full-time paid work, who were working standard hours only, did not have the same rates of long-standing illness. This was also true for the groups without caring responsibilities which included single and married professionals and middle-aged non-professionals.

Table 5.4 Incidence of Long-standing Illness amongst Full-time Paid Workers

CARING/PAID WORK STATUS	NO. WITH LIMITING LSI	NO. WITH NON-LIMITING LSI	NO. WITHOUT LSI
Carers in 'Medium/Higher Status' paid work with 'standard' hours (N=10)	1	2	7
Non-carers in 'Medium/Higher Status' paid work with 'standard' hours (N=12)	1	1	10
Carers in 'Medium/Higher Status' paid work with 'non-standard' hours (N=27)	5	8	14
Non-carers in 'Medium/Higher Status' paid work with 'non-standard' hours (N=28)	1	4	23
Carers in 'Lower Status' paid work with 'standard' hours (N=1)	--	--	1
Non-carers in 'Lower Status' paid work with 'standard' hours (N=3)	--	1	2
Carers in 'Lower Status' paid work with 'non-standard' hours (N=3)	--	2	1
Non-carers in 'Lower Status' paid work with 'non-standard' hours (N=6)	--	1	5
TOTAL	8	19	63

Notes: 'Medium/Higher Status' includes SEGs 1,2 Employers and Managers, SEGs 3,4 Professional Workers, SEG 5 Intermediate Non-manual Workers and SEG 6 Junior Non-manual Workers.

'Lower Status' includes SEGs 7,10 Personal Service and Semi-skilled Manual Workers, SEG 11 Unskilled Manual Workers and SEGs 16,17 Inadequately Described Occupations.

'Non-standard' refers to women on call or working overtime, shifts or at home. 'Standard' refers to those who do not work extra hours.

Numbers in some groups were too small to allow calculation of percentages.

Table 5.5 Incidence of Long-standing Illness amongst Part-time Paid Workers

CARING/PAID WORK STATUS	NO. WITH LIMITING LSI	NO. WITH NON-LIMITING LSI	NO. WITHOUT LSI
Carers in 'Medium/Higher Status' paid work with 'standard' hours (N=15)	2	2	11
Non-carers in 'Medium/Higher Status' paid work with 'standard' hours (N=11)	--	6	5
Carers in 'Medium/Higher Status' paid work with 'non-standard' hours (N=14)	3	1	10
Non-carers in 'Medium/Higher Status' paid work with 'non-standard' hours (N=7)	--	4	3
Carers in 'Lower Status' paid work with 'standard' hours (N=10)	1	2	7
Non-carers in 'Lower Status' paid work with 'standard' hours (N=8)	--	2	6
Carers in 'Lower Status' paid work with 'non-standard' hours (N=4)	1	--	3
Non-carers in 'Lower Status' paid work with 'non-standard' hours (N=3)	1	--	2
TOTAL	8	17	47

Amongst the 72 women in part-time paid work, seven out of the eight with a limiting long-standing illness also had caring responsibilities (Table 5.5). The groups with the highest prevalence of non-limiting long-standing illness were,

however, those without any caring responsibilities at all. Those part-time paid workers without caring responsibilities also reported relatively high levels of GP consultation on their own behalf. 59 percent had consulted about their own health in the last six months compared with 44 percent of part-time workers with caring responsibilities (Table 5.6). 64 percent of part-timers who had consulted three or more times were also accounted for amongst the non-carers. Could it be that ill-health had 'selected' these women into part-time paid labour and a low level of caring responsibility? Was this all they could manage under the circumstances?

Table 5.6 Number who had Consulted GP in Last Six months - Personal Health

CONSULTATION	FULL-TIME PAID WORKERS		PART-TIME PAID WORKERS	
	CARERS (N=41)	NON-CARERS (N=49)	CARERS (N=43)	NON-CARERS (N=29)
No. Not Consulted	16	19	24	12
No. Consulted	25	30	19	17
No. Consulted > 3 Times	8	9	4	7

Interestingly, the majority of the ninety women across all of the groups in full-time paid work reported a similar figure of one to two GP consultations for own health in the last six months. Ten of the women had, however, consulted between three and five times despite stating that they had no long-term illness troubling them. Over half (56 percent) of the forty-three part-time paid workers with caring responsibilities had, at no time, talked to a doctor about their own health in the last

six months. This applied to just 39 percent of the forty-one full-timers in the same situation. Was it the case that part-time commitment to the paid labour market relieves at least some of the pressures on health? Alternatively, were full-time workers in Netherley and Woolton, like those in other Liverpool studies (Pearson and Spencer, 1989; Pearson et al, 1990), better placed to fit GP attendance around trips to and from work? Were trips to part-time jobs being made in the middle of the day or in the evening when GP surgeries are closed?

Differences in consultation patterns *within* each of the groups of women with caring responsibilities also seemed interesting (Tables 5.7 and 5.8). Just over half of the carers with full-time or part-time jobs and three-quarters of those looking after the home, had consulted a GP on behalf of people they did or did not live with. A quarter of the part-timers and the women at home had talked to a doctor on someone else's behalf but not their own. This compared to just a sixth of full-timers. Only a small number of women had consulted for themselves and no-one else, although the figure did amount to one quarter of full-timers with caring responsibilities. The questions raised for the in-depth interviews by these patterns of consultation were as follows: Does difference in health status alone explain these contrasts? Under what circumstances do women ignore their own heath needs? Under what circumstances do women consult a doctor on behalf of the people they care for? Could health problems be tackled at a joint consultation with children or not? Do variations in the difficulties experienced in scheduling activities across paid labour and/or caring commitments account for some of the differences in consultation rates on behalf of other people?

Table 5.7 Number who had Consulted a GP in Last Six Months - Carers

	SELF ONLY (N=18)	SELF & OTHERS (N=47)	OTHERS ONLY (N=28)	NO ONE (N=28)
Full-Time - 'Medium/Higher Status' (n=37)	6 (1)	15 (10)	7 (6)	9 (6)
Full-Time - 'Lower Status' (n=4)	2 (2)	1 (1)	1 (-)	-
Part-Time - 'Medium/Higher Status' (n=29)	2 (-)	9 (7)	9 (4)	9 (3)
Part-Time - 'Lower Status' (n=14)	3 (2)	5 (1)	2 (1)	4 (-)
At Home (n=37)	5	17	9	6

Note: Figures in brackets denote the number out of group working non-standard hours.

Table 5.8 Number who had Consulted a GP in Last Six Months - Non-Carers in Paid Employment

	SELF ONLY (N=46)	SELF & OTHERS (N=1)	OTHERS ONLY (N=1)	NO ONE (N=30)
Full-Time - 'Medium/Higher Status' (n=40)	25 (19)	-	1(1)	14 (8)
Full-Time - 'Lower Status' (n=9)	5 (3)	-	-	4 (3)
Part-Time - 'Medium/Higher Status' (n=18)	11 (6)	1 (-)	-	6 (1)
Part-Time - 'Lower Status' (n=11)	5 (2)	-	-	6 (1)

Note: Figures in brackets denote the number out of group working non-standard hours.

It may seem inappropriate to present the above 'findings' in a chapter concerned with method. However, the purpose was to illustrate the evolving nature of the research project and the ways in which the postal questionnaire contributed

to the content of and thinking behind the development of the interview schedule. Further analysis of the postal survey was only carried out when it could be properly informed by the information on household-level processes revealed in the in-depth interviews. It is those findings which will be outlined where relevant alongside the interview material in later chapters.

5.5.2 The In-depth Interviews

Following the initial analysis, groups of women distributed between the study areas were identified to reflect a cross-section of the social roles and the economic, social network resource and health circumstances shown on Figures 5.4a and 5.4b. The groups covered women with the range of types of caring responsibility from 'healthy' children to an elderly relative at home or living independently. They included full-time and part-time paid workers and working-age women in the various categories of 'not in paid employment'. Amongst working women, the groups embraced those in higher and lower-status employment, those working standard hours and those doing shifts, overtime or work at home. Women with a non-limiting or limiting-long-standing illness were represented alongside those without and variations in economic and social resource circumstances were also covered. In this way, it was hoped that the interviews would reveal the widest range possible of processes surrounding household health management.

The women were contacted by telephone in order to request an interview. They had not previously been asked to indicate their willingness to be interviewed on the postal questionnaire as it was felt that this may deter some from responding.

Those for whom no telephone number was established were sent an introductory letter and visited personally. A total of thirty-seven women agreed to talk in greater depth. They were asked for permission to tape-record the conversation for later transcription and it was understood that they could switch off the machine at any time. The first interview acted as the pilot. The rest were spaced over a five month period in order that the schedule could be modified as issues emerged from the analysis (Strauss, 1987; Strauss and Corbin, 1990). A general question was, for example, added after the first six interviews which asked women what they would like to do 'for their health'. This seemed to facilitate an easier discussion of smoking than more direct questions posed at first. Of course, some relevant issues had to be omitted from the outset in the interests of keeping the interview to a manageable length. For example, an explicit exploration of the effects of health beliefs on behaviour was excluded in order to concentrate on the role played by the practical scheduling of activities. It was felt that if health beliefs were important they would be raised by the women themselves or would emerge implicitly.

The final interview schedule is shown in Appendix 4. It was semi-structured and like the postal questionnaire was theoretically informed by the conceptual analysis of contingent social relations and circumstances outlined in Chapters Two-Four. As mentioned in Chapter One, the interview also included a number of intensive research techniques other than simply open-ended questions. For example, prompt cards were used to initiate discussion of: i) household and personal income (Appendix 5A); ii) the level of dependency of adults and disabled people being cared

for; and iii) the degree of limitation experienced by the women interviewed who had a long-standing illness (Appendix 5B).

During the initial telephone conversation, each woman was also asked if she would keep a diary of daily activities for a period of up to a week before the interview (Campion and Gabriel, 1985; Gortmaker, Eckenrode and Gove, 1982; Lawson and Ingleby, 1974; Morrell and Wale, 1976; Rakowski et al, 1988; Verbrugge, 1980 and 1985). Several diary sheets were then sent with a covering letter (Appendix 6). In all, twenty-nine out of the thirty-seven women interviewed kept the diary for between one and eight days (Figure 5.7).

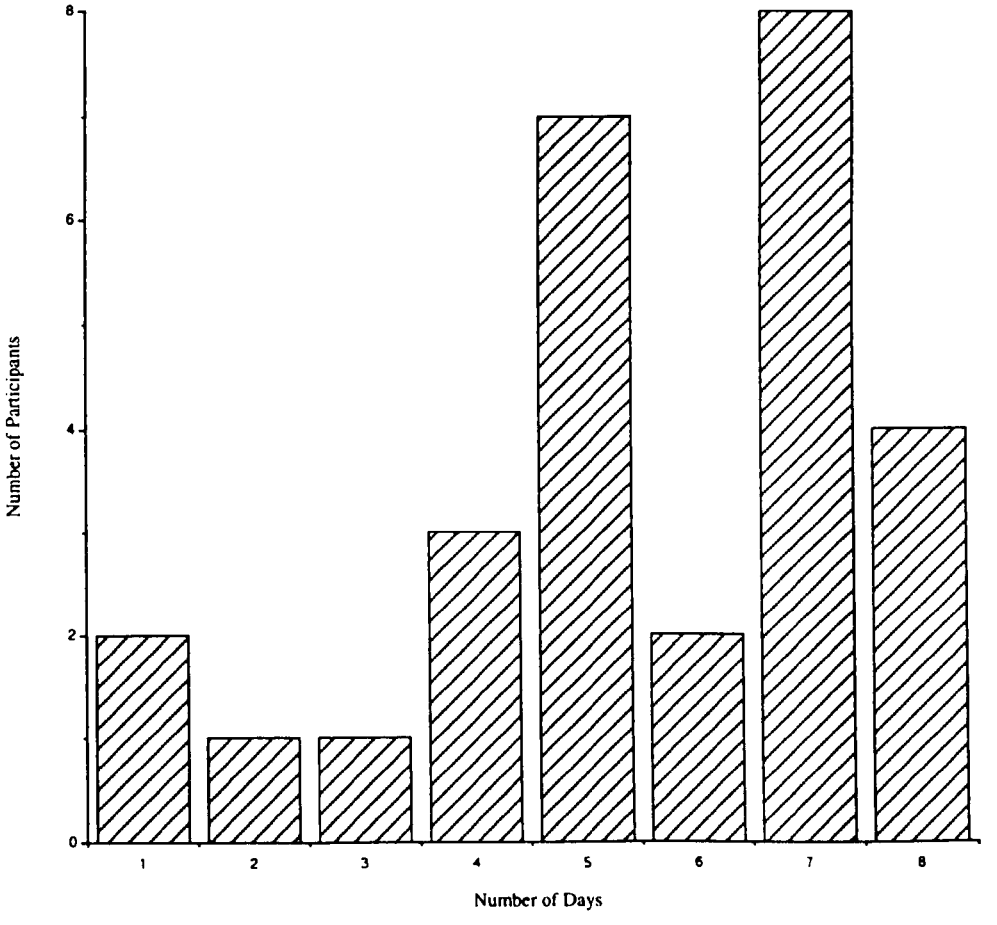


Figure 5.7 Completion of Activity Diary

The diary was designed using examples of previous research instruments for activity analysis (Jones, Bradley and Ampt, 1987; Jones and Polak, 1990). The minimum of examples of activities were given so that participants could write down what they regarded as important. The diary provided the focus during the interview so facilitating the discussion of the different aspects of household response (cf. Ferguson and Jones, 1986, p.84):

i) *Decision context* - the nature of the activity choices which have to be made and the constraints which determine the options;

ii) *Decision process* - the mechanism by which the preferred option is selected including an investigation of the bargaining processes and trade-offs involved;

iii) *Decision outcome* - the direct and secondary adjustments to daily behaviour patterns considered necessary to cope with the new situation.

Ferguson and Jones (1986) used display boards for people to reconstruct the structure of their day from the diaries:

> "Once the family have constructed a set of displays showing the structure of their day, the interviewer initiates a discussion of the reasons for the observed behaviour and explores with the household their main linkages and constraints - the degree of flexibility in timing or location of activities, the extent to which household members perform joint activities etc ..." (ibid, 1986, p.87).

A display board was not used in Netherley and Woolton because of constraints on the length of the interview. Instead, the diary sheets themselves were used in the same way in order to focus on time-space constraints, inter-personal linkages,

household decision rules, preferences and priorities and possible options and sources of information. The women were asked about differences between weekdays and weekends, how typical the diary days were and the effects of longer-term changes in activities such as children starting school or leaving home. The diaries were not subsequently analyzed as their purpose was solely to facilitate discussion during the interview itself.

Of course, there are disadvantages to using the diary method as a means of collecting time-budget data. Respondents may not provide enough information unless previously instructed what to include, they may get bored with filling out the diary, they may omit potentially embarrassing activities or change their behaviour as a result of completing the diary (Plewis, Creeser and Mooney, 1992). For instance, one participant in Netherley commented that the lack of direction in the diary instrument had been off-putting. She completed only two days because she did not know which activities to include or not include. Another, by contrast, found the diary to be too structured. When asked if her diary days were typical, she replied:

> "Yes. There could be a lot more into that word but I thought, 'No, better keep a face. I won't tell you about the screaming or the tantrums or..' [Oh you could have done!] Thought I'd better be a bit polite and keep it out. No, if you would have given me plain blank paper.. Well, I should have told the truth on the back because I could have wrote it more - done more work for you" (Early 30s - Income Support).

Despite the disadvantages, however, self-completed diaries still provide more accurate time-budget information than interviews which solely rely on recall (Plewis, Creeser and Mooney, 1992). This is especially the case if the diary period and

format are carefully considered in order to capture the activities of interest without jeopardising completion by imposing a task which involves too much effort. As Corti (1993) argues:

> "The 'diary-diary interview method', where the diary keeping period is followed by an interview asking detailed questions about the diary entries, is considered to be one of the most reliable methods of obtaining information" (ibid, 1993, p.1).

Finally, the interviews included vignettes (Campion and Gabriel, 1985, Finch, 1987b; Feitelsom, 1992; Muhlenkamp, Walker and Bourne, 1983) which addressed potential management strategies under hypothetical health situations (Appendix 7). The women were asked to bear in mind their diaries and to imagine what would happen if, for instance, a particular family member had an accident or was taken ill in the middle of the night. They were also asked about collecting a prescription from the all-night chemist in the city centre as this was felt to be an occasion when transport difficulties might be revealed. Overall, the vignettes were used to:

i) capture possible variations in the responses of women, who are and are not in the paid labour market, to hypothetical health situations which take place at different times of day;

ii) examine the role of economic and social resources in women's management strategies and women's own role in their social network;

iii) assess the position of different family members in the order of priorities for meeting health needs; and

iv) examine the means by which women cope with conflicting social role commitments in different health situations.

The advantages of vignettes are that they can be used to cover issues which may not be easily dealt with in the rest of the interview. They:

> "... offer the opportunity to explore normative issues in a way which approximates to the complexities with which such issues are surrounded in reality, or, at least, comes closer to reflecting the complexities than other techniques commonly used in a survey" (Finch, 1987b, p.111).

In addition, vignettes add variety to the interview format and provide another means of building a non-directive form of question into the research. Potential difficulties are associated with how responses are interpreted simply because they are hypothetical. However, the vignettes used in the Netherley and Woolton interviews did prompt most women to recall actual events which it seemed might not otherwise have been mentioned.

5.5.3 Social Exchange in the Interview Process

As noted in Section 5.4.2, research is conducted in the context of social exchange. It is central to the debate about the research process that:

> "... the social forces of class, race and gender, as well as other social identities, impose themselves" (Seidman, 1991, p.72).

Power relationships exist between the researcher and the 'researched' and so there are issues of control and exploitation to be considered. The ethics of particular research practices are, therefore, important and it has been argued that ethnographic methods afford the most egalitarian and reciprocal relationship between the researcher and participants. Brannen (1993), for instance, asserts that semi-

structured interviews produce a "therapeutic pay-off" (p.344) because of the interest on the part of the researcher and the participant's awareness of being part of a wider group in a similar situation.

However, it is increasingly recognised that even ethnographic methods involve ethical dilemmas. Stacey (1988) maintains that participants are open to exploitation in the following ways:

i) information given by one may undermine the account of another;

ii) withdrawal by the researcher at the end of the fieldwork can leave participants with feelings of abandonment and betrayal;

iii) however much data collection is shared, the textual product is an authoritative document credited to the researcher.

The development of trust in an interview situation makes it, potentially, extremely exploitative with participants left feeling vulnerable if they reveal personal information (Finch, 1984). It is also difficult for many respondents: "... to anticipate these dangers at the outset of the interview" (McCracken, 1988, p.27). Status between women is as important as gender itself in the research process (Allen, 1993; Scott, 1984):

> "Whilst most feminists have taken the potential unintended consequences of participation in research seriously ... Few ... refer to explicit attempts to 'research' the meaning and impact of participation, as an integral part of methodology. We need to take much more seriously the potential harm, that participation may be more of an intrusion/imposition/irritation/responsibility than a benefit" (Kelly, Burton and Regan, 1994, p.36).

For example, although many participants in Phoeonix's (1994) study said that they enjoyed being interviewed, some found the experience intrusive. They were left wondering what could happen if the information 'fell into the wrong hands'. As Fonow and Cook (1991) point out:

> "A well crafted quantitative study may be more useful to policy makers and cause less harm to women than a poorly crafted qualitative one" (ibid, 1991, p.8).

These are all issues of which I was aware through reading the literature prior to starting fieldwork. However, it was not until I was actually carrying out the interviews that I came fully to appreciate their significance. Two women gave painful and tearful accounts of becoming separated from their husbands since filling out the postal questionnaire. Another said that keeping the diary had depressed her because she realised: "... how little I do with my life". One woman wanted assurance at the end of the interview that "the dole" would not find out details of her household income. Another trusted me with the information that, although she and her partner live together, she continues to claim Income Support as a single parent[11]. Some also commented unprompted that the interview experience had been a positive one. Cornwell (1984) argues that by building a rapport over a series of follow-up interviews the researcher gains a "private" as opposed to a "public" account from participants. However, a counter argument might be to ask how much more vulnerable participants are when longer-term relationships have been built up.

[11]In the household-level analysis presented in Chapters Seven-Nine, some detail has inevitably been lost in order to protect the identity of the women interviewed. General categories such as Mid-20s and catering worker have been used rather than Age 24 and canteen assistant at local factory. Pseudonyms have also been allocated to family members.

I commented in Chapter One that this research has been a learning process. Clearly, it would be important, in future work of a similar nature, more fully to consider the likely impact on participants prior to undertaking fieldwork.

As noted earlier, many feminists have argued that the power imbalance between women respondents and researchers is in favour of the latter. Cotterill (1992), however, suggests:

> "... that interviews are fluid encounters where balances shift between and during different interview situations, and there are times when researchers as well as the researched are vulnerable ..." (ibid, 1992, p.593).

Brannen (1988) also makes the point that the interview setting can be difficult for researchers as well as respondents. I found the interactional and power dynamics different from interview to interview, depending upon the combination of the age, class and employment status of participants against my own. I only interviewed white women although I did contact one of Chinese and two of Asian ethnic origin. They did not want to take part. Also, although I have helped to look after more than one elderly family member, I was learning completely from participants when it came to talking about caring for children. I told the women that I was a student. Some seemed to feel intimidated by this and I was clearly 'in control' in those interviews. Others said "how great it must be to be able to study and not to have kids". Interviewing other women still, I felt almost apologetic that I did not have a 'proper job'. Finally, as a 'Brummie' in Liverpool I did feel an 'outsider' in a number of the homes I visited. At least on the experience of these interviews, therefore, I would agree with Glucksman's (1994) view that:

> "However 'feminist' in terms of aims, perspective or methods adopted ... it is impossible to overcome within the research context the inequalities of knowledge between researcher and researched. Rooted as these are in the real social divisions of knowledge that are created between people in contemporary society they represent a central contradiction that inevitably characterizes academic feminist research. No amount of sensitivity or reciprocality, for example in the interview situation, can alter the fact that while the task of the researcher is to produce knowledge, those being researched have a quite different interest in relation to the situation" (ibid, 1994, p.150).

5.5.4 Analysis of the In-depth Interview Material

Social relationships are also vital to a second important concern of feminist writers. That is, the question of data interpretation and what constitutes 'reliable knowledge' (Maynard and Purvis, 1994; Maynard, 1994). Much of the debate has been at an abstract level criticising, for instance, masculinist notions of science and forms of knowledge influenced by the Enlightenment (Harding 1986; 1991 and Smith, 1988). As Maynard and Purvis (1994) point out, however, adapting these arguments to the everyday practicalities of conducting empirical research is a difficult task:

> "It is clear ... that the notion of experience needs to be problematized, since individuals do not necessarily possess sufficient knowledge to explain everything about their lives. Accounts will vary depending on such factors as where respondents are socially positioned, memory etc. There is no such thing as raw or authentic experience which is unmediated by interpretation" (ibid, 1994, p.6).

The process of interpretation by the researcher is also important in this context:

> "... reaching conclusions is a social process and that interpretation is a political, contested and unstable activity. Feminists have to accept that there is no technique of analysis or methodological logic that can neutralise the social nature of interpretation" (ibid, 1994, p.7).

After all, by its very nature feminist work is theoretically grounded (Maynard, 1994). Whatever perspective is adopted, feminism provides a theoretical framework which focuses, for example, on gender divisions or patriarchal control. This framework informs the researcher's understanding of the social world. Maynard and Purvis (1994) continue:

> "... feminist researchers can only try to explain the grounds on which selective interpretations have been made by making explicit the process of decision-making which produces the interpretation, and the logic of the method on which these decisions are based. This entails acknowledging complexity and contradiction which may be beyond the interpreter's experience, and recognising the possibility of silences and absences in their data (ibid, 1994, p.7).

It was thought initially that information gained from the interview respondents in the present study would be coded and analyzed using the NUD-IST qualitative computer package[12]. NUD-IST was favoured above, for instance, Ethnograph 4 as it appeared to be better able to handle large data sets. It is also a 'theory building' software package which means that combinations of codes can be tested in order to see if ideas about links are compatible with what actually appears in the text (Fielding and Lee, 1992). 'Contact with the data' is not lost if the researcher consistently checks that the links generated by NUDIST make sense. In general, computer analysis makes for faster data handling than if potential links between codes are assessed by hand using cards. In the event, however, the data set generated by the interviews in Netherley and Woolton was of a size which could be analyzed by hand without 'losing sight' of what respondents had actually said.

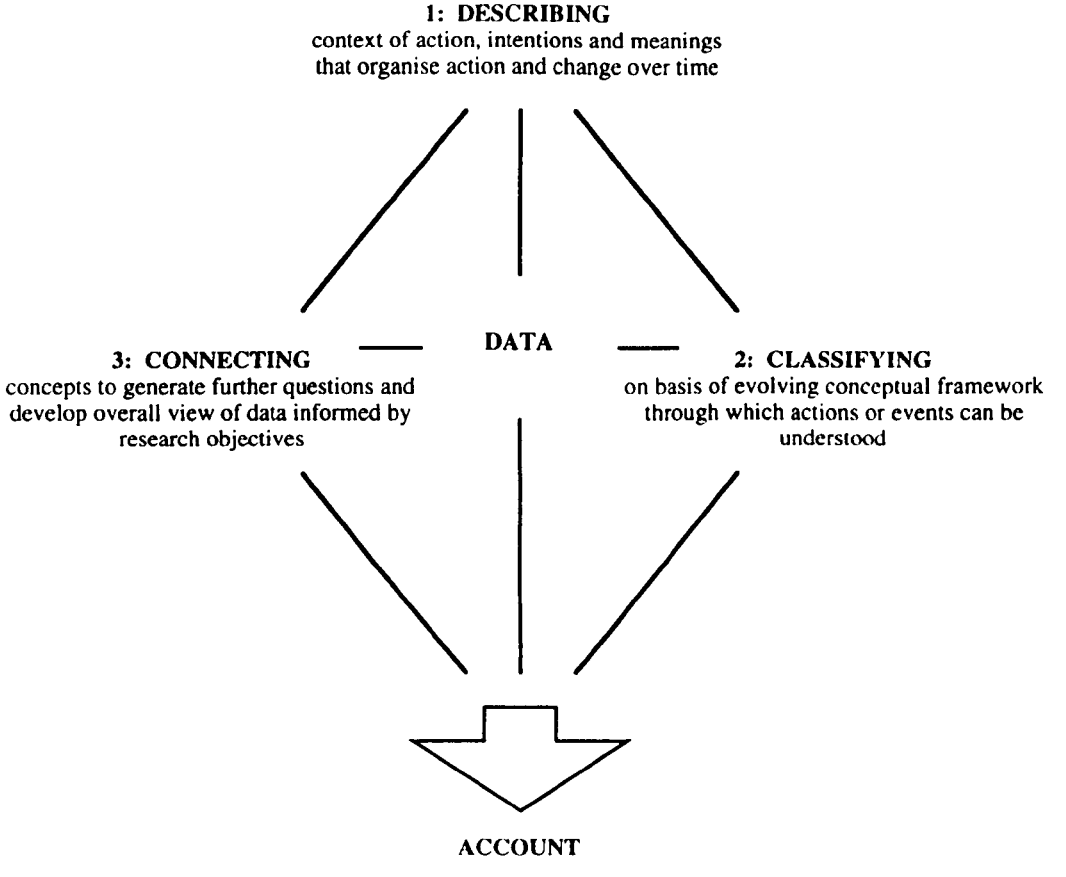
[12]NUD-IST stands for Non-numerical Unstructured Data Indexing Searching and Theory-building.

A hierarchical set of linked codes (code, sub-code, sub-sub-code etc.) was developed which reflected both contingent social relations and circumstances and the outcomes in terms of everyday activities and health-related behaviours (Dey, 1993; Strauss, 1987; Strauss and Corbin, 1990; Wolcott, 1990). The data could, for example, be immediately classified at a nominal level in terms of women's labour market category or characteristics of the person being cared for. Other categories were then developed which classified, for instance, the uses to which women put economic or social resources. These included gaining flexibility to schedule paid work and caring and overcoming physical mobility constraint both generally and in relation to health.

As the data are brought together into categories in this way it becomes possible to discriminate more clearly between the criteria for allocating data to one category or another. The whole process is on-going and iterative. Some initial categories may be sub-divided and others may be subsumed to create new ones. Figure 5.8 summarises the concept behind this approach to analysis. In particular, the approach does not involve waiting until all the data have been collected before commencing coding. In fact, the interviews continued to be analyzed both during and after the six month period of fieldwork. A process of review and reflection was employed in order to check that ideas generated from earlier interviews were still relevant at later stages. Notes were kept for this purpose as lines of thinking were developed in the light of a continued review of recent literature as well as the empirical evidence. As Miles and Huberman (1983) explain, by classifying the data in this way, further questions are generated about the processes under observation.

The interview schedule can then be modified to reflect revealed gaps in understanding. Having recognised that gaps may exist in the data in the light of the issues discussed at the start of this sub-section and the end of the last, it is a major benefit of this approach that it allows at least some of those gaps to be addressed.

Figure 5.8 Qualitative Analysis as an Iterative Process



Source: cf. Dey, 1993, pp. 30-54.

CHAPTER SIX

THE RESEARCH LOCALITIES

6.1 Introduction

As noted in Chapter One, capitalism and patriarchy are the key social relations upon which women's everyday lives are contingent. Although some (eg. Duncan, 1989 and Duncan and Savage, 1989) have denied the causal role of space in the operation of those systems, the counter argument, that space actively moulds the workings of class and patriarchal relations is more convincing (eg. Massey, 1984, 1988, 1993 and 1994; Meegan, 1989 and 1995). Space and place are, for instance, fundamental to women's experiences of paid employment segregation, domestic labour divisions and pressures to conform to specific gendered roles (McDowell, 1993; Women in Geography Study Group, 1984). They are also important factors in the social construction of meaning in connection with health-related behaviours. Historically-derived experiences and attitudes in relation to health and illness and the systems of care set up to deal with this are all spatially specific (Phillimore, 1993).

Before presenting the analysis of household-level processes in Chapters Seven-Nine, therefore, the conditions in the study localities will be explored. These conditions are constituted in terms of those contingent social relations and circumstances which exist in Netherley and Woolton and are relevant to the decision-making framework outlined in Chapter Four. Hence, women's social roles and health experience and the nature and distribution of economic and social

resources will be examined using secondary information sources and the social area characteristics revealed by the postal questionnaire survey. The discussion will range from the regional, to the city and local area levels as each contributes particular contingent social relations and circumstances for health-related decision-making.

The chapter will focus to begin with on the historically-derived characteristics of gendered social roles in the Merseyside labour market and the socio-economic conditions now experienced by a significant proportion of people in the region (Section 6.2). Health statistics for the population will then outlined in order to draw attention to the potential size of the caring task in Liverpool and the fact that the foremost health problems are ones for which there is considerable scope for improvement through the altered lifestyles and increased uptake of preventative screening advocated in policy (Section 6.3). The final section will describe the internal variations in health and social conditions across the city in order to highlight contrasts between and within the study areas. Results of the postal questionnaire will illustrate how faithfully Netherley and Woolton mirror the Liverpool situation generally (Section 6.4). It will become clear that, in terms of the changing characteristics of labour market participation and the distinct relationship between poor socio-economic circumstances and ill health, Liverpool provides an ideal location in which to address the issues surrounding women's management of household health needs under different social circumstances.

6.2 Social Roles and the Economy in Liverpool

The Merseyside region has a long history of socio-economic decline, unemployment and deprivation dating back almost to the turn of the century and linked to the lack of diversity of its economy (Cunningham, 1970a). Successive regional policy efforts have aimed to encourage economic regeneration and employment growth, but they could not counter the effects of the underlying shift in the UK economic axis towards the South East where other ports are within easier reach. Only during the Second World War and the post-war boom was anything approaching an economic recovery ever achieved in the region. As Lane (1987) puts it:

> "Ships, docks, cargoes and the people associated with them were, at the beginning of the twentieth century, Liverpool's past *and* future. In the twentieth century the city's economy did diversify into manufacturing, but it came late, was never sufficient and was too impermanent to offset the dramatic and headlong decline of the port from the late 1960s. The condition of Liverpool today - economically, politically, socially - is a direct outcome of the changing fortunes of the port" [original emphasis] (Lane, 1987, p.35).

Green's (1994) analysis of the changing spatial distribution of poverty and wealth in the UK between the 1981 and 1991 Censuses of Population affirms this account. On all three statistical measures of concentration[13] and for many of the

[13] i) The *degree* measure - the percentage value shown for specific indicators of poverty and wealth eg. unemployment rate, no car households, households with two or more cars and households in rented accommodation. It represents average experience at LLMA and LAD level;

ii) The *extent* measure - the percentage of all wards within the defined area ranked in the top decile group of the national distribution of wards on each poverty and wealth indicator. It is used to illustrate intra-LLMA and intra-LAD variations in experience;

iii) The *intensity* measure - calculated as the mean of wards ranked in the, arbitrarily chosen, highest three on the indicators selected. It describes localised severity of poverty and wealth in areas.

indicators used, Liverpool's position is one of acute poverty and the situation has compounded in the decade between the Censuses. Notably:

> "... a first insight into a comparison of rankings on *degree, extent* and *intensity* measures is provided by the unemployment ... and inactivity ... indicators at the LLMA [Local Labour Market Area] scale. Immediately it is apparent that some areas achieve high rankings on all three measures of distribution. The foremost example is Liverpool [see Table 6.1] on the unemployment rate indicator: it is ranked in first place on the *degree* measure, nearly two-thirds of its constituent wards appear in the 'top' decile group on the national distribution of wards ranked on the unemployment rate (it is ranked second out of 280 LLMAs on the *extent* measure), and comes second only to Glasgow on the *intensity* measures. In [all] other instances, there is much greater variation in the rankings on the *degree, extent* and *intensity* measures." [original emphasis] (ibid, 1994, p.57).

This situation of poverty was as true for the Liverpool LAD [Local Authority District] in 1991 as it was for the LLMA:

> "Again, Liverpool emerges as a prime example of an area achieving high rankings on all three measures of spatial distribution for many of the poverty indicators (in particular, see no car households..., unemployment ..., and SEG class D: no occupation)" (ibid, 1994, p.58).

The Liverpool Quality of Life Survey also confirmed the contemporary high levels of poverty in the city (Chief Executive's Department, 1991).

Table 6.1 Unemployment Rate - 1991: Rankings of LLMAs on *Degree*, *Extent* and *Intensity* Measures

LLMA	DEGREE SCORE	DEGREE RANK	EXTENT SCORE	EXTENT RANK	INTENSITY SCORE	INTENSITY RANK
Liverpool (NW)	18.31	1	63.51	2	43.07	2
Sunderland (N)	15.77	2	53.12	6	28.14	9
West Bromwich (WM)	15.41	3	70.00	1	17.60	78
South Shields (N)	15.35	4	59.09	3	23.03	26
Coatbridge & Airdree (S)	15.33	5	35.00	14	17.94	76
Hartlepool (N)	15.27	6	35.29	12	27.02	12
Mexborough (YH)	15.14	7	57.14	5	17.57	79
Merthyr Tydfil (W)	14.71	8	40.00	9	18.83	63
Glasgow (S)	14.33	9	35.14	13	47.35	1
Gelligaer (W)	14.00	10	58.82	4	22.21	28
Greenock (S)	13.98	11	26.92	24	24.50	23
Motherwell (S)	13.49	12	25.00	29	21.05	36
Pontypridd (W)	13.30	13	35.90	11	25.36	20
Rotherham (YH)	12.86	14	26.67	25	20.06	50
Redruth & Camborne (SW)	12.86	15	18.18	47	15.14	115

Key to Regions: SE: South East; EA: East Anglia; SW: South West; WM: West Midlands; EM: East Midlands; YH: Yorkshire and Humberside; NW: North West; N: Northern; W: Wales; S: Scotland.

Source: Green, 1994, p.57.

Massey (1984) and McDowell and Massey (1984), in particular, have argued that local economies such as Merseyside, in the past dominated by 'male' jobs in manufacturing and port-related industries (Lloyd, 1970), have been converted into areas of high unemployment subsequently most attractive to light manufacturing and service industries which primarily employ 'flexible' women workers. Hayes (1987) describes the sectoral changes in employment in Liverpool. Between 1961 and 1985 Liverpool lost 64 percent of its manufacturing jobs against 37 percent nationally. Other production industries, for example construction, declined by 65 percent against a national loss of 39 percent. 'Blue collar' services declined by 50 percent and 'white collar' jobs increased by 31 percent in the same period. This trend

towards reduced male and increased female economic activity is, therefore, seen as part of the industrial restructuring process and the gendering of paid labour market opportunities in an area as a function of the local industrial mix (Elson and Pearson, 1989; Pearson, 1989). Spatial divisions of paid labour imply spatial patterning in the balance between the amount and type of male and female employment because capitalist divisions of labour are gendered (Duncan, 1991). Significant for the emphasis of this research in particular, is the substantial and sustained rise in levels of part-time working for women in Merseyside and the roles which their jobs have come to perform in supporting households because the decline in the local economy described above (Green, 1994) is principally a decline in the availability of traditionally 'male', lower skilled jobs. The 1991 Census of Employment showed that the proportion of women in the total labour force in Liverpool had risen to 50.7 percent as compared to an average for Great Britain of 48.2 percent.

Beechey (1986), using Wales and the West Midlands as examples, argues that regional specificities also exist in the pressures on women to assume certain combinations of social roles and that these are set up by historical precedents for female paid labour participation. More precisely:

> "... individual relations between men and women and indeed constructions of femininity and masculinity, will be spatially variant as they develop in the contexts of workplaces, homes and local social networks ... These constructions will then influence the roles men and women take up - how they each experience and use their social environments ... For just one illustration, rates of occupational segregation have been shown to vary substantially between different labour markets ... Nor is this variation purely a matter of local industrial mixes reflecting national rates of sex segregation in different industries. Segregation rates in the same industry also differ on a local scale, perhaps reflecting different 'levels of patriarchal hegemony' in different places" (Duncan, 1991, p.424).

In Walby and Bagguley's (1989) study, for example, the proportion of female part-timers in production industries was much lower than the national average in Lancaster but higher than the average in Thanet. For these authors, regional variations in the gendering of paid employment and associated domestic labour divisions are not merely contingent on changing capital-labour relations but are contributory to spatial outcomes of industrial restructuring.

In Liverpool, forms of 'flexibility' have, in fact, been a central and long-standing feature of the paid labour market for both men and women. By virtue of its being a port, the city required a large but casually employed workforce, so irregular incomes and periods of unemployment were commonplace (Cooke, 1987; Cunningham, 1970b and 1970c). Lane (1987) points to a study conducted for the Ministry of Labour in 1929 which:

> "... listed 28 industrial sectors as employers of casual labour and identified 231 separate call-on points or stands along the seven miles of waterfront" (ibid, pp.88-89).

Dock labourers, ship repair tradesmen and warehousemen were invariably hired off these stands by the hour or the day and at low wage rates. For women at the bottom end of the social scale, therefore, it has been very much the norm to combine the 'homemaker' role with low status, short-term employment in order to supplement the household income:

> "The maintenance of family income was the critical thing for the casually employed and the paid work done by women was extremely important in each succeeding generation ... Whether it was working as a trader, taking in laundry, keeping a lodger or mending sacks and bags in a warehouse, income from one or several of these could be essential. However, these contributions to the household economy were as uncertain as those made by men. For women, as for men,

there were very few opportunities for regular, waged work (ibid, 1987, pp.95-96).

In this context of over-supply of female labour into a restricted labour market:

> "All the oppressive and exploitative practices which confronted women workers generally came into sharp focus. Thus, even in those industries which relied on skilled, experienced women workers, such as the tobacco industry, employment conditions were characteristically poor" (Grant, 1987 quoted in Meegan, 1995, p.94).

The casual recruitment of male workers also impacted on women's experience of their social roles in other ways. The:

> "... culture and consciousness generated amongst the male dock workforce stressed and applauded the demonstration of skills and abilities inextricably linked with masculinity in our society. Implicit within this culture was the delineation of femininity and a distinct female world. An entrenched relationship between gender and occupation was partly sustained by people's very sense of themselves as male and female. The boundaries of the female labour market were supported by a consciousness which defined the essence of masculinity and femininity" (ibid, 1987 quoted in Meegan, 1995, p.94).

In the Inter-War years, the growth of mass production and light engineering meant additional female employment in low paid, repetitive factory work but this was mainly only available to single women prior to marriage (Ayers, 1988). Such changes in the labour process, as a result of industrial restructuring and capital investment in manufacturing industries, encouraged the transfer of women out of skilled into semi-skilled and unskilled processes:

> "In this sense, the pre-existing characteristics of the sexual division of labour were progressively more sharply drawn ... The loss of skill status experienced by specific groups of women reinforced the tendency for the objective skills retained by women to be degraded. The adverse consequences of the sexual division of labour for local women workers were thus consistently confirmed, materially and ideologically" (Grant, 1987 quoted in Meegan, 1995, p.95).

In addition, the employment growth areas of the 1960s, for example car manufacturing (Lloyd, 1970), continued to employ a largely male workforce.

At the same time, the social networks of the extended family and neighbourhood have been a vital substitute to the cash economy in the inner-city areas (Cooke, 1987) and the role of women in these networks has been historically pivotal. Describing dockland Liverpool earlier this century, Lane (1987) notes:

> "The organisation and management of survival was, of course, done by women. Teenage boys and men, for their part, could escape to the ships" (ibid, pp.96-97).

The majority of childcare which enabled women to work in Liverpool factories during World War II was also provided by relatives and neighbours despite the provision of wartime nurseries by the authorities (Ayers, 1988). Clearly, the resources that women employ to cope with the time-space constraints they experience can also vary in line with the distinctive local character of social roles. Local industrial, household and community histories have all contributed to the development of cultural views concerning the appropriate use of economic and social resources. Modes of household financial management have, in particular, been linked to income level and occupational status both of which vary according to local labour market characteristics and:

> "The same can be said for the role of local social networks. In some areas a new mother will enter a community of married mothers positioned in a particular role of childrearing and domestic labour *vis-a-vis* their 'breadwinning' husbands ... In others she will be part of an alternative culture focused around single motherhood, group childcare, the benefit system and paid work ... As Bowlby et al (1986) state, the local area is not just a 'setting' for the development of gender relations, it is in fact an extension of their process of production" (Duncan, 1991, p.425).

As with many large cities, the areas of sub-standard housing in inner-city Liverpool were subject to slum clearance during the 1960s as employment continued to be internally redistributed from the city centre port areas to the outer industrial estates (Lloyd, 1970). Large numbers of people were moved to 'overspill' housing estates, such as Cantril Farm, Kirkby, Speke and Netherley, on or outside the city boundaries. At least some of the sense of community support and neighbourliness did move with them although new forms of relationship have also emerged (Meegan, 1989). In her study of elderly people, Wenger (1995) showed, for example, that entirely family dependent support networks with frequent contact are more common amongst working-class families in Liverpool. Local self-contained networks, which are typically arms-length relationships with a smaller number of relatives or friends, are found amongst middle class or skilled working-class people.

From the above discussion, it is evident that unemployment, a low income and poor living conditions are all consistent features in the lives of a significant proportion of Liverpool people from the very old to the young. It is this long-term and multiple nature of urban deprivation which marks Merseyside out as 'different' in the UK and European context and which has led to its being the only region of its kind designated Objective One status by the European Community. In this strategy £600 million of European resources, combined with an equivalent amount of UK public money, will be invested in order to try to regenerate the region. The historically-derived characteristics of gendered social roles, women's pivotal contribution both to production and social reproduction and the nature and distribution of economic and social resources in Liverpool clearly provide a uniquely

appropriate context for this research into health needs priorities within families. It is vital to understand that health-related behaviours cannot be abstracted from the holistic social and personal contexts in which women in Liverpool find themselves. In particular, attention is drawn in the next section to the heavy price, in terms of their own health and the level of caring for others required, which women have paid for the city's long history of high unemployment, low-status employment and economic deprivation.

6.3 Health and the Need for Care in Liverpool

There is strong evidence to suggest that the legacy of Liverpool's industrial past continues to play an important role in the health of its population (Kavanagh et al, 1993). Particularly for the middle and older generations, there are problems associated, for example, with past occupational exposure to asbestos, noxious chemicals and excessive noise in the docks and various manufacturing industries. Within contemporary occupations, serious environmental hazards still remain and, for a large proportion of Liverpool's working population, these factors combine with the pressures on health of a low income and high unemployment risk (Taylor, 1994). In addition:

> "As the traditional port industries declined ... many of the younger fitter members of the population left the region to seek employment elsewhere" (Ashton et al, 1994, p.24).

In 1992, the latest year for which figures are available, the All Causes Standardised Mortality Ratio (SMR) for the city stood at 120. This means that death rates were 20 percent greater than expected when they were compared to the figure for England

and Wales as a whole (females 18 percent and males 22 percent)[14] (Liverpool Health Authorities, 1993).

At a more detailed level, the recent statistics for mortality paint an additionally disturbing picture for Liverpool not least in terms of the potential constraints of health status amongst the population. Tables 6.2 and 6.3 show SMRs for selected cancers, coronary heart disease and stroke for all age groups in the period 1988-92. As is the case for the country as a whole, deaths from circulatory diseases and cancers "dominate the mortality profiles for both men and women" locally (Ashton et al, 1994, p.50). However, it is clear from the figures shown that SMRs in Liverpool are well above the England and Wales average for men and only those for breast cancer and stroke are below the average for women. If younger age groups are considered separately the conclusions are more worrying still, particularly for women. Between 1986 and 1990, the mortality rate due to heart attacks in the 35-64 age group was high enough for men at 45 percent above the national average, but for women the figure was 78 percent above. In the same period, excess male mortality rates from lung cancer were 54 percent with the rate for females again higher at 80 percent. This meant that premature mortality from lung cancer among women was more than double the national figure (Liverpool Health Authority, 1991).

[14] SMR = The ratio of observed to expected deaths compared with the population of England and Wales. It is expressed as a percentage whereby the national average is 100. A value above 100 is, therefore, higher than average and a value below 100 is lower. Standardisation takes into account differences is the age and sex profiles of different populations.

Table 6.2 Standardised Mortality Ratios (SMR) for Liverpool - 1988-92: Cancers

CAUSE OF DEATH	MALES	FEMALES
All cancers (ICD 140-208)	127	122
Cancer of trachea, bronchus and lung (ICD 162)	156	183
Cancer of female breast (ICD 174)	---	94
Cancer of cervix (ICD 180)	---	170

Source: Liverpool Health Authorities, 1993, p.70.

Table 6.3 Standardised Mortality Ratios (SMR) for Liverpool - 1988-92: Heart Disease and Stroke

CAUSE OF DEATH	MALES	FEMALES
Ischaemic heart disease (ICD 410-414)	121	119
Cerebrovascular disease (ICD 430-438)	111	99

Source: Liverpool Health Authorities, 1993, p.71.

Notes: ICD = International Classification of Diseases

It has been argued that mortality statistics are not the best indicator of *present health* or morbidity in a population. There is, however, little local-level data regarding episode rates for general practitioner consultations which is one of the few ways to assess morbidity accurately (Ashton et al, 1994). Those other types of indicator which are available for Liverpool confirm the picture described above using SMRs. The ward-level association between deprivation and heart disease

holds, for example, when hospital admission rates are considered (Ubido and Ashton, 1992). In addition, at the 1991 Census of Population, 17.3 percent of Liverpool residents reported having a limiting long-standing illness (Shepton, 1994). Such illness is associated, generally, with lower social class and advancing age (Blaxter, 1990). As Wenger (1995) has shown, only 17 percent of the elderly population in Liverpool are classified as middle-class on the Registrar General's five category scale. The number of working-age people in the city is also decreasing against a 10 percent increase in the number aged 75 and over since 1971 (City of Liverpool, 1993). The 85+ age-group, for instance, was one of the few to increase in absolute size between the 1981 and 1991 Censuses. At the opposite end of the life-course, the 0-4 age-group also expanded and this group, too, generates a heavy caring demand (Taylor, 1994).

Lung cancer, heart disease and stroke are each priority areas for which targets for the reduction of mortality were set by the government in *The Health of the Nation*. Lung cancer and heart disease have also been identified as specific "priorities for the city" of Liverpool (Liverpool Health Authorities, 1993, p.1). As noted in Chapter Two, the onus for improvement is very much placed upon education towards individual healthy lifestyles amongst the population. Reduction of mortality from cervical cancer is also an area in which individual action is emphasised, in this case regarding the response to preventative screening programmes:

> "Traditionally, inner-city areas have tended to have lower coverage rates than suburban or rural areas. Liverpool figures, although rather lower than other Districts in the Region [Mersey RHA], compare

favourably with similar Districts in other metropolitan areas" (Ashton et al, 1994, p.69).

Despite this, the SMR for cervical cancer in Liverpool stood at seventy percent above the England and Wales average in the 1988-92 period. Even though the uptake of cervical cytology screening has increased in recent years (Table 6.4), scope for considerable improvement clearly remains.

Table 6.4 Percentage of Liverpool women who, at the end of 1988-93, had been given a smear test in the past 5.5 years

AGE (years)	1988	1989	1990	1991	1992	1993
20-24	42	45	46	49	51	53
25-29	59	63	67	73	73	73
30-34	64	70	75	80	79	78
35-39	71	75	78	81	80	79
40-44	70	76	79	80	80	78
45-49	63	72	75	76	76	74
50-54	57	67	70	73	73	70
55-59	38	53	62	65	67	65
60-64	25	39	50	54	56	57

Source: Liverpool Health Authorities, 1993, p.32.

A survey of women registered at one general practice in the Dingle area of the city also showed lower-income groups to have less healthy lifestyles in terms of smoking, diet, alcohol consumption and exercise (Fernandez-Romeo and Ubido, 1990). Importantly, however, local policy makers have begun to recognise that it can be inappropriate to attribute blame entirely to the low income groups whose

health threatening behaviours contribute to the statistics described above. They refer to Graham's (1987) work on smoking outlined in Chapter Three:

> "Male smoking rates [in Mersey RHA] exceed female in the later age groups, although in the 45-54 group the pattern is reversed. This may be explained by ... the high female rates in socio-economic group 3 non-manual compared to males. Research has shown that smoking serves a positive purpose for women living on low incomes, enabling them to cope with the stresses and pressures of managing their family's health, whilst knowingly jeopardising their own ... In a [further] recent lifestyle survey which covered Wirral and Cheshire, 31% of men and 28% of women smoked ... Significant for this discussion ... is the fact that 52% of women smokers stated that it helped to calm their nerves and deal with stress, whilst for men the figure was only 43%" (Ashton, 1994, p.53).

Health is, therefore, an issue of major concern for Liverpool and the continuing size of the caring task for families and communities is considerable. Given the discussion in Chapters Three and Four, it is clear that the weight of this burden falls unequally upon women and that recent changes in the philosophy of health care and systems for service delivery can exacerbate rather than ameliorate individual situations. As described in Chapter Three, under circumstances of scarce resources and heavy caring responsibilities, the propensity is for women to forego many of their own health needs (Graham, 1992 and 1993). This must only serve to add a significant element of cumulative causation to the mortality and morbidity statistics for the city. Socio-economic inequalities in health are a real and continuing problem in Liverpool. In particular:

> "The dramatic restructuring of the local economy in the past 20 years has reinforced the position of a minority of people on low income, living in poor environments and often at additional risk from unhealthy behaviours" (Ashton, 1994, p.2).

These socio-economic differences find spatial expression in the:

> "severe inequalities in health as measured by almost all indicators of health between the different parts of the city" (Hussey, 1993, p.1).

It is this topic to which the discussion turns in the next section.

6.4 Health and Social Variations Within the City - Locating the Study Areas

In the study referred to in Section 6.2, Green (1994) calculated an index of isolation for poverty and wealth indicators at ward level across LLMAs and LADs:

> "Comparison of 1991 and 1981 scores on the index of isolation for *unemployment* and *inactivity rate* indicators reveals that the isolation of those people of working age excluded from employment in many of the large urban areas became more acute over the decade in absolute terms" [original emphasis] (ibid, 1994, p.91).

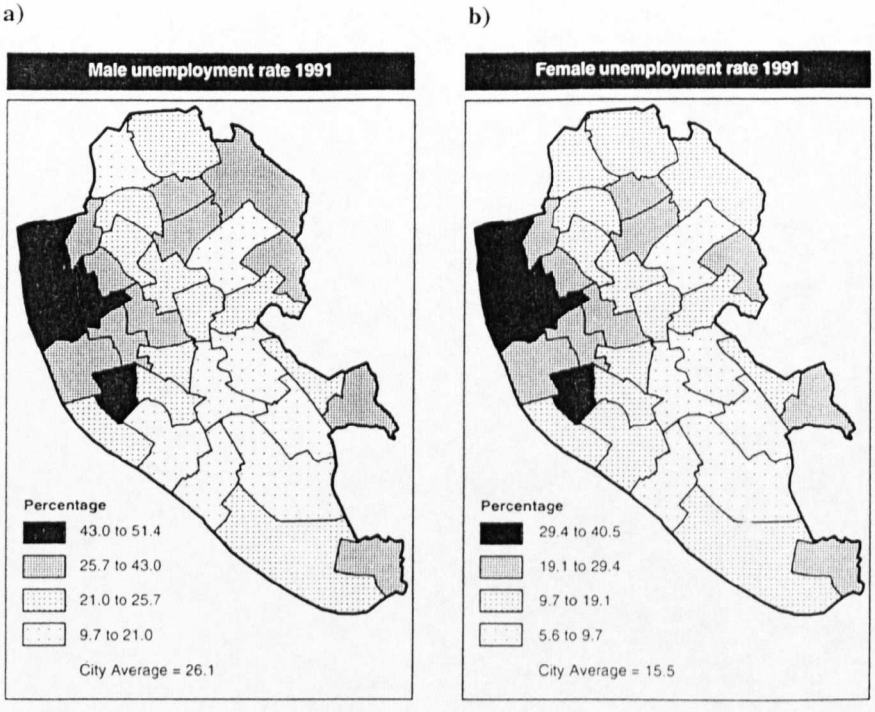
Liverpool, whether defined as the LLMA or the LAD, was amongst these urban areas. For unemployment rate, specifically, Liverpool LLMA had the highest value on the index of isolation nationally in 1991. Again, this is linked to the trend towards:

> "... the contraction of demand for less skilled workers" (ibid, 1994, p.91).

In 1981 Liverpool LAD was ranked 8 on the SEG class C: semi skilled and labourers indicator for the index of isolation. In 1991 it had fallen to rank 74. In terms of the study areas, a city average for self-defined unemployment which stood at 21.6 percent at the 1991 Census of Population disguised a rate of 28.1 percent in Netherley compared to one of just 9.3 percent in Woolton (Shepton. 1994). As Figure 6.1b shows, unemployment specifically amongst women is considerably greater in Netherley. Indeed, amongst women who replied to the postal questionnaire as part of the current research, eight out of the twenty women on Income Support or registered unemployed lived on the Netherley council estate.

This accounted for 36 percent of women not in paid work in that area. In contrast, only 14 percent and 17 percent of women without paid jobs, in the medium and higher income areas of Woolton respectively, were registered unemployed.

Figure 6.1 Unemployment - 1991 Census of Population



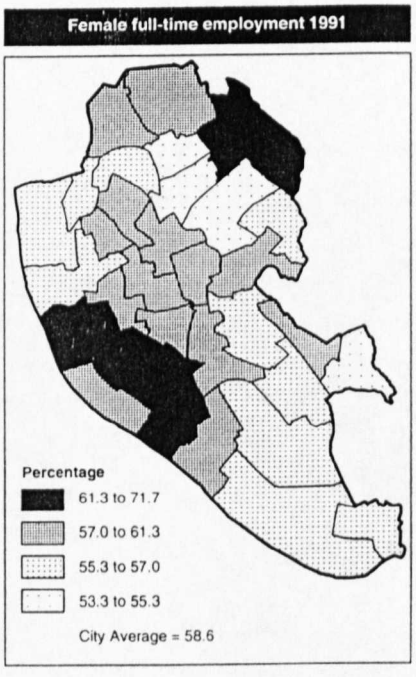
Source: Liverpool City Council, 1993, p.21.

Other area indicators of income levels also illustrate the contrasts between and within the two wards. In terms of employment status, full-time working is more common amongst women in Woolton (Figure 6.2a). Netherley was one of just three wards in the city with over 44 percent of employed women working part-time in 1991 (Figure 6.2b). As Figures 6.3a and 6.3b show, the percentage of unskilled manual workers, generally, is far higher in Netherley and the proportion of employers, managers and professionals far lower. This picture was again

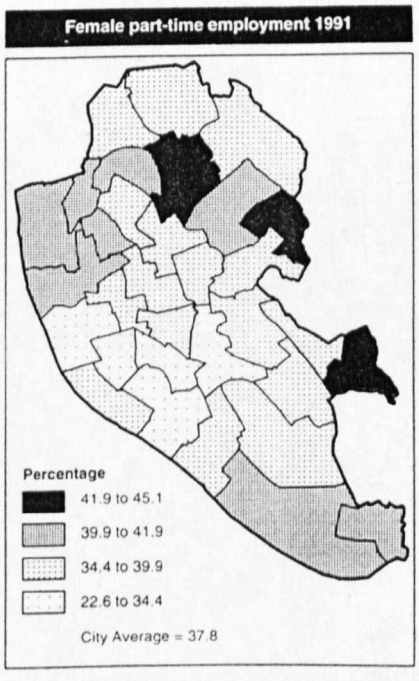
confirmed by the postal questionnaire responses. All nine women in the professional paid work category lived in Woolton and so did 23 out of the 32 in the employers and managers category. 59 percent (46/78) of working women in the medium income and 68 percent (21/31) in the higher income areas of Woolton were working full-time. This compared with around half (23/47) in the three Netherley areas combined.

Figure 6.2 Employment amongst Women - 1991 Census of Population

a)

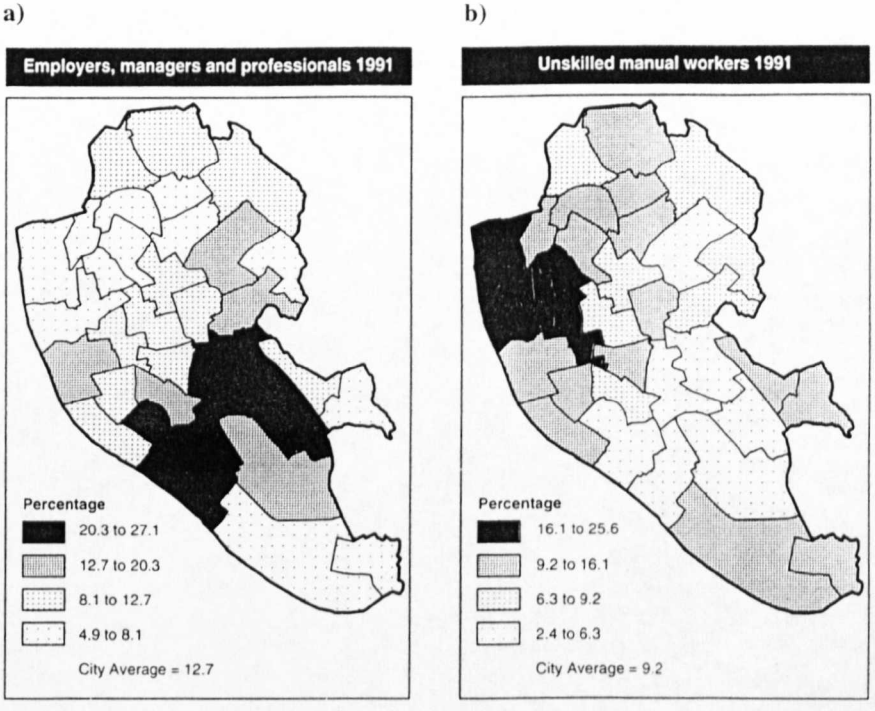


b)



Source: Liverpool City Council, 1993, p.29.

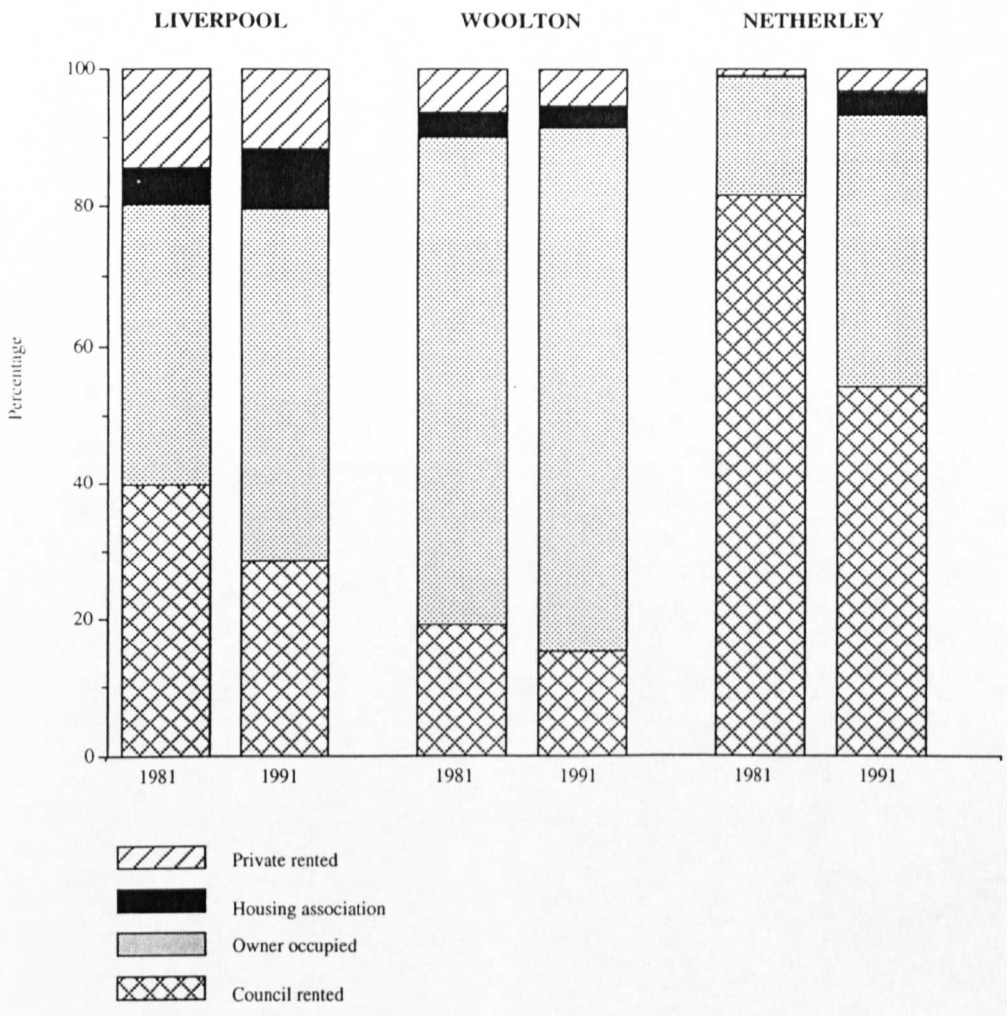
Figure 6.3 Socio-economic Groups - 1991 Census of Population



Source: Liverpool City Council, 1993, p.31.

With the demolition of its high-rise council flats, Netherley was one of the wards in Liverpool which saw considerable changes in its housing stock over the 1980s (Figure 6.4). However, it still has far fewer owner-occupiers and a greater proportion of council tenants than Woolton. As the postal questionnaire shows, variations have also developed within Netherley ward with the building of new estates for owner-occupation in recent years (Table 6.5).

Figure 6.4 Change in Housing Tenure between 1981 and 1991 Census of Population



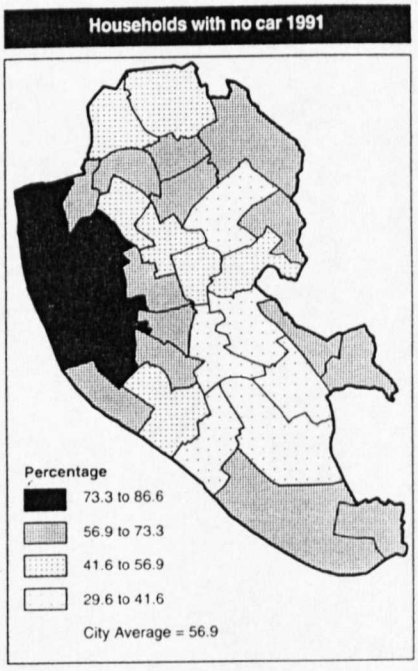
Source: cf. Shepton, 1994.

Table 6.5 Housing Status - Working-age Postal Questionnaire Respondents

SOCIAL AREA	% OWNED	% RENTED	% OTHER
Netherley - Mixed Low Income Council Estates/ Low Income Terraced (N=17)	59.0	35.0	6.0
Netherley - Poorest Council Estates (N=39)	41.0	59.0	---
Netherley - Medium Income Owner Occupied (N=30)	80.0	20.0	---
Woolton - Medium Income Owner Occupied (N=107)	89.0	7.0	4.0
Woolton - Higher Income Owner Occupied (N=48)	90.0	4.0	6.0

The data for car driving, car and telephone ownership (Figure 6.5 and Table 6.6) and 'lone parent' households (Table 6.7) paint a similar picture of contrast as do the "Super Profiles" employed by the 1993 Public Health Annual Report (Liverpool Health Authorities, 1993). These were defined in a manner similar to, but more detailed than, the social area typology used in the present study (City Planning Department, 1984). They distinguish different types of residential area on a very local level on the basis of data from the 1991 electoral role, credit information and market research. Figure 6.6 shows that the contrasts within Netherley and Woolton have changed little in the decade between the Censuses.

Figure 6.5 Car Ownership - 1991 Census of Population



Source: Liverpool City Council, 1993, p.47.

Table 6.6 Income Indicators - Working-age Postal Questionnaire Respondents

SOCIAL AREA	% WHO CAN DRIVE	% WITHOUT CAR	% WITHOUT TELEPHONE
Netherley - Mixed Low Income Council Estates/ Low Income Terraced (N=17)	35.0	41.0	18.0
Netherley - Poorest Council Estates (N=39)	28.0	44.0	28.0
Netherley - Medium Income Owner Occupied (N=30)	37.0	23.0	10.0
Woolton - Medium Income Owner Occupied (N=107)	80.0	14.0	6.0
Woolton - Higher Income Owner Occupied (N=48)	83.0	13.0	2.0

Table 6.7 Lone parenthood in Liverpool and the study areas - 1991 Census of Population

	LIVERPOOL	WOOLTON	NETHERLEY
Lone parent households as % of total households with children	24.2	9.1	27.7
% of children aged 0-15 in lone parent households	24.2	8.4	27.3

Source: Shepton, 1994.

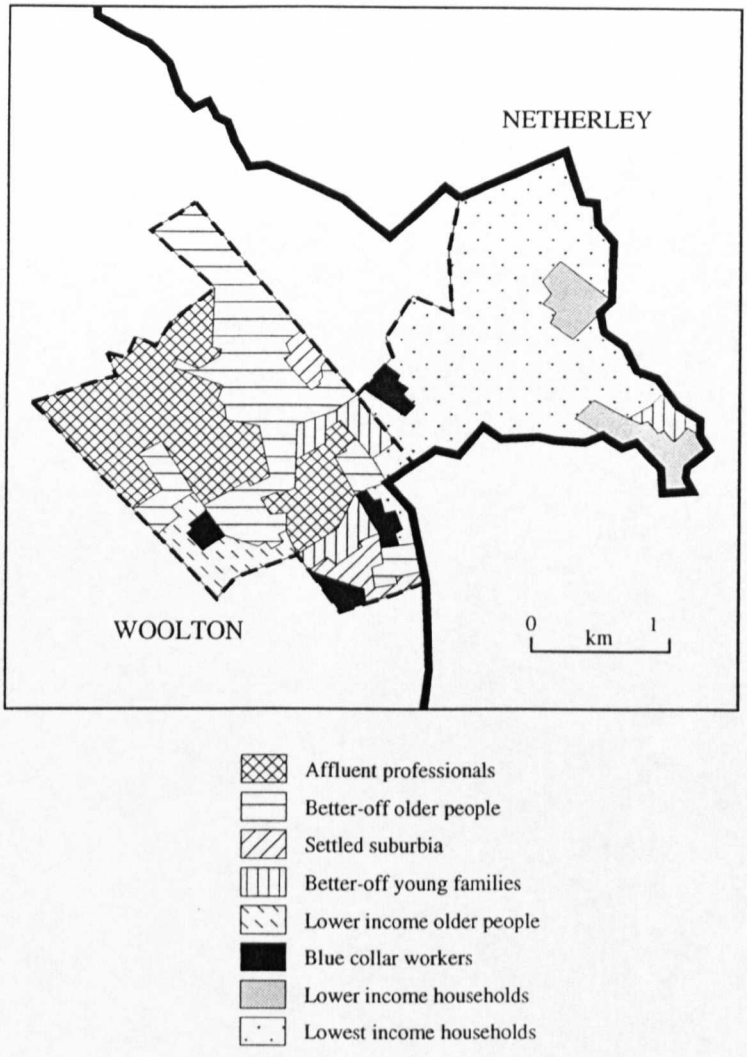
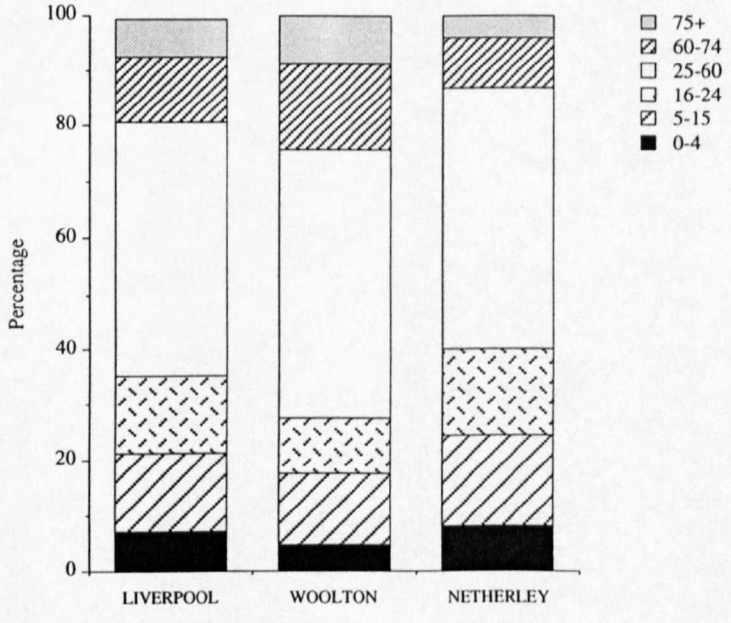


Figure 6.6 Netherley and Woolton - Social Areas in 1993

As noted earlier, the number of elderly people has increased in Liverpool in recent years. Figure 6.7 shows that the proportion in the 60-75 and over 75 age-groups was higher at the 1991 Census in Woolton than Netherley. However, as Taylor (1994) notes, this disguises more than a 60 percent increase in Netherley ward since 1971. In the postal survey, the highest income area in Woolton had the lowest proportion of women with a sick, elderly or disabled dependant at home. The same area had the least number of women looking after a dependant in another household (Table 6.8). It may be that this indicates differences in the ability of households to purchase alternative care. In terms of other types of caring need, 28 percent of postal questionnaire respondents on the Netherley council estate had a pre-school child living with them. This compared with much lower figures in the other areas (Table 6.9).

Figure 6.7 Age Groups - 1991 Census of Population



Source: Shepton, 1994.

Table 6.8 Households with a Sick, Elderly or Disabled Dependant - Working-age Postal Questionnaire Respondents

SOCIAL AREA	% DEPENDANT AT HOME	% DEPENDANT LOCAL
Netherley - Mixed Low Income Council Estates/ Low Income Terraced (N=17)	6.0	18.0
Netherley - Poorest Council Estates (N=39)	13.0	13.0
Netherley - Medium Income Owner Occupied (N=30)	13.0	17.0
Woolton - Medium Income Owner Occupied (N=107)	12.0	19.0
Woolton - Higher Income Owner Occupied (N=48)	2.0	10.0

Table 6.9 Households with Pre-school Children - Working-age Postal Questionnaire Respondents

SOCIAL AREA	% WITH PRE-SCHOOL CHILD
Netherley - Mixed Low Income Council Estates/ Low Income Terraced (N=17)	----
Netherley - Poorest Council Estates (N=39)	28.0
Netherley - Medium Income Owner Occupied (N=29)	10.0
Woolton - Medium Income Owner Occupied (N=107)	14.0
Woolton - Higher Income Owner Occupied (N=48)	15.0

As Table 6.10 shows, the incidence of limiting long-standing illness at the 1991 Census of Population was proportionately greater at all age-groups in Netherley as compared with Woolton. Once again, the postal questionnaire carried out for the present research also allows differences within the wards to be assessed. Working-age women living in the council housing area of Netherley reported by far the highest rate (61.5%) of long-standing illness; almost three times (21.3%) that in the higher income owner-occupied area of Woolton (Table 6.11). Of those with a long-standing illness in the council area, 57 percent (13/23) also said they were

limited in their activities. This compared with just two out of the ten women in the higher income area of Woolton. The majority reported having some form of arthritis. The contrast is, especially, of concern given the young ages of respondents in Netherley; 64 percent of working-age respondents in the council area were under the age of forty-five. This compared with 73 percent in the Woolton higher-income area, a difference which is too small to account for the contrast in rates of illness between the areas.

Table 6.10 Residents with Limiting Long-term Illness - 1991 Census of Population

	% OF RESIDENTS BY AGE WITH LIMITING LONG-TERM ILLNESS						
WARD	ALL AGES	0-15	16-44	45-59/64	60/65-74	75-84	85+
Netherley	16.4	3.7	8.3	27.8	41.6	57.4	79.7
Woolton	14.5	2.4	4.8	15.7	27.3	48.7	70.0
Liverpool	17.3	3.2	7.6	27.6	37.6	52.5	71.5

Source: City of Liverpool, 1993, p.16.

Table 6.11 Rates of Long-term Illness (Limiting and Non-limiting combined) - Working-age Postal Questionnaire Respondents

SOCIAL AREA	% LONG TERM ILLNESS
Netherley - Mixed Low Income Council Estates/ Low Income Terraced (N=17)	35.3
Netherley - Poorest Council Estates (N=39)	61.5
Netherley - Medium Income Owner Occupied (N=30)	30.0
Woolton - Medium Income Owner Occupied (N=107)	35.5
Woolton - Higher Income Owner Occupied (N=47)	21.3

Studies of deprivation and health in Liverpool (eg. Platt and Ashton, 1991) have consistently confirmed the association between ill health and poor social and economic circumstances. An overall health index correlated strongly with the overall deprivation index (r = 0.85). Clearly, although Netherley is not the most deprived ward and Woolton is not the least deprived (Shepton, 1994), the broad spectrum of socio-economic characteristics of the city's population are represented. The two wards are uniquely suitable for the ensuing analysis of health-related behaviours under contrasting social circumstances. As Ashton et al, (1994) write:

> "Not all individuals living in 'deprived' areas are deprived, but the average deprivation index is a good general indicator of the type of area" (ibid, 1994, p.25).

Once again, it is this difference amongst women in Netherley and Woolton which will be stressed in the next chapters when the results of the interview stage of the research will be discussed.

6.5 Summary

By using the decision-making framework outlined in Chapter Four, this thesis aims to explore the social construction of meaning in connection with household health-related behaviours. This chapter has attempted to illustrate the fundamental importance of space and place to a development of that understanding. It has, for example, shown how particular localities produce the circumstances which structure women's lives in terms of gendered divisions of household paid and unpaid work. It has also described the historically and spatially-specific forms of the division of labour which were produced by the particular economic, social and cultural history of Merseyside and which have fed through to influence the roles

assumed by men and women in the region today. Within the paid labour market, flexibility has been a central and long-term feature for both men and women. Inequalities in employment and income levels have traditionally been commonplace. However, for women those inequalities have been magnified by the fact that they were assigned the 'homemaker' role within highly gendered household divisions of labour, at the same time as participating in the 'low-status' and poorly paid secondary labour market. The context of fluctuating cycles of paid work availability and consequent endemic unemployment has meant that households on Merseyside have historically relied on local social networks for practical assistance. Those social networks which were established in the older, inner areas of the city were, however, disrupted by the creation of 'overspill' housing estates in the post-war period.

The unemployment and deprivation which continues to characterise both the inner urban areas and the outer suburban public housing estates is of an extreme form within the UK. It is the implications which this has for health generally within the city and for women's health in particular which is of central importance to the argument of this thesis. Unemployment and deprivation multiply the burden of women's social roles in ways which need to be clearly revealed to those involved in the provision of health and social care. The spectrum of household circumstances represented in Netherley and Woolton provides an appropriate framework for the detailed analysis of these complex causal relationships which is to follow in Chapters Seven-Nine.

CHAPTER SEVEN

HOUSEHOLD DIVISIONS OF SOCIAL ROLES

7.1 Introduction

As noted in Chapter Three, although both men and women may find themselves with caring responsibilities the actual experience of caring is gendered. This is largely due to normative social structures which continue to place expectations on women to be the *primary* carer at all stages in the life-course. For example, the age at which the caring role is assumed, the kinds of feelings of obligation and the type of dependant being cared for are all factors which have been shown to vary between male and female carers (Parker and Lawton, 1994; Qureshi and Walker, 1989; Ungerson, 1987). Hence, the necessity to 'juggle' a particular combination of social roles is also gendered and the choices about how to handle caring needs are often the main considerations for women in any decision to enter or remain in paid work (Corti, Laurie and Dex, 1994).

The balancing of caring responsibilities and paid work participation changes as women progress along the life-course (Finch, 1987a). The type and level of time constraints they experience also necessarily fluctuate in line with these shifting combinations of social roles. As a simple example, a single, childless young woman with a full-time job is differently constrained in terms of time commitments when compared with an older, part-time working mother. As children grow up the restrictions that school times place on women's activities also alter and a middle-aged carer for an elderly dependant living in another household must contend with

different time-space conditions again. Each individual progresses through the evolving web of constraints in a distinct manner depending on life events and choices made. Although it was beyond the scope of this research to follow individual women over time, the in-depth interviews and diary exercises carried out in Netherley and Woolton can still be used as 'snap-shots' of experience at different life-course stages. The drawing of contrasts between current situations is a major focus of this analysis and the central questions addressed are as follows (cf. Pahl, 1984):

i) how is paid labour outside the household distributed amongst its various members under different social circumstances?

ii) how are unpaid caring and domestic tasks for the household and wider family correspondingly apportioned?

iii) what are the inter-relationships between these two divisions of labour?

A decision-making framework for this negotiation of household activities was outlined in Chapter Four. It is the aim of the present chapter and Chapter Eight to expand on that framework both conceptually and using empirical evidence from the in-depth interviews. This chapter will, therefore, explore gender divisions in household social roles. Chapter Eight will focus on the distribution of different types of resource amongst household members. The aim of both these chapters is

to set the context for the discussion, in Chapter Nine, of health and health care decisions in the interview households.

The conceptual part of the discussion is presented in Section 7.2 where it will be argued that financial resources and help from the social network can each be substituted for the carer's labour-time and so can be used to adjust the *effective* level of felt caring need. Hence, the practical availability to women of economic and social resources must influence the division of their time between competing activities including domestic and caring labour, paid employment and also leisure. This is not, of course, a one-way substitution since economic resource levels are themselves strongly influenced by paid work participation. In many cases, therefore, the processes underlying household activity divisions are cumulative.

In addition, control over direct use of resources cannot be entirely divorced from the many other determinants of paid and unpaid labour divisions between family members. Such influences include the beliefs and attitudes of individuals within the household, including the woman herself, concerning the rights or wrongs of prescribed gender roles and the feelings of attachment she has for the person in need of care. Often, however, an interactive process can be in operation whereby attitudes are dependent on and shaped by the availability of resources in the first place. As noted in Chapters Three and Four, class and level of education, the status of a woman's job and the income she can command have all been shown to influence divisions of the different types of household labour (Hakim, 1991; Horrell, 1994). The women interviewed were selected in order to cover the range of such

differentials and these are drawn out within the description of household divisions of labour provided in Sections 7.4 and 7.5. As indicated earlier the analysis focuses particularly on the changing nature of caring responsibilities across the life-course. These will, therefore, be discussed in Section 7.3 as context for the remainder of the interview evidence.

It cannot be emphasised enough that it was not the purpose of the intensive interview survey to describe conditions through 'representative' case studies. It was intended, instead, to examine the *complexity of negotiation processes* for paid and unpaid labour within families, to use examples of the *variety* of household arrangements in order to illustrate the nature of activity scheduling decisions for women and further to reveal how the women perceive themselves in this framework. The aim is less generalisation and the depiction of associated features than an understanding of the parameters of choice and priorities in the social contexts provided by Netherley and Woolton. If there are 'general impressions' to be taken from what follows, they are about the systems and structures within which choices are made in the real, historically-contingent circumstances of life in households in suburban Liverpool. This is the case because, as will be revealed, the interviews do reflect the local trends in household divisions of labour and need for care described in Chapter Six.

The nature of paid employment within the interview households, for instance, follows the trend of industrial restructuring in Liverpool away from 'male' jobs in car manufacturing and port-related industries towards more 'flexible' employment

for women. The women interviewed cover the range of low-status, part-time work which has developed, particularly, in the 'caring' sectors of the labour market and the higher status, full-time paid employees also tend to be working as teachers, nurses and other service industry professionals. In addition, the divisions of unpaid labour in the interview households reflect the historically-derived pressures on low-income women to assume the home-making and caring roles which were also described in Chapter Six. The comments of many of these women make it clear, too, just how difficult it is for families to survive in a climate of high male unemployment if they do not work. The interviews reflect the continuing importance of Liverpool women's traditional role of bolstering fluctuating male earnings. Finally, the interviews illustrate the enduring part which social networks play as a substitute to the cash economy in the city. The links between family members who moved to the outer estates and those who remained in the inner city areas are clear. Overall, the households included in the intensive survey illustrate the widening nature of socio-economic inequalities between families who have an income from paid employment and those who do not. Before outlining the interview findings, however, the discussion turns to the conceptual examination of the nature of 'difference' in terms of paid and unpaid work and economic and social resources (Section 7.2). It is intended that this will provide the framework for thinking about the qualitative data to follow.

7.2 The Definition of Carer Groups

As noted earlier, a decision-making framework for the day-to-day scheduling of women's activities was proposed in Chapter Four with the family-household

defined as the primary context in which activity divisions are negotiated between individuals. It was pointed out that the shape of constraints faced by women depends not only upon circumstances within households but also upon the relationships of households to outside social networks and structures in society. In this section, that conceptual framework is extended in order to provide detailed context for the forthcoming description of divisions of labour and resources within the households studied.

If, just to begin with, the household is defined as a single unit, it can be located along conceptual scales which represent resource levels and the total collective time expended by its members on paid and unpaid forms of work. Each circle in Figure 7.1 represents an hypothetical household designated in this manner. A household located at position (A) on the diagram might, for example, contain a relatively well-off widow who lives alone. This woman has to meet only her own requirements for domestic labour so she can be flexible as to when the work is carried out. She may provide occasional baby-sitting for grandchildren but the primary responsibility for their care lies with someone else. Position (B) might be occupied by the household of a middle-aged, higher-income, dual-earner couple whose teenage children are old enough to help out with domestic tasks and require just occasional lifts in the car. Equally, it could be occupied by the household of a single, full-time working professional whose only caring responsibilities are to relatively healthy parents who live elsewhere.

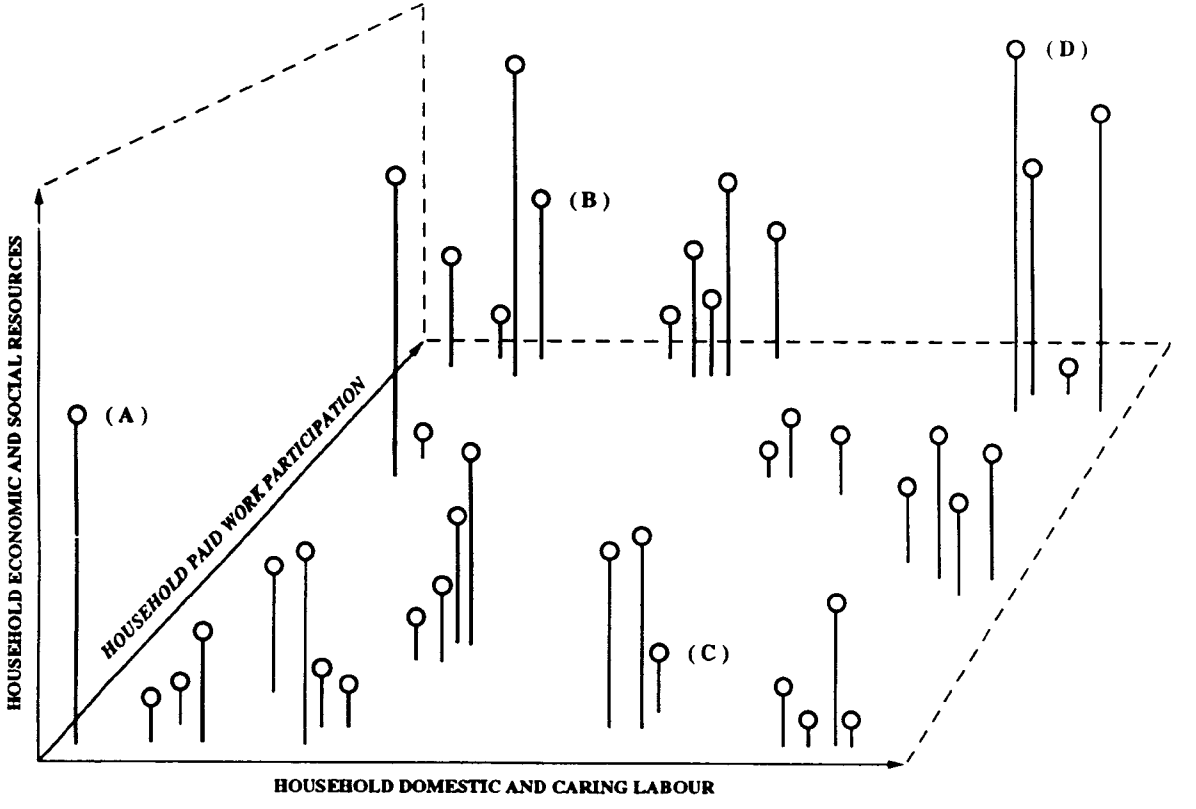


Figure 7.1 Household Resources and Labour Requirements

The type of household at position (C) might comprise a low-income retired couple whose children, the potential source of social support, have moved out of the local area. One partner is disabled and the other has to handle all of the required caring tasks alone. At position (D), another type of household with heavy domestic labour and caring needs might consist of a couple with pre-school and young school children. Both partners hold down demanding jobs but they have a relatively high income between them and considerable support in the form of childcare from the family network.

The overall position of the household depends upon its composition in terms of the wider social relations of class, gender, race and generation. For example, poor health is more generally associated with lower social class and advancing age (Blaxter, 1990). Hence, households which include a pensioner and those in Social Class V are more likely to be located towards the top end of the scale for caring need. They are also more likely to have a low level of paid employment participation by virtue of a greater susceptibility to unemployment. Households which comprise a single mother and her young children would perhaps be similarly placed because gender relations in the paid labour market make it difficult for women to combine full-time working with heavy childcare requirements (Popay et al, 1982). For the sake of simplicity, economic and social resources have been placed on the same scale in Figure 7.1 because they are considered to be both additive and substitutable. Obviously, however, resources available by virtue of having a high enough income are quite different in character and flexibility from those which depend on family and friends. Where a household is located on this

scale must again depend upon the interactions of social relations as they affect the balance between and available amounts of the two possible types of resource.

When it comes to divisions of labour and the use of resources, it is, however, clear from Chapters Three and Four just how inadequate it is to settle for defining the household as a single unit unless it comprises a solitary person. In other forms of household, domestic and caring labour, paid employment participation and the benefits of economic and social resources are shared, often inequitably, amongst the members. With the addition of a dimension for individual health status, therefore, the scales outlined above can be repeated and separately elaborated for women *inside* the household context. This is shown in Figure 7.2 which is a direct expansion of the four scales shown in the basic conceptual framework outlined in Chapter Four (Figure 4.1). The location of women within this overall framework must still hinge upon the outcomes of class, gender, race and age relations. However, it is not the situation of the household within interacting social structures alone which is important to individuals. They are also affected by the ways in which the same social relations are played out on the smaller intra-household scale. Of course, gender divisions of labour and resources have been shown to vary with household class, race and generation but they do also depend upon the nature of personal relationships between family members.

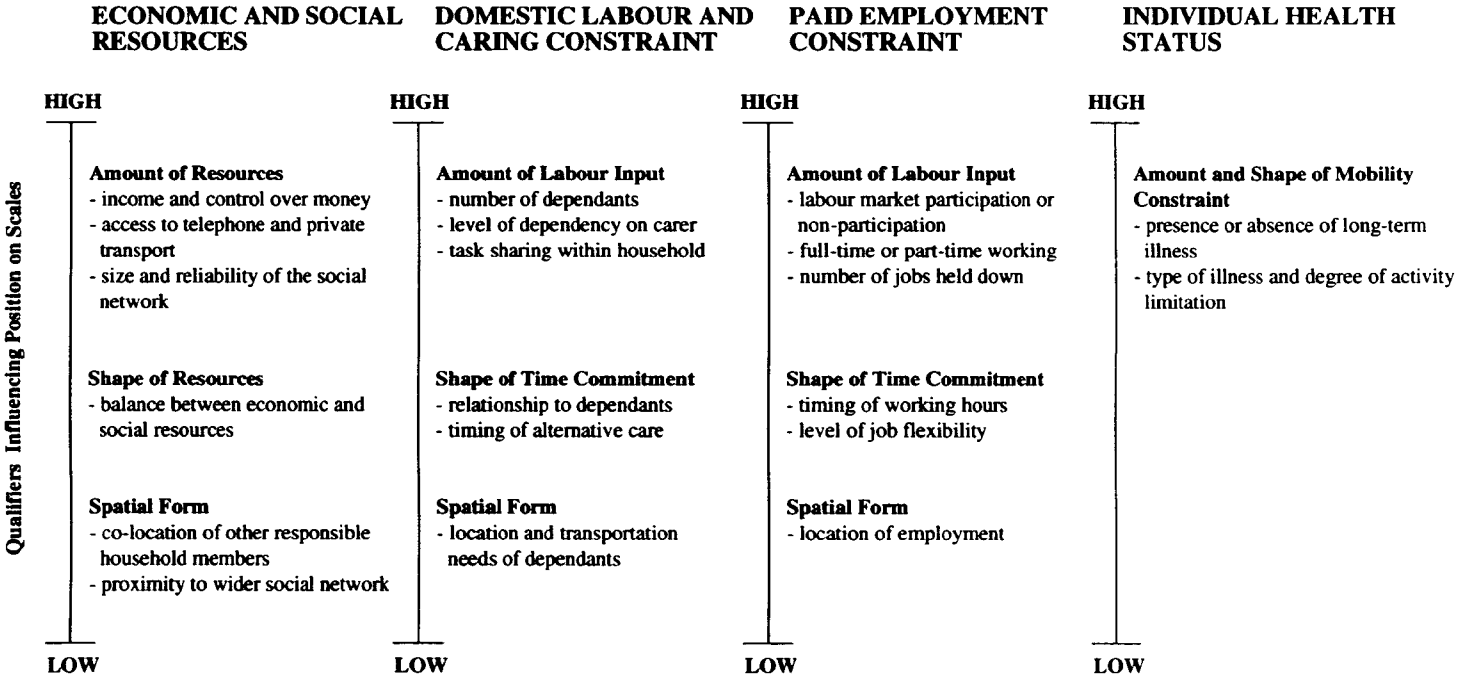


Figure 7.2 Time-space Decision Factors for Women within Households

Rather than actually denoting individual positions, the factors presented in Figure 7.2 are those qualifiers which serve to configure the scales of constraint illustrated. These scales can, however, be defined with greater precision as follows:

i) the level of resources available to women can be seen to rise from little or none at all, through combinations of increasing economic and/or social resources, to significant and flexible quantities of both;

ii) the time constraint experienced as a result of domestic and caring work depends very much upon the degree of effort this demands of the carer. Does the dependant require a small range of domestic tasks or large amounts of personal care? Does he or she need constant attention as opposed to being left alone for long periods? Is the carer's own time relieved by school or day-centre attendance by the person cared for?

iii) the time constraint experienced as a consequence of paid employment participation can be seen to range from none in the case of the unemployed through varying levels of flexible and non-flexible part-time and full-time working. Additional demands in a job would include having to do overtime or take work home and the necessity to be on call;

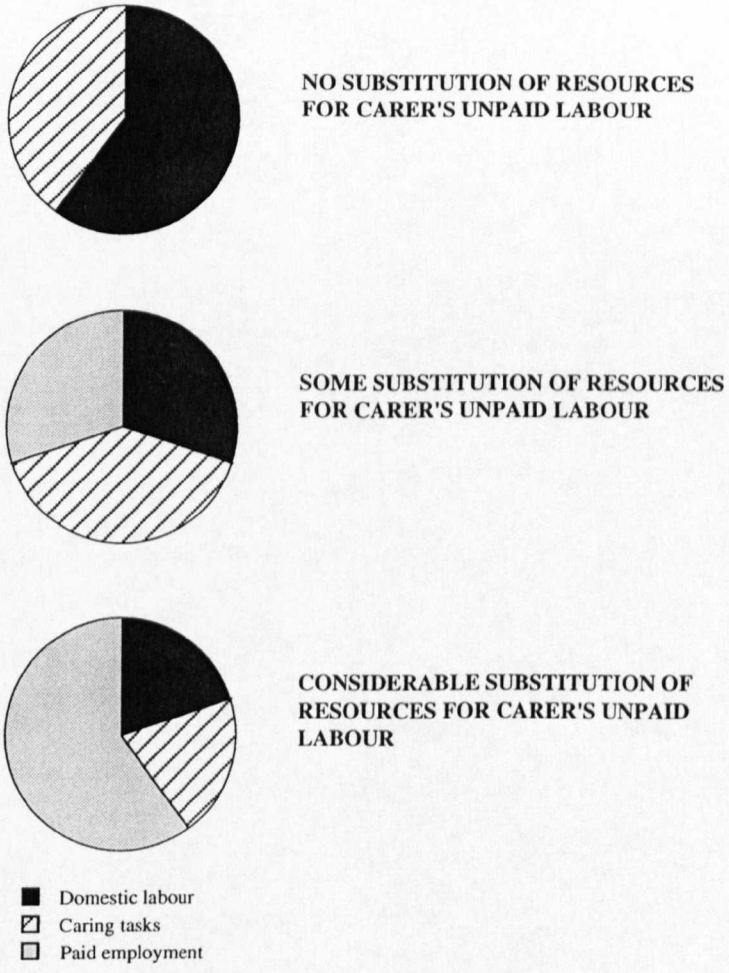
iv) the scale for health-related activity limitation extends from having no health problem at all through any number of possible illnesses and levels of associated disability.

Personal time-space flexibility can, therefore, be seen to depend upon the outcome of interactions between all of the decision factors outlined in Figure 7.2 and the combination of women's positions on each of the scales described.

Figure 7.3 provides a very basic illustration of the ways in which labour time and economic and social network resources might be substituted in order to alter individual experiences of time-space constraint. In the top diagram, for example, the heavy household need for domestic and caring tasks is being met entirely by the input of labour-time from its primary carer. This leaves her little or no time free for outside employment and probably leisure activities as well. In the second diagram, small levels of resources are being substituted for unpaid labour by the carer and this allows her time for a part-time job. In this case, resources might mean payment to a childminder or having a grandparent available to collect children from school. It could equally mean a partner being free to provide childcare which coincides with evening job hours. In the third diagram, the same woman holds down a full-time job because sufficient resources are available to cover her domestic commitments. She might pay an all-day childminder to care for her pre-school children and a cleaner for the household tasks. She and her partner might both have cars and they can afford not to have to shop around in order to save on the food budget. In these ways, as outlined in the introduction to this chapter, both the

effective need for caring felt by the woman and the constellation of her activities may be altered.

Figure 7.3 Alternative Divisions of Primary Carer's Time In Household with Heavy Domestic Labour and Caring Need



Obviously, there is little limit to the combination of constraints which can be experienced and the divisions of time theoretically feasible. Economic and social resources may, for instance, be substituted for domestic labour by a woman who is restricted by limiting long-standing illness. In some households, the partners may completely swop their social roles such that an even greater proportion of the woman's time may be accounted for by paid work participation. The range of interactions possible between the factors presented are summarised in Figure 7.4. In this final diagram in this section, the dashed line is used to indicate that time-space flexibility as configured by paid and unpaid labour and individual health status is not necessarily fixed but can be altered by the use of available resources.

Figure 7.4 Time-space Constraints on Individual Women

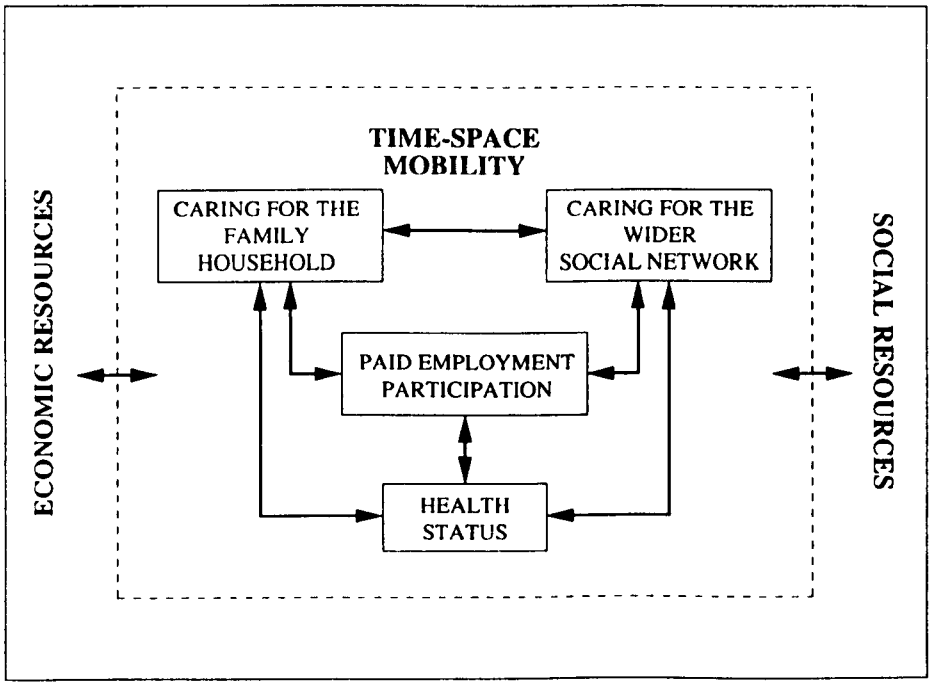


Table 7.1 Types of Working-age Carer amongst Postal Questionnaire Respondents

	WOMEN WHO:	NO. IN POSTAL SURVEY	NO. INTERVIEWED IN-DEPTH
i)	Care for an adult in a separate household	19	6
ii)	Care at home for an adult (including a grown-up child) with low dependency	17	4
iii)	Care at home for a highly dependent adult (including a grown-up child)		3
iv)	Combine care of adults at home and in a separate household	2	---
v)	Combine care of healthy children and an adult in a separate household	17	5
vi)	Combine care of healthy children and an adult at home	1	1
vii)	Care for healthy school-age children	51	9
viii)	Care for healthy children including pre-schoolers	27	4
ix)	Care for a disabled pre-school or school-age child	7	5
	TOTAL	141	37

Note: It was not possible, prior to the interview, to distinguish the dependency level of an adult being cared for by women in groups ii) and iii).

The argument that domestic and caring labour is the discriminant factor in women's activity decisions is the main one to emerge from the above discussion. For the purposes of the analysis in the next section, therefore, it is possible to define types of carers on the basis of the constraint scale outlined earlier. As Table 7.1

shows, more precisely this means groups based on the level of dependency of the people cared for. Indicated on the table, is the number of women interviewed against the total number of postal questionnaire respondents of working-age in each respective group. Once again, it is clear that the nature of caring being undertaken by the sample reflects that anticipated in Chapter Six. A significant proportion of the women are, for example, looking after an adult with health problems at home or helping an elderly person to live as independently as possible. There are large numbers of healthy school-age children who also need looking after and a small, but significant, group with disabilities.

It is important here to reiterate the point made in Chapters Three and Four that *difference* amongst women in terms of the distribution of inequality (Crompton et al, 1991; Hakim, 1991) is what is important for this research. It must, for instance, be borne in mind that women operating towards the extreme ends of the scales described for caring need, low income and gendered divisions of household labour are the most challenged in terms of activity scheduling decisions. The links between household divisions of paid and unpaid work, women's health status and their access to different types of resource can now be examined systematically across the varying categories of caring need shown in Table 7.1. The implications for the time-space flexibility of women in the different carer groups are drawn out throughout the discussion. As noted in Chapter Five, patterns from the larger-scale postal survey will only be introduced where appropriate to reinforce the 'general context' for the processes being described. It should be noted that certain individuals do appear more frequently than others in the discussion. Again, this is

not to claim that these interviews are at all generalisable to other households in similar circumstances. It is simply that certain groups are less well represented in the sample with whom contact was achieved but the comments made in the small number of households do still raise *issues* which are likely to be more widely relevant.

7.3 The Nature of Dependency and the Caring Process

The analysis begins, in this section, with a detailed outline of the different levels and forms of caring need which emerged from the interviews in Netherley and Woolton. How, for example, does caring for healthy children vary from looking after those with disabilities? Are different types of adult dependants more in need in terms of labour input than others? What is the effect of gender on the level of caring labour generated by having an adult dependant. Overall, this section aims to expand on the constraint scale described earlier (Figure 7.2) for caring responsibilities in order to illustrate the size of its influence on women's activities.

7.3.1 Children and the Dependency Scale

The age of children made a considerable difference to the kinds of caring need felt by the mothers interviewed. In general, secondary school-age children were seen as less of a responsibility than younger ones because they can be left to their own devices much more:

> "She still needs her Mum, but she spends a lot of time sort of with her own friends and doing her own thing. She's not reliant on me for everything. She's quite capable of getting her own lunch and that, you know sorting herself" (Early 40s - Full-time secretary describing daughter aged 14).

Obviously, very young children also require large amounts of labour-intensive personal care. Having siblings at very different stages of development, therefore, seemed to complicate arrangements considerably:

> "I think it's getting a little bit more frantic now. There's quite a big age gap between them [sons aged 13 and 6] and I think a couple of years ago - I mean Paul [younger son] didn't really have a life of his own ... And so really our activity tended to be around Luke - but now they're both getting their interests ... so we find now we're being pulled in different directions ... I think we're beginning to see the age gap much more than we did two years ago" (Mid 40s - Full-time personnel manager).

For those with disabled youngsters, there are often extra caring demands such as physiotherapy provision and more routine personal care tasks usually continue well beyond the time period parents can expect with otherwise healthy children:

> "When they're babes in arms it doesn't make a lot of difference. Like at twelve months old I think you really start to notice differences. Like Sarah was walking at twelve months and Hayley was very much a baby still then - couldn't walk till she was two ... And she actually needs more teaching. I mean we've been toilet training her for twelve months. I had Sarah toilet trained in like two days ... And ... when she was first born you read all the literature and it all says the more stimulation you can give them early on the better the long term effects. So you feel you've got to be stimulating all the time" (Late 30s - Full-time teacher).

For these mothers, especially, a nursery or school place for the child provides more time to fit other activities into the day. As one single mother living in Netherley put it when asked if her day has to fit around her physically disabled three year-old and two other children:

> Basically, right round. Only since James has been going to nursery and that I've been able to pick myself up and go to town on my own and say have a look around ... instead of going to the same shopping precinct where it's just shopping and that's it ... It's like as if, I

> don't know, like as if a weight's been took off your shoulders it's so different ..." (Early 30s - Income Support).

Whatever their marital, family and employment circumstances, however, the majority of mothers felt that their own activities are structured to a lesser or greater extent by the needs of their children. Mentioned most often in this context, in addition to nursery and school hours, were mealtimes and children's hobbies. For example, when asked the degree to which her own day fits around her husband and child, one woman replied:

> "I mean I normally go to my Mum's and I'll take her from school and she stays there and plays with my nephews. And like it's rushing home then to get the dinner cooked before Alan gets home so I have to race her. But God, if I leave it to the last minute or I miss a bus and its mad panic when I get in to get the dinner done before he gets here" (Mid 30s - Looking after home).

Another said:

> "They're all in the same school ... It's quite good really because when I come out of here [house] to take them to school my bus [to work] is just there so I only have to see them across the road - and then, obviously like, when I come home I'm back home again for them ..." (Mid 40s - Part-time cleaner).

7.3.2 Adults and the Dependency Scale

A scale of dependency is also evident for those providing care to adults. At the lower levels of constraint are women who, for a few hours each week, provide company and do shopping and housework for elderly parents in order that they might live independently:

> "He's self-caring except I go down and do his laundry and I do his housework ... I have to remind him it's bath today and things like that, but as for his shopping and meals and things, he's alright with that ... He pays all his own bills ... he doesn't have any problems

there. It's mainly just the housework and keeping an eye on him you know" (Late 40s - Full-time administrator describing help given to elderly father).

Not all the people who receive this kind of 'social care' live on their own. In one particularly notable case, the father of the woman interviewed, who had recently suffered a heart attack himself, was caring for his partially paralysed wife at home. Her physical disabilities were also the result of a heart attack which had left her needing help with all personal tasks such as dressing and undressing, bathing and washing her hair. This couple were both in their eighties at the time their daughter was interviewed:

> "... They're very independent actually. They like me to be there ... They can cook but I do the washing and ironing for them and they prefer me to do that ... If they want any help I'll go over and give them some help you know" (Early 50s - Looking after home).

Also at the lower end of the scale for caring need experienced are those who look after low-dependency adults at home. Amongst the interview households, this usually meant people who had already been living in the household when they became sick or disabled. Most often, it also meant that the women were caring for partners living with chronic illnesses such as asthma or a heart condition. These women talked about 'keeping an eye' on their partners, having to think up activities to keep them busy and just occasionally giving help with bathing and other personal tasks:

> "Well ... I encourage him to keep off the chair because with a heart condition you're supposed to try and potter around ... Like I encourage him to do a bit of cooking and that when I'm around. He likes to do it anyway, but I've got to watch because he forgets when he leaves a pan on things like that ... he's inclined to slip in the bathroom ... sometimes he wakes up through the night ... and he's sitting up and he's breathing heavy so I give him the Ventolin.

You've just got to try and attempt to bring him out of things like that" (Late 50s - Full-time care worker).

In the majority of cases where an elderly parent or parent-in-law was actually living in the interview household, they were typically highly dependent individuals requiring everything from domestic servicing to labour-intensive and time-consuming forms of physical care. Usually the carer had moved the person being cared for into her own home because there was little alternative. One woman described the responsibilities of looking after her mother, who was in her nineties, as follows:

"She doesn't do a great deal now ... I mean everything is done for her more or less ... I have to bath and get her ready for bed, cook her meals and do the washing ... Of course the difficulty is ... getting a day off isn't it and going on holiday? ... I have a friend who's had her for two weeks every summer and then my son ... she's gone there for a week. But as she gets older I think it's going to be more difficult for people to cope really. [You wouldn't ask them as she gets older?] Well it is difficult isn't it? I think because you have a responsibility for people" (Late 50s - Part-time job in school).

As was the case in the previous studies cited in Chapter Four (Qureshi and Walker, 1989; Ungerson, 1987), it is noticeable amongst the interview households, that a considerable gender bias exists in the proportion of caring labour for elderly dependants accounted for by domestic servicing. In contrast to the above example, where the carer did at one stage receive some help in the house from her mother, another woman described the attitude to household tasks of her father who also lives with her:

"... he's a man who's never had to do anything for himself. My Mum's done everything for him, cooking, washing, everything and

> he was eighty-four when my Mum died ... Anyway, the first two years weren't too bad and when I packed up work ... he didn't even make himself a cup of tea - he stopped doing that because he's getting older isn't he?" (Early 50s - Invalid Care Allowance).

It is a similar situation for many women who help a widowed father to remain living independently. Running through the disability checklist (Appendix 5A) one Netherley woman said:

> "Housework is definitely a problem for him because he doesn't like doing it. He just refuses to do it, he just doesn't see it. I mean I go on a Saturday and I go right through and I can go back the next Saturday and everywhere's full of grease and dust because he has three cooked meals a day but he never cleans the cooker after him or anything like that ... But, I mean, it's not that he's got difficulties, he just doesn't do it" (Late 40s - Full-time administrator).

Adults in the high-dependency category also include grown-up children and partners with physical and/or mental disabilities. The necessity to give these people large amounts of attention and not to leave them unattended even if they do not need physical care, means that their carers were amongst the most constrained in the survey in terms of time-space flexibility. The mother of a twenty-five year old with Down's Syndrome explained this in the following manner:

> "Just keeping her company that's all ... If she doesn't like sitting here, she's got her own telly and video upstairs ... she just pleases herself. It's just somebody to be with her"
>
> "If anything happens in school [day centre], she's alright at school, I get it when she comes home. I'll get all the shouting ... I'm the one that gets the lot" (Early 50s - Recently retired from part-time catering job).

It is hardly surprising that, amongst the women caring for adults, it was those looking after highly dependent people at home who, like the mothers of young

children mentioned earlier, described their own activities as most structured by the needs of the person they care for. This point is illustrated, firstly, by a woman who looks after her eighty-nine year-old father and, secondly, by the wife of a stroke victim in his mid fifties:

> "Basically just make his breakfast for him, take it up on a tray. Then go up about half an hour later, take him another cup of tea and if he wants any tablets ... At lunchtime take his lunch up to him ... He gets up about four o'clock ... And basically that's it, I'll do his washing and his ironing for him and all his cooking ..." (Early 50s - Invalid Care Allowance).

> "Like he can't wash his hair and things, he can't wash his back. ... [So how much time during the day do you spend helping him or do you just do it altogether?] Just altogether you know" (Late 50s - Gave up job to care for husband).

Day centre and club places do seem relatively available as alternative sources of care to those with a grown-up disabled child and this does release time for other activities in the same way that nursery and school provide opportunities for the other mothers. For the carers of elderly parents and disabled partners interviewed, however, such openings were much less common. Only where the provision of care for a frail elderly person had been taken over by a residential or nursing home was the woman's own time commitment less demanding. It involved taking in magazines and newspapers for the dependant to read and just generally 'being company'. In these cases, the wheel has come full circle back to a level of need similar to, if not less than, that experienced by those providing 'social care' to someone in another household:

> "My Mum's in a nursing home so I go and see her once or twice a week ... She was living here but she's in a nursing home now because she has to have a zimmer and she needs a lot of help really ..." (Late 40s - Part-time library assistant).

7.3.3 Combining Responsibilities for Dependency Groups

The interview survey also located six women who were combining responsibilities for different types of cared-for people. One mother of two teenagers and a primary school-age child was caring at home for her husband who suffers with severe depression and agoraphobia. The other women had children of a similar age range and were helping one or both of their parents in another household. The following extract exemplifies the women's experience of multiple dependency as 'constantly being pulled in different directions':

> "... Rushing around I am ... I always feel as if I'm in a hurry. That's it basically - I always feel as if I'm rushing here there and everywhere and I really should slow down ..." (Mid 40s - Part-time cleaner).

It is consistent with previous studies, discussed in Chapter Three, that the majority of women in this group were the middle-aged mothers of teenagers. Therefore, although they were caring for parents, the demands of having children had begun to lessen (Brody, 1981; Davis, 1981; Wearness, 1990; West, 1984). Two of the women were, however, only in their early thirties. They were combining the care of an adult with looking after children as young as one year old. A Netherley single mother on Income Support said:

> "... It's about getting a job isn't it? ... I think I've got enough to do - run around after Tom then go down to my mother's - it's all go" (Late 30s - Income Support).

7.4 Variations in the Household 'Partnership' of Labour

It is evident from the above discussion that household divisions of labour are of primary importance to the configuration of everyday activities for women. This

section, therefore, examines the inter-relationships between women's participation in the external paid labour market and the distribution and level of unpaid caring and domestic tasks within the household. Attention is drawn, particularly, to the differential nature of 'sharing' labour under varying social circumstances.

7.4.1 The Role of Children in Household Labour

In the same way that mothers talk of their older children in terms of a lower dependency and caring need, age also makes a difference to the kind of contribution children can make to the division of unpaid household labour. An older child may, for example, help out with childcare for younger siblings:

> "She's [childminder] been on holiday in term time once ... I wasn't in this job then, so I could still put Hayley [Age 2] on the bus in the morning because I started work that bit later and Sarah [Age 12] ran home from school ... everyday to be here at about twenty-past-three and she took her off the bus. She's usually delivered to the childminder's, but in those two weeks she was delivered here and Sarah took her" (Late 30s - Full-time teacher).

Some older children also take on domestic labour and personal care for a mother who, herself, has a limiting illness:

> "My other daughter, our Julie, she did have the main caring but she's gone away with the Sea Cadets ... so our Ann's [Age 17] stepped into the breach. The main caring that I need is like helping us up of a morning because I'm very, very stiff first thing and that" (Late 40s - Registered Sick due to rheumatoid arthritis).

It is noticeable, however, that in the interview households which do contain secondary school-age and older children any contribution to unpaid labour is usually being made by daughters. Most often, sons only seem to carry out domestic tasks where they have their father's example to follow. One woman, for instance,

described how her husband enjoys cooking when he is home from his job which involves periods abroad. The rest of the time, she and her two sons, aged twenty-seven and sixteen, take it in turns to cook the evening meal depending on who arrives home first:

> "We have a different household when he's [husband] home ... Because when he's home he does all the cookery ... When Ian's here we all sit down and eat, when Ian's not here we'll eat when we're hungry and we'll all eat different things ... We're very liberated that way" (Late 40s - Full-time administrator).

7.4.2 Gendered Roles in the 'Domestic Partnership'

No matter how 'helpful' children may be, they are, however, just part of the equation for the division of household domestic work. When they are very young, there is also relatively little that they can really be expected to contribute. As might be expected from the previous studies cited in Chapter Three (Henwood, 1987; Martin and Roberts, 1984), the majority of mothers of school-age and pre-school children interviewed said that they are the ones who take primary responsibility both for domestic tasks and childcare. This was, particularly, the case in the lower-income families where divisions of paid and unpaid labour seemed to be the most 'traditional' between the sexes. Whilst their partners often do shiftwork or work long hours in full-time employment, women in these households work in low-status, part-time jobs or else they are entirely occupied in the home. When asked, for example, if her husband helped to put up new curtains, one of the women in the survey replied:

> "You've got to be joking! No, when I was looking back [at diary sheets] I was going - no, you wouldn't think he lived here, he doesn't do anything. He makes Joanne's [daughter] lunch sometimes and of a night washes dishes - or he forgot last night because he worked late

> so I had to do it this morning. But no he don't do nothing except make a mess!" (Mid 30s - Looking after home).

The husband concerned works 9am to 5pm in a clerical job during the week and also has a second job on Saturday. None of the women talked, however, of partners expressing the kinds of explicit views, noted by Joshi (1984), about whether or not mothers should return to paid work.

In those lower-income households where the children have now grown up completely and the present caring role of the interviewee is towards a middle-aged or elderly dependant, it seems equally common for social role divisions to be 'traditionally' gendered. The household referred to in the next example, for instance, comprises the wife, who is employed in a paid job between 10am and 2pm each weekday, the husband, who works twelve hour days and nights in the Liverpool docks and their son who is in his twenties:

> "[Do you get any help around the house?] *Sometimes* Mike [husband] *helps* me. Tonight he's cooked the tea so *I've been lucky*" [author's emphasis] (Early 50s - Part-time catering assistant).

In most cases, whether or not an adult dependant lives with the carer, the main responsibility for looking after them again falls on the woman concerned:

> "[Does anybody else give you a hand with your father?] My son shaves him once a week ... trims his hair when he wants it trimming. I'll say I have to go to town, or a couple of weeks I have to go to Broadgreen Hospital myself so I wasn't here for lunch and I asked him to come over and give him his lunch he would do. Basically, that's it" (Early 50s - Invalid Care Allowance).

It is consistent with the findings of previous research outlined in Chapters Three and Four (Green, 1988; Parker and Lawton, 1994; Qureshi, 1990; Qureshi

and Walker, 1989) that the women in this study also describe gender differences in the *type*, not just the *amount*, of care given to elderly dependants by themselves and their partners, their sons and daughters and sisters and brothers. In general, if the men contribute at all, it is to help to 'keep an eye on' the dependant concerned, provide transport occasionally and carry out household repairs and similar jobs around the home. In contrast, as daughters and daughters-in-law, the women most often give more time-consuming help with housework, the main shopping and certain personal care tasks which the parent cannot manage by him or herself. One participant in the study described the contributions made by herself and other family members, specifically, to the care of her own eighty-two year-old mother:

> "I do her washing and cooking, wash and set her hair for her and, you know, things like that".
>
> "When she goes for her pension - she goes every fortnight so it's over a hundred and odd pound. So, of course, most times Mike [husband] picks her up and takes her because she is a bag of nerves, you know with money".
>
> [Do you get any help to look after your mother?] No. Well, my brother travels from Runcorn on a Sunday to bring her round here and Mike takes her back home about 10 o'clock at night ... So that's the only help really. I've got a brother that lives a hell of a lot nearer to where my Mum lives [in Woolton] and she never gets to see him - what? - three or four times a year if she's lucky. So, it's families" (Early 50s - Part-time catering assistant).

There are other examples of families who divide social care for an elderly relative in a similar manner to this. For instance, having said that she herself does all of her father's housework, another woman answered as follows, when she was also asked about help with caring:

> "One of my brothers is not working and doesn't live far, so he goes round and does any odd jobs he needs doing - helps with the garden and things like that. But no, as yet no [help], not yet" (Late 40s - Full-time administrator).

Of course, in cases where the male partner is actually being cared for himself, the entire load of domestic work and, where applicable, childcare must necessarily be shared unequally:

> "I get up about 8 o'clock, do the breakfast - I wash about every other day - go up and make the beds, tidy up. Then me and my husband go for a little walk for about an hour and then we come back and I start preparing for the tea ... My husband's paralysed down one side so we just take our time, you know" (Late 50s - Gave up job to care for husband).

As Rimmer (1988) also pointed out, for most single mothers, there is also little choice but to carry out the greater proportion of domestic labour and childcare. Where these women hold down a full-time job in addition to their family commitments, the busy domestic load must even be compressed into a much shortened time period:

> "I don't do anything really big during the week - it's just really getting the kids' stuff ready for school the next day ... and getting my own stuff ready for work ... It's the weekend I do all the big jobs" (Early 30s - Full-time clerical worker).

7.4.3 The 'Sharing' of Unpaid Labour in Higher-income Households

Also consistent with the previous research discussed in Chapters Three and Four (Hakim, 1991; Martin and Roberts, 1984), only those women who are themselves in higher-status employment really talked about 'sharing' the domestic load with their partners. However, just as Brannen and Moss (1988) discovered, even in these cases 'sharing' was mainly in terms of the simpler childcare tasks such as transport to and from school:

> "... I have to say we operate quite well as a team. I mean, although that's [diary] what I did, I thought I'm sure if John were to fill one in it would look just as active in different directions ... In truth, he's pretty good John really ... We don't think about who's responsibility

> or who's job? We just decide who's going to do it and get on with it really, so we do share it" (Mid 40s - Full-time personnel manager).
>
> "... He's always been very domesticated ... it doesn't bother him ... and he's always been good with the kids ... especially when I had Steve [youngest son]. If Steve woke in the night it wasn't me - if Ian was here, he'd go and see to him. I mean even we had the grandchildren staying with us the other week and the baby was teething and was a bit restless through the night - and when I woke up in the morning ... he was down here with them made up, quite happily changing nappies and everything. He's always been good with the kids" (Late 40s - Full-time administrator).

Four of the five mothers, to whom it applied, also said that they take chief responsibility for managing with a young child's disability. Notably, it was mothers, not fathers, who, where it was not directly apparent, had observed any disability prior to initial diagnosis:

> "I mean the back of my mind I always knew there was something but like the health visitor said to me, 'You don't want him seeing psychologists and everything' and I thought 'Well I don't, maybe it would be worse for him ... maybe he will settle down' ... And Derek [husband] just wouldn't accept it ... I'd read little things and say, 'Do you think that's what's wrong with him?' You know, about autistic children and things. But he just like switched off and didn't want to know. I mean he's OK about it now ... That's because he's got to be really" (Early 40s - Part-time care worker).

Even in higher income, dual-career households, where women were again more likely to talk in terms of 'sharing' responsibilities, they still seem to anticipate being the ones who will forsake paid employment if it comes to a choice. Both members of the couple in the next example are full-time teachers. The wife was asked why it would be she and not her husband who would give up paid work if their child with Down's Syndrome came to need more intensive care:

> "I don't know ... Like I said, neither of us would really want to give up work totally. I'm not your little housewifey type who could sit here and spend one day doing the shopping and another doing the

> laundry sort of thing. But if Gerry gave up work he'd like to open a business, a sports shop or something like that. So we've talked about doing that sort of thing rather than give up. Again, you see, if one of you gives up it makes life for the other one easier. Because I make him do his share of the child collecting and making the tea and so on, so it's as hard on him as it is for me really. Whereas, if one of you is doing more of that it makes it easy for the other one" (Late 30s - Full-time teacher).

7.4.4 Re-negotiating Household Roles in a Variety of Contexts

There was some evidence of a re-negotiation of social role divisions in low-income households during periods of male unemployment. For instance:

> "... I was at college full-time, the four children were at school and their Dad used to mind the twins because he'd been made redundant. That's why I took the opportunity of going back into education where I'd always been at home with the children you see" (Early 30s - Full-time clerical worker).

The couple in this example had since been divorced and the wife had, therefore, continued in full-time employment. In the main, however, this research confirms the findings of studies already outlined (Morris, 1990; Qureshi and Walker, 1989). In cases where the male partner had been unemployed, any re-negotiation had either not taken place at all or had proven to be temporary, with the situation reverting as soon as the male partner found a new job. This point is illustrated by two Netherley women. At the time of the interview, the husband and father of the first had both been unemployed long-term but the partner of the second had gone back to work after a period of some months:

> "Now and again he'll [husband] do a bit of shopping. He doesn't do the main shopping, but he'll get milk and bread and stuff from the precinct. [For the main shop] I'll go there on the bus and come back in a taxi"

"I've got a sister who still lives at home and she looks after the house and everything. He [father] works but he's out of work so" (Late 20s - Looking after home).

"My husband was working [in factory] ... and they all got made redundant so for about eight months he was looking for a job before this one came up - so that gave me the opportunity to get a little job which was a bar job. But ... I hated it, so I only stuck it for as long as it took him to get a job and that was that I left ... its a pain in the arse getting up when you've just had your tea and I missed putting the kids to bed and everything so" (Mid 30s - Income Support).

Again, as suggested in Chapter Four, only in certain more 'extreme' circumstances had a longer-term and continuing re-negotiation of domestic labour and/or childcare divisions taken place between partners in the lower-income households. A notable example is provided by one study participant who is in her thirties, suffers with chest problems and rheumatoid arthritis and is seriously limited in her general activities and physical mobility as a result. Significantly, for this research, her case illustrates how ill health can limit women's ability to carry out all kinds of caring and domestic tasks. Her husband had taken over the entire domestic load including cooking, housework and the care of their five children who ranged in age from teenage to pre-school. He was now registered unemployed and, because of his responsibilities at home, did not anticipate ever being able to get a paid job again. The family had no car and no telephone and were sinking further into debt. Another case illustrates how, in particular, limiting illness exacerbates the limitations on labour market participation and earnings already felt by women as a result of the caring role. For example:

"Well I left the Girobank when I went out to Germany [with army husband]. Then I worked in the Mess for a while. Then I fell pregnant and I didn't work until the twins were at school and the youngest was at nursery ... I wanted to go back to what I was doing,

you know, when I gave up to raise a family. And I was told that it was a young person's - I was only thirty-odd like - but working with computers was a young people's industry ... And I just did like part-time jobs, a bit of cleaning, a bit of barwork and that, you know. But I thought it was a waste of all that training and experience and that. Then when Maggie [Thatcher] wanted the married women back I wasn't fit enough then because data processing you nearly always use just one hand. And, as I say, this hand is like OK, but this it seizes up, you know, so" (Late 40s - Registered Sick due to rheumatoid arthritis).

"I was there twenty-five years. But the last three years I had to change [jobs] ... I had to sit on a little eighteen inch, three-legged stool, no back or arm-rest or anything and it was agony, agony, absolute and it was making my back worse. So, in the end, I thought well I just couldn't do another two years of it, I just couldn't. And if I had I would have had a little pension ... but I had to forego it. So, in the end, for health reasons I took early retirement" (Late 50s - Recently retired from part-time laboratory job).

Where it does not restrict mobility too severely, long-term ill health in either partner seems to provide an opportunity to modify gendered social roles. This was certainly the case for middle-aged couples, whatever their income level, whose relationships in the past had clearly conformed to the more 'traditional' domestic labour stereotype. One example is provided by a couple for whom this had not caused any difficulties in their relationship:

"I worked part-time because ... the chest specialist said that he only had a couple of years left in him. This was before the inhalers were brought in ... and he was really bad ... so I thought, 'Well as soon as [son] Stuart's old enough I'll have to go to work' ... So we managed it and that was why and then as Stuart got older and Ken was still with us, happily he was still with us, it became a way of routine. Then you get a little selfish and you start suddenly thinking, 'I'll save my salary as something to lean on if anything happens to Ken or Ken couldn't work so that you'll have something behind you'. And so this is why we only had one child. I thought I could manage to keep one and look after one and bring him up properly. So in one sense it was necessity and in another I got used to doing it. And also when it became that it wasn't necessity when Ken was working ... it became it was something nice to do for three days a week".

> "[Do you mind giving me a few details of what it involves to look after your husband?] Well, it means that I do all the gardening. Well, I used to do it all. Now I have to get someone in because now I can't do it ..." (Late 50s -Recently retired from part-time laboratory job).

In another household, the re-negotiation of social roles had only served to heighten the problems already being experienced:

> "... So I gave it [work] up, so that was two years ago and my husband had already been on invalidity for a couple of years. And, when I was at work, I was coming home, he'd basically have taken over the house, he was doing the cooking - he's that type of person you know - and my meals would be put down in front of me. I wasn't asked like, it was just put there. I wouldn't complain because I was brought up that, if it's put in front of you, you accept it ... And eventually, when I did give up the shop, I found even the house wasn't mine. It didn't feel the same ..." (Early 50s - Invalid Care Allowance and since divorced).

Another 'extreme' case, involves a couple whose four year-old son is so severely disabled that he needs constant attention and labour-intensive physical care. The child suffers from cerebral palsy, is blind and also has epilepsy. In this low-income household, the domestic and caring roles are not reversed but do seem, relatively, to be more even than the average:

> "[And your husband helps? ... In the general sort of things?] Oh everything yes, I couldn't do it without him. I mean our morning routine is Don [husband] will bath and dress David [son] and I will feed him his breakfast. I mean, because it's probably twenty minutes to bath and dress and probably half an hour to feed, you know, so we've got to do it between us because one of us has got to get washed and dressed in between in order to take him out to the taxi you know. So yes, he does help, he helps a lot really - changing nappies and, well everything, in everything you know, feeds him ... Like, if he was at work I don't know what I'd do really because he'd be up and out of a morning so it would be left to me ..." (Early 40s - Looking after home).

The particularly equitable nature of childcare divisions in this latter household may, however, be specific to the couple concerned who also have an unusually shared experience of labour market participation. They used to run a newsagent shop together and, as the wife explained:

> "... we were only in the shop six, eight months when we first had David so I just used to sort of ferry him backwards and forwards. And I'd take him up to the shop and then Don would bring him back home ... Because Don opened up at six so I'd go in about ten and then Don would come home and have a couple of hours sleep. So, yes, we've always worked together. You've got to haven't you really with a little one? So, yes, I do get a lot of support" (Early 40s - Looking after home).

It is also noticeable that, in each of the above cases, it is the unemployed status of the male partners which has allowed negotiation of their continuing high level of domestic labour participation. This reveals the nature of the labour market for 'male' jobs in which it seems virtually impossible to combine part-time working with a caring role.

7.5 The Time-space Implications of Household Labour Divisions

7.5.1 Time-bound Forms of Paid Employment - Scheduling the Caring Role

The fact that most semi-skilled and unskilled, full-time jobs require long hours and/or shiftwork schedules that are incompatible with nursery and school times, is one of the main obstacles to the contribution to caring, especially for children, of male non-professional and non-managerial workers. Most families, however, could not survive on the relatively low wages from the woman partner's working without the money earned by the men. For instance, the husband described in the first example below works on the railways and earns £260 per week. His wife, on the other hand, brings home just £40 per week from her part-time job as

a catering assistant. The woman in the second illustration receives £80 out of her partner's weekly income of £130 from his factory job. She also receives Child Benefit for her two children and continues to claim Income Support, without declaring that she is co-habiting, because the family cannot manage on her partner's wages:

> "[So how does his day fit around yours?] Well, it depends what shift he's on. Like he's on nights this week, so he sort of comes in about seven-thirty in the morning and then he leaves about half-ten at night - but he sleeps during the day ... And then other days he does afternoons, which is two o'clock to ten o'clock. And some other days he just works a day shift, which means he goes in about seven and he's off about half-past-three in the day. So it varies you see" (Late 30s - Part-time catering assistant).

> "He works shifts, so he starts at six, but he's got a long drive to Skelmersdale so usually he's out of the house by 5 o'clock. And he works from five till two in the afternoon, so he won't get home till three. Or he works two till ten, so he's out of the house at one and doesn't get back till eleven" (Early 30s - Income Support).

For many families in the interview group, therefore, overall scheduling difficulties are reduced if the woman works in a part-time paid job which is compatible with school and nursery opening. As the woman, who works as a catering assistant, referred to above, explains:

> "They're [three sons] at school ... That's why I got the job really because I'm off when they're off. That's the only real reason I'm taking this job at the moment. Maybe it'll change in the future, I don't know. But summer holidays I'm off when they're off ... bank holidays ... so I don't need to get anyone to look after them which is a good thing I think" (Late 30s - Part-time catering assistant).

Again, this reaffirms the findings of studies reviewed in earlier chapters concerning the nature of household strategies for substituting care (Martin and Roberts, 1984; Rees and Willox, 1991). An alternative strategy, already described elsewhere (Dex

and Shaw, 1988; Jones, 1989; Pickup, 1989), is for women to go out to work at the times when a partner is available to provide substitute childcare:

> "... I'd been at home since I'd had my son. And when Sue was about four I got a Saturday job to sort of go out with other adults during the day instead of talking to children all the time. But that just fitted because my husband was with them weekends ..." (Early 40s - Full-time secretary).

Another mother worked in the evenings as a part-time nurse. She described how she used to wait at the garden gate for her husband to return from his day job. She would then 'hand over' the three children and run to catch the last bus that would get her to the hospital in time. It is important, here, to reiterate a point made by authors cited earlier (Hardy and Glover, 1991; Rimmer, 1988). Not only do lone mothers face the same inequalities as other women in the labour market, they are also without a partner who may provide, albeit limited, alternative childcare in the ways described.

In fact, the majority of paid-working women in the overall postal survey were to be found in the predictable lower-status occupations in which part-time working is readily accommodated (Employment Department, 1990a; Hakim, 1979 and 1987b; Rees and Willox, 1991; Sly, 1993). As Figure 7.5 shows, for women of working age with and without caring responsibilities, this means shop work and jobs in the personal service industry such as catering, cleaning and barwork. Even those in professional, managerial or administrative employment are restricted in the range of their work. As in larger-scale earlier surveys (Martin and Roberts, 1984), the higher-status workers in Netherley and Woolton work in the 'caring' sectors of health, education and welfare as well as various clerical occupations.

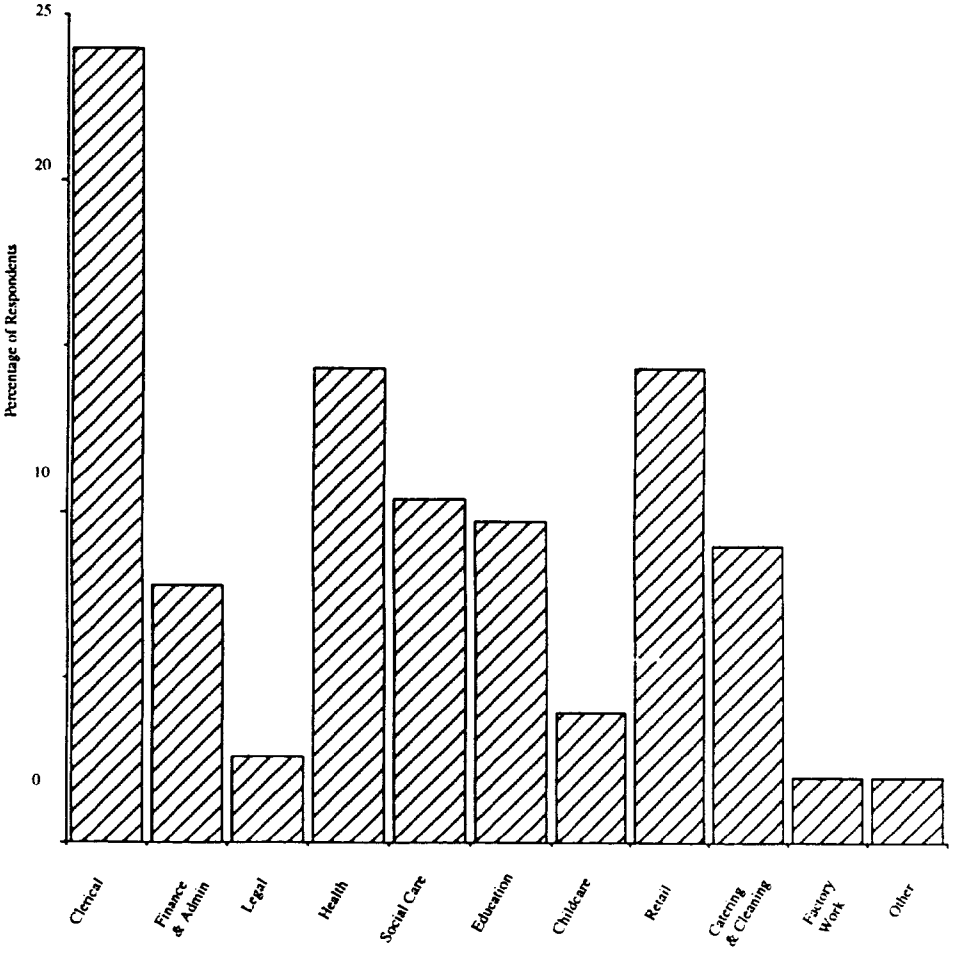


Figure 7.5 Range of Employment - Working-age Postal Questionnaire Respondents

Table 7.2 shows, also for the overall survey, the percentage of full-timers and part-timers in the categories of Socio-economic group. It is clear, as noted in Chapter Three, that a part-time job involves being in a lower Socio-economic group than full-time working. It is also clear from Table 7.3 that those, specifically with the caring responsibilities defined earlier, are more likely to be working part-time or not at all. Those with young children, particularly, are less likely to be in full-time work. Overall, of the eighty-five working-age survey respondents who did not have a paid job, fifty-five were accounted for in the carer groups. In particular, as Table 7.4 shows, the vast majority of women, who classed themselves as looking after the home, had caring responsibilities.

Table 7.2 Socio-economic Group - Working-age Postal Survey Respondents

SEG	FULL-TIMERS (N=89) %	PART-TIMERS (N=65) %
1,2 Employers and managers	27.0	12.3
3,4 Professional workers	10.1	—
5 Intermediate non-manual	28.0	24.7
6 Junior non-manual	21.3	30.8
7,10 Personal service/semi-skilled	10.1	20.0
11 Unskilled manual	3.4	12.3

Table 7.3 Employment Status by Carer Group - Working-age Postal Survey Respondents

CARER GROUP	No. FULL-TIME	No. PART-TIME	No. NO JOB
Adult separate household (N=19)	7	8	4
Adult at home (N=17)	5	6	6
Adults at home/separate household (N=2)	1	-	1
Children/adult separate household (N=17)	4	6	7
Children/adult at home (N=1)	-	-	1
School-age children (N=51)	15	20	16
Children including pre-schoolers (N=27)	8	2	17
Disabled child (N=7)	1	2	4
TOTAL	41	43	55

Note: Groups are too small to allow calculation of percentages

Table 7.4 Caring Responsibilities - Working-age Postal Survey Respondents not in Paid Employment

REASON NOT WORKING	No. IN OVERALL SURVEY	% WITH CARING RESPONSIBILITIES
Looking after home	42	85.7 (N=36)
Unemployed/Income Support	18	61.1 (N=11)
Ill health	18	38.8 (N=7)
Student	7	14.3 (N=1)
TOTAL	85	100 (N=55)

7.5.2 The Time-space Context of Women's Labour

The need to accommodate caring commitments and domestic tasks before considering paid employment, evidently, has major implications for women's time-space flexibility. As in previous studies (Focas, 1989; Jones, 1989; Rees and Willox, 1991; Women and Geography Study Group, 1984), for the women in Netherley and Woolton, these implications are not felt simply in terms of the timing of work hours in the ways already described. They are also felt in terms of geographical proximity to home being of major importance to the compatibility of paid work with domestic demands:

> "It's only down the bottom. Do you know [road name]? It's just there ... And it's just handy because with the children being in school and that" (Early 40s - Part-time care worker).

> "I enjoy it, I mean I do enjoy my job. But, it's got a lot of pluses going for it at the moment apart from enjoying it. It's local. I've got no travelling, so hence no bus fares, which makes a big difference to what you can earn. Because, if I had a lot of bus fares to pay out of it as well, I think I'd be looking for a better paying job than that ..." (Early 40s - Full-time secretary).

Twenty of the thirty-seven women interviewed were currently in paid work and two had only recently retired. Of these, eight had jobs within walking distance ranging from fifteen minutes away to just across the road. They worked, for example, in local schools as canteen or supervisory assistants or in nearby shops. A further five had jobs within five miles of home on an 'easy' local bus route and five worked in the city centre. The latter group also took the bus or went in the car with their husbands. Only four of the women interviewed, two nurses, a teacher and a personnel manager, used their own car to get to work further afield in the suburbs or city centre. Again, as noted earlier (Dawliffe Hall Educational Foundation, 1991), it is these women, who work in higher-status jobs, who usually have greater

scope to accommodate caring *within* their employment schedules and are, as a result, less restricted to the very local labour market. For example:

> "It's a very unstructured job really ... I mean, I've just got a job to do and if I need to go to the dentist or pick the children up I do that. If I need to work late I do that. But, to be honest, that probably comes with seniority, you know. In the team I'm in now everybody's a manager so nobody thinks about what hours you work - it's very, very informal ... I think it's trust and empowerment and it's all the things that make people want to do their jobs better, you know. I mean, it wouldn't worry me if I started work tonight and worked till 12 o'clock because I had to do something for tomorrow. I wouldn't think about I'm working you know - it's all just part of your life together" (Mid 40s - Full-time personnel manager).

Finally, in this context of income, none of the women interviewed talked of the kinds of lower-status homeworking detailed in other studies (Cragg and Dawson, 1981) as a means of overcoming problems of time-space constraint in relation to paid work. This reveals the important contingent role of place in household management strategies for the historical position of Liverpool in the division of labour has meant that industries open to home-working have not, traditionally, been present. Manufacturing and low-paid service sector jobs continue to constitute the types of employment available to women.

Whatever their employment status and type of caring responsibility, many women did, however, describe the kind of 'trip-chaining' outlined in Chapter Four (Rosenbloom, 1989) as a key means by which they accomplish diverse tasks in as short a timescale as possible. Usually, such arrangements centre on journeys from work and collecting children from school. For instance:

> "Martin - he's the eldest one - he comes in about five-to-four. But the other two, most days I pick them up about quarter-past-three ... [So do you come home and go out again?] Or I stay shopping ... by the time I get out it's gone half past and the boys come out at

> quarter-past-three. So I have a chance usually to get into the shops and get whatever groceries I need and go and pick the boys up and come home" (Late 30s - Part-time catering assistant).
>
> "I'll go [to visit mother in nursing home] sometimes straight from work ... I don't get into a pattern so she doesn't expect me on a certain day. I just go different days and pop in whenever I can. I find that's the best way ..." (Late 40s - Part-time library assistant).

One particularly ingenious way of saving on overall shopping journeys and accomplishing a variety tasks through trip chaining was described by a single mother from Netherley who lacks access to any private transport:

> "I'm still taking [driving] lessons now ... He'll pick me up from work ... I get all my shopping on my lunch break and throw it all in the back of his car so it saves me £3 in a taxi home. So, I mean, it's not cost me as much this driving lesson because it's got me home as well with my food ... Because I try not to shop during the weekend - I try and get it in through the week a little bit a day and then every fortnight just a big load" (Early 30s - Full-time clerical worker).

As anticipated in Chapter Three (Crompton et al, 1990), flexibility in the choice of paid work amongst the women interviewed was found to be strongly linked to their access to household resources, particularly economic resources. For instance, low-income women, who lack the use of a car, are relatively confined to the local area for employment if they are to be home in time for children returning from school. The labour market in such a geographically restricted area, particularly in outer estates like Netherley, does not hold many opportunities even for low-paying part-time jobs:

> "Oh it's terrible with only him working and I can't get a job because I've got to mind the baby. [Will you get a job when the younger one's older?] It's difficult you see because I always say what do you do when the kids are on half term if it's not a job in a school? You know you've got to think of that ... (Early 30s - Looking after home).

> "... I'd like a job - I've looked for one - I can't get one. I've got no experience or nothing ... I'd just like a shop or something, you know, I'm not fussy ... But it'd have to fit in with the kids like. I couldn't have them coming home on their own or nothing, I'd have to be here. And that's another reason, you know, finding a job to fit in with me as well ... I always look - there's a Job Centre in Belle Vale and I always have a look, you know, for jobs in the precinct [Belle Vale shopping centre about one mile away]. And there's a few little shops round here. There's never anything there" (Late 20s - Looking after home)

The woman referred to first, in the examples above, had only recently been able to afford driving lessons and her husband was taking his turn to learn at the time of the interview. She was worried that, if the couple could not pay for the expensive repairs required on their thirteen year-old car, the transport flexibility they now enjoyed would be very shortlived. The second woman is also unable to drive and her husband, a trained mechanic, allows her very rare access to the 'household' car. This kind of situation is mutually reinforcing since women who are already higher earners usually have access to transport in their own right and this gives them the freedom to travel to better paid jobs further afield.

7.6 Making a Choice between Home and Paid Work

As noted earlier, women's paid employment participation is connected with attitudes to the caring role and not just with the practicalities of scheduling work hours outside the household. The present section will, therefore, examine the reasoning behind women's prioritisation of paid work and caring responsibilities. It will explore how those priorities change across the life-course and note, once again, the way in which the attitudes of higher-income women can be singled out from those of the remainder of the interview group.

7.6.1 Caring as a Priority Across the Life-course

It was pointed out earlier that the age of children makes a significant difference to their level of dependency. This is reflected, here, in the changing attitudes to the caring role that many mothers describe having at earlier and later stages in the family life-course:

> "[Does your day have to fit around anyone else in the family?] No, not now. It did when the children were younger, I worked part-time then. But since Steve is off my hands sort of thing - because Steve is seventeen ... I mean, they're self-carer now so I don't have to bother with them now ..." (Late 40s - Full-time administrator).

> "I was working Saturdays only from when she was about four. And then ... because she was in secondary education and I felt that I could go out during the week ... I was only looking to work three or four hours a day ... because I still felt that she would need me to be at home more than I was away from it ... And this job did start off as part-time ... I keep saying once she's sixteen I will look at my job then and see where I want to go, see whether I want to stay in education or whether I want to move on and do something else. So then it would be a full-time job I'd be looking for because of her age ..." (Early 40s - Full-time secretary).

Such attitudes are largely associated with feelings of guilt about what it means to be a 'good mother' at different times in a child's development. The majority of current mothers of primary and pre-school children, who had stayed at home or were employed part-time, expressed their reasons for doing so in this way. One woman, for instance, described the kind of pressure she felt, even through working part-time in a supermarket, after her daughter had started school:

> "I thought that'd be no problem - it was half-past-eleven till half-past-two and then I'd have time to come and pick her up. But then they said it was Saturday as well which was a bit of a nuisance because really that's the only time I see her is weekends with her being at school. So my Mum used to mind her of a Saturday and she used to make me feel guilty then - 'Oh, can't you stay off today? I want to go to the museum. Oh..'. And she'd spend like the three hours in the shopping centre with my Mum and she could see me anyway, but she'd say, 'I don't want to go the precinct anymore, I want to go to

my Mum'. So I couldn't work full-time. I'd just feel really terrible" (Mid 30s - Looking after home).

Not all of the women in the older age groups had taken the opportunity to expand their paid employment participation in later life. The majority had, in fact, stayed in the same low-status, part-time jobs which they had taken originally in order to accommodate strong views about the appropriate role of a mother in relation to her children. When asked, for example, if they work part-time out of choice two participants in the study answered as follows:

> "Yes. Really it started when the children were younger. I've been working there eighteen years so my son was nine and my daughter was eleven. And I always felt I should be at home when they got home from school. That was just my opinion and so that's how it started ... I think women should work, but I think you've got to be careful how you fit it in with your family and your children because I think you need to be there at times. And there's that many part-time jobs I was lucky really. The hours are ideal, nine till one ..." (Late 40s - Part-time library assistant).

> "I didn't go to work until they were five and I've been in the same job since. I thought, 'Oh well, take them to school and be here when they were coming home'. My friend round the corner, she used to be at work and her kids were in here more times than in their own. I thought, 'Well that's not on, it's not on'... I was full-time up until I had the kids and then I just went part-time. I used to work in Littlewoods. Anyway on the pools" (Early 50s - Part-time catering assistant).

It is consistent with previous research (Martin and Roberts, 1984), that a significant proportion of these women either had not capitalised on previous training or had forgone a relatively well paid full-time job. For example:

> "I am a trained teacher, but I haven't taught since I was married. So I've just got a little job in the school - supervisory assistant - which I can cope with ... I've been doing that since my youngest son was six years old because I knew I didn't want to go out to work when I had children and so that fitted in quite well with them. So I've been there ever since and he's twenty-three now" (Late 50s - Part-time job in school).

Again as Martin and Roberts (1984) suggest, this remaining in part-time work is largely associated with a lack of skills or experience appropriate to better paying jobs in the contemporary labour market. Those women referred to at the start of this section, who had gone back into full-time employment, had found it necessary first to return to education or retrain in areas such as word-processing and they had needed the backing of partners in order to do so.

Also significant, is the fact that the middle-aged women who have stayed in part-time jobs either have disabled children who continue to need care in adulthood or else they have acquired new caring responsibilities for elderly parents. As one respondent pointed out, prior to her mother's move into a nursing home it would have been much more difficult to accommodate her caring needs into a full-time employment schedule:

> "There's no problem, there's never any problem with work, they're very good. And if I needed time for my Mum that would be no problem ... But I could manage everything without, with being part-time, without taking any time off work ..." (Late 40s - Part-time library assistant).

As is the case with young children, living with an adult dependant who requires very labour-intensive and time-consuming attention means that low-income women have little choice but to give up paid work altogether. This is particularly evident for those with a disabled partner or older relative for whom, as indicated earlier, there are few alternative available sources of care:

> "... Well I used to work before my husband had the stroke. Once my husband had the stroke I gave up work" (Late 50s - Looking after home).

Not being able to work causes particular difficulties if a woman really does need a full-time job in order to support herself:

> "... since I've become divorced I went onto Income Support and they're on your back all the time to try and find a job ... So I kept saying to them I wanted a part-time job because I have my Dad to look after ... So they said, 'Well, to be in receipt of Income Support you've got to be available for full-time work, not part-time work you see'. So the only way round it was to try and get the Invalid Care Allowance ... so I went along to the doctors, got the forms from the EN, filled them in and eventually we got the invalidity for my Dad and then I claimed for the care allowance ... But, anyway, it brings me up to fifty-five pound a week, which is about eleven pound more than when I was in receipt of Income Support. But at least I haven't got the Job Centre now sending me after jobs which, to be quite honest, I wasn't looking for because I just couldn't" (Early 50s - Invalid Care Allowance).

The attitudes of middle-aged carers in the survey also appeared to be influenced by ideas about what is the prescribed gender role for a woman. Not only did women describe feelings of guilt about not taking primary responsibility for a dependant, as illustrated by the first example below, those in paid work also talked in terms of not being able to give as much time as they really should to caring:

> "And I think really if I had got the asthma it could have been a bit of stress from my mother because it's very hard putting them in a nursing home. You think, 'Should I look after them?' And you know deep down it's a twenty-four hour job and who else can help you really, nobody can, can they? ... You think you should have her here really, but it's other people's lives as well as mine. It's my husband's, it's my son, my daughter. Although they're very good to her, it's very hard to have someone that you can't go out, you've got to always think who's going to be here to look after her ..." (Late 40s - Part-time library assistant).

> "I feel guilty because I can only get down once a week to see him [father] ... Where before, when he was here [Netherley], I could pop in and sit and have a natter or go and have a cup of tea with him over there. But now when I go, because Saturday and Sunday are my only days off, I sort of whip in and [slicing sound] the veg, I'm nattering as I'm going, I'm cleaning up as I'm going around ... But

> it was his choice to go down there [Vauxhall] and I think, 'Well really, should I feel guilty?' because he was alright anyway. He had his friends around and he just wanted to go back into his own neighbourhood where he was brought up. So, it's his choice isn't it?" (Late 40s - Full-time administrator).

In addition, as Ungerson (1987) also found, women tend to think that they may be 'neglecting' children if they are caring for an adult too. At the same time, those looking after in-laws can feel guilty about not 'being there' for their own parents.

7.6.2 The Different Attitudes of Higher-status Paid Workers

As might be expected (Hakim, 1991; Martin and Roberts, 1984), the mix of priorities talked about by the current full-time working mothers of young children is discernibly different from those of the other women described. In addition to thinking of the children, they also mentioned factors such as personal job satisfaction and their own financial contribution to keeping up the family lifestyle. For instance:

> "... I used to feel guilty that it was affecting what we were supposed to be doing with Hayley you know. When you've got a mentally handicapped child, you're led to believe that the more stimulation you can give them in the early years the better the long-term effects. And then when you've come in from work and you're absolutely shattered and you've got to make the tea and collect the kids and all the other things - by the time you sit down, or you've got her in the bath, you just don't feel like doing anything else ... I don't know. Like I said, I wouldn't like to give up. I was off work for about five weeks about twelve, fifteen months after Hayley was born, with depression ... at the end of the five weeks I was ready to go back to work. I just couldn't see myself sitting at home full-time doing nothing. I need to go out to work really. Whether or not I'll keep up full-time for the rest of my life I don't know (Late 30s - Full-time teacher).

Amongst the women interviewed, it is noticeable that the few who actually began the family life-course already in higher-status jobs are the ones not likely to want

to leave paid work after they start a family. These women, whatever their stage in the life-course, are also the ones most likely to have their domestic needs accommodated by their current employer and have not, therefore, been forced into lower-paying alternative employment as a result of caring responsibilities.

Significantly, even the women in higher-status employment say that they will still give up if they ever feel that a child is suffering as a direct result of their working:

> "I've never ever felt in all the time that I had to send them to school when I shouldn't send them to school because of my job. But I made that decision early on that if it came to a choice it'd have to be the boys. And OK I'd have to take them out The College [private school] and if that was the price, you know, we'd give it a try ..." (Mid 40s - Full-time personnel manager).

In addition, the women in demanding jobs all seem to feel the necessity to compensate their children for time that they cannot spend 'being there':

> "If we're training volunteers I don't get home till about nine, ten and the kids are all in bed. I feel that's sort of [pause] that's wrong, you know - not wrong, but I feel guilty. I feel I haven't seen them all day. That upsets me sometimes ... I think that's why at the weekend I make up for it and then they're up to all hours. As my Mum says, I'm not a bit firm with them at all. I'm bloody soft with them ... and I give in too easy to them [laughs] (Early 30s - Full-time clerical worker).

> "I think the trouble with working full-time when you've got children is you tend to find that you overcompensate a bit and you always seem to be doing something extra for them ... I have got one or two items of committee work that I do, one for a school and one for a children's nursery, but other than that I don't have many hobbies of my own to be honest. They're mostly linked to doing things with the kids (Mid 40s - Full-time personnel manager).

There are, of course, many other types of benefit and pressure associated with the mix of social roles which different groups of women experience. These are

important issues in the context of women's health and will be dealt with in detail in Chapter Nine.

7.7 Summary

The aim of this chapter has been to demonstrate how women's experiences of time-space are influenced by the nature of social role divisions in the household in which they operate. Although previous analyses which take the activity approach (eg. Palm and Pred, 1978; Tivers, 1978 and 1986) have tended to concentrate on mothers of young children, this study has explored the spectrum of women's experiences across the whole range of potential paid-working age. It has demonstrated that, despite increasing levels of participation in paid work and the 'freedoms' gained in recent decades, women are still the primary carers at all stages in the life-course. This caring role presents them with complex *evolving* webs of constraints and opportunities as the type of need they are faced with changes. The choices made are strongly influenced by women's own feelings and perceptions of themselves in relation to the overall negotiation framework and outcomes are, therefore, both reflective and constitutive of individual identities. A strong thread running through this framework of choices and identities is women's access to economic and social resources. In general, higher-income women are less constrained by caring and domestic labour responsibilities. Their participation in higher-status, full-time paid employment tends to reinforce this position. Whatever the shape of the caring role, however, it emerges as the discriminant factor in household negotiating processes and women's consequent activity decisions.

The view that caring need is discriminant in this way provided the 'platform' for the definition of carer groups outlined in Section 7.2. It is the experiences of those groups which can be fed through to provide a realistic basis on which to consider matters concerned with the delivery of health and social care. It is important to look at the issues in this way because caring is a primary constitutive force in the lives of women and has powerful effects on the attitudes of individuals to their own health (Graham, 1984, 1988 and 1993). What this chapter has sought to do is to explore these general concepts with reference to the specific contingent circumstances of women in Netherley and Woolton. Overall the interviews have revealed a number of key issues in relation to women's social roles:

i) the need to recognise complexity in understanding the nature of caring;

ii) the difficulties of scheduling competing activities particularly where paid work or multiple caring responsibilities are part of the equation;

iii) the role of place in the social construction of individual time-space decisions; and

iv) the significance of negotiated 'partnership' under various household conditions, to the experience of domestic and caring labour.

In the latter context, important issues were raised at the end of Section 7.5.2 concerning household financial power and control. However, these have implications for women's experience of time-space in a wider sense than simply labour market participation. The issue of the 'sharing' of household resources forms the focus of the analysis outlined in the next chapter. Whilst the present chapter has explored the scales of constraint in the time-space decision-making framework (Figure 7.2) which are concerned with gendered divisions of household social roles, Chapter Eight will expand on the two resource scales which have not so far been discussed.

CHAPTER EIGHT

INEQUALITIES IN HOUSEHOLD RESOURCES

8.1 Introduction

This chapter will describe the nature and distribution of economic and social resources both within the interview households and between members of the family network outside. Section 8.2 examines issues of power and control in the 'sharing' of household resources. Section 8.3 explores the ways in which economic resources can be used to gain flexibility in scheduling activities and Section 8.4 looks at the circumstances in which social resources are employed instead. Finally, in Section 8.5, the discussion points to the ways in which labour market conditions and the social security system interact to provide the context for managing in low-income households.

8.2 Material Resources - Issues of Management and Control

8.2.1 The Management of Household Income

As noted in Chapter Three, previous studies (Pahl, 1980; Volger and Pahl, 1993) have raised the issue of the differential distribution of resources between family members. This section explores this issue of the management versus control both of household financial income and other types of material resource including the 'family car'. Evidence from the interviews is used to illustrate how, as anticipated in Chapter Three (Graham, 1984 and 1988), it is the women in low-income families who have primary responsibility for budgeting for basic everyday

needs such as food and clothing. The following extract concerns the arrangements for weekly financial management between one woman and her partner in Netherley:

> "... The DS give me seventy pound a week for me and the two kids. Eighteen Family Allowance. Eighty off Andy. So, a hundred and sixty-five -that's my total income ... [And is that what he brings home, eighty?] No he picks up a hundred and twenty, but with the car payments and stuff that goes out on direct debit and all the rest of it - and, of course, I have to leave him something for going to work so I just take eighty. [And do you do all the managing?] Yes. [So you pay the bills and all that?] Yes, except the car. Anything outside household bills he can pay, such as taking me out, buying the car, the kids' birthdays ... [So all their clothes and things comes out of your money?] Unless it's something I can't afford. I'll say 'I'm having trouble with this one, I want an extra blah to buy a coat or whatever'. If it's just little things - dresses and socks and that - I can afford that (Mid 30s - Income Support).

This household did, however, seem relatively unusual in the interview group for one in which the woman herself was not working. It seems significant for the level of personal control over resources which this mother described, that she is particularly strong-minded when it comes to her views about men. She described, for instance, how important she feels it is not to be married, for the children to have her name and for the house too to be in her own name. She also continues to claim Income Support, as opposed to Family Credit on the basis of her partner's earnings and, therefore, has an income in her own right.

Elsewhere, the situation is not nearly as evenhanded. Male partners might pay the household bills, but women not in paid work often have to manage the everyday spending on a relatively small and finite weekly allowance. The woman referred to in the next example described how she takes money from the food budget to pay for her daughter's clothes. Specifically, when asked to place her household in an income band, she replied:

> "Oh I couldn't do that because I don't know how much he earns [laughs] ... I mean his wages go straight into his account and then it goes straight out. He has to pay the bills and things - I get the housekeeping. I get about £45 to £50 a week. That's just for the food and things for the house. And then Joanne - I suppose it comes out of her like Family Allowance and it just pays for her clothes - it's £10 a week. I always end up putting money towards the clothes she wears, they're expensive ..." (Mid 30s - Looking after home).

This case can also be used to illustrate how, as already noted (Graham, 1992 and 1993), it is children and partners who take priority in the budgeting decisions of women in low-income households. Clearly, the interviews reaffirm findings elsewhere (Glendinning and Millar, 1991; Morris, 1988; Pahl, 1980; Rimmer, 1987) that, in the context of financial resources, there are strong differences in levels of concrete *control* over spending between the genders in instances where only the men are in paid employment.

In dual-earner families, a difference is also noticeable, in this issue of control versus management of resources, if the woman's job is part-time and low status and her income is, as a result, much the lower. Such interviewees, like some of the respondents to Martin and Roberts' (1984) survey, describe how they need to work in order to supplement the money they receive from a partner:

> "My wages all go on the food and things really because Derek just pays the bills. I mean Family Allowance - that I get - it's just clothes for the children it goes on basically. I don't get that much off Derek so.. Because, as I say, his money really just goes on the mortgage ..." (Early 40s - Part-time care worker).

Not only does this show the considerable significance of women's paid work to the economic survival of many families in the study areas, it also stands in stark contrast to the situation of full-time working women in the sample for whom a personal wage takes considerable pressure off purchases for themselves and their

children. Working ostensibly for extras rather than necessities, the following survey respondent placed her household's after-tax income at £200-300 per week and her personal earnings at £100-200. This indicates the much more even contributions being made by this wife and her docker husband as compared with couples in which the women work part-time:

> "When I started doing this job I said, 'Oh I'm not going to work to pay the bills'. But I found myself that when a bill arrives ... I'll use mine. But it was always intended that ... we'll use mine for the jobs that need doing on the house and holidays and maybe a new car ... But actually, I think people do have good intentions and that but I think you see it sort of starting to be eaten up by bills and things like that. But no, all my wages don't go into the household definitely not. Christmas takes a lot of them [laughs] ... As I say, it's not a vast amount but yes it does make a difference. It means we can go abroad every year and we don't have to scrimp and save. When I'm in town, if I see a jacket or a pair of shoes I like I know I can buy them - and the kids as well, they can have extras" (Early 40s -Full-time secretary).

Women in high-status employment have a greater say in the sharing of household financial resources because they command a high level of income in their own right. One full-time nursing sister and ward manager described, for instance, how both her own and her husband's wages go into a joint bank account in order to pay the bills. In addition, as also anticipated by previous research (Graham, 1993), single mothers in any income bracket have significantly increased control over spending by virtue simply of their domestic circumstances. Although she looks after six children on the relatively low after-tax income of £183 per week and does not receive maintenance because her ex-husband is unemployed, one single mother described, for example, how she now has total control over the household finances

complete with all its problems. In reply to a general question about feeling under strain she said:

> "Oh yes, does it go dark at night? Yes I do, yes. But it's all just part of being a Mum isn't it? If there wasn't any strain I think I'd worry ... I mean, I'm constantly biting my nails and scratching my hair you know - 'What should I give them for their tea tomorrow night?' 'Oh God', you know, ' have I got enough money to the end of the month till I get paid? ... Can I dodge the milkman this week and pay somebody else?' ... I have all that so that's strain isn't it? It's all unnecessary because if I got myself a little bit more organised I wouldn't have to be like this - but that's life" (Early 30s - Full-time clerical worker).

8.2.2 Mobility as a Resource - Control of the Car

As indicated in the last chapter, in terms of time-space flexibility in the public sphere, any inequity in the distribution of household economic resources is felt primarily through differential use of the 'family' car. As previous studies have also shown (Hamilton and Jenkins, 1989; Whipp and Grieco, 1989), this can simply result from unequal behaviour on the part of individual men or it might be that women have to fit around a partner's need for transport to work. Amongst the working-age women who replied to the postal questionnaire, almost 60 percent of those without a car did not have a paid job. 34 percent of women who said the car was used by someone else in their household most regularly also had no job (Table 8.1). Husbands and, to a lesser extent sons, were mentioned most often in this context. 82 percent, or nine out of the eleven women in 'unskilled' paid employment either had no car or said that it was used by someone else most regularly (Table 8.2). The same applied for 68 percent of the twenty-two women in 'semi-skilled' manual or personal service work. This compared with eight out of forty-one women whose jobs as employers, managers or professional workers

placed them in Socio-economic groups 1-4. 44 percent of the women in SEGs 1-4 classed themselves as the most regular car user in the family and a further 27 percent said that they shared access equally with only one other person.

Table 8.1 Access to Household Car by Employment Status - Working-age Postal Questionnaire Respondents

CAR ACCESS	% NO JOB	% SEG 11	% SEG 7,10	% SEG 6	% SEG 5	% SEG 1-4
No car in household (N=52)	59.6	5.8	9.6	9.6	9.6	5.8
Another most use (N=70)	34.3	8.6	14.3	24.3	11.4	7.1
Shared > 1 other (N=10)	20.0	10.0	---	30.0	---	40.0
Shared 1 other (N=39)	20.5	---	7.7	17.9	25.6	28.2
Respondent most use (N=68)	29.4	1.5	5.9	10.3	26.5	26.5

Notes: SEGs 1,2 Employers and Managers;
SEGs 3,4 Professional Workers;
SEG 5 Intermediate Non-manual Workers;
SEG 6 Junior Non-manual Workers;
SEGs 7,10 Personal Service and Semi-skilled Manual Workers;
SEG 11 Unskilled Manual Workers.

Table 8.2 Percentage of Women in SEGs with Access to Car - Working-age Postal Questionnaire Respondents

SEG	% NO CAR	% ANOTHER MOST USE	% SHARED > 1 OTHER	% SHARED 1 OTHER	% WOMAN MOST USE
NO JOB (N=85)	36.5	28.2	2.4	9.4	23.5
SEG 11 (N=11)	27.3	54.5	9.0	---	9.0
SEG 7,10 (N=22)	22.7	45.5	---	13.6	18.2
SEG 6 (N=39)	12.8	43.6	7.7	17.9	17.9
SEG 5 (N=41)	12.2	19.5	---	24.4	43.9
SEG 1,2,3,4 (N=41)	7.3	12.2	9.8	26.8	43.9

Examples of low car access taken from the interviews in Netherley are as follows:

> "[Do you have a car?] Yes, I've been in it twice. We've had it for twelve months. [Do you drive?] No, I'm too scared to ... [Does your husband take the car out much?] Yes, he's out every day in the car. He goes to the DIY shops and he goes to the shopping precinct and round to his uncle's in it and all the time, the chippy" (Late 20s - Looking after home and husband unemployed).

> "... I only have the car myself every.. When Andy's in work obviously, like this week, I'll have to do my shopping in the morning time and get the car back for one so he can go to work. Then next week I'll have to do all my shopping in the afternoon when he's home from work and I can have the car ..." (Mid 30s - Income Support).

Gender differences in the possession of a driving licence and access to transport are not, however, associated solely with income level and employment status. In this study, as elsewhere (Focas, 1989; Pickup, 1989), they are also linked

to age (Figure 8.1). Many of the older women interviewed have, therefore, to depend on their partners or use public transport instead:

> "My husband takes me [to work]. Obviously he's full-time and he's at the university too ... So I get the bus back. I don't drive - that's not his fault, I just never wanted to drive. I don't know why really. I think it's the responsibility isn't it?" (Late 40s - Part-time library assistant).

> "... he did a twelve hour shift last night so I walked to work. But by the time I was ready to come home he was out of bed anyway so he picked me up. But that's how it works - so some days I get a lift there and back and other days I have to walk ..." (Early 50s - Part-time catering assistant).

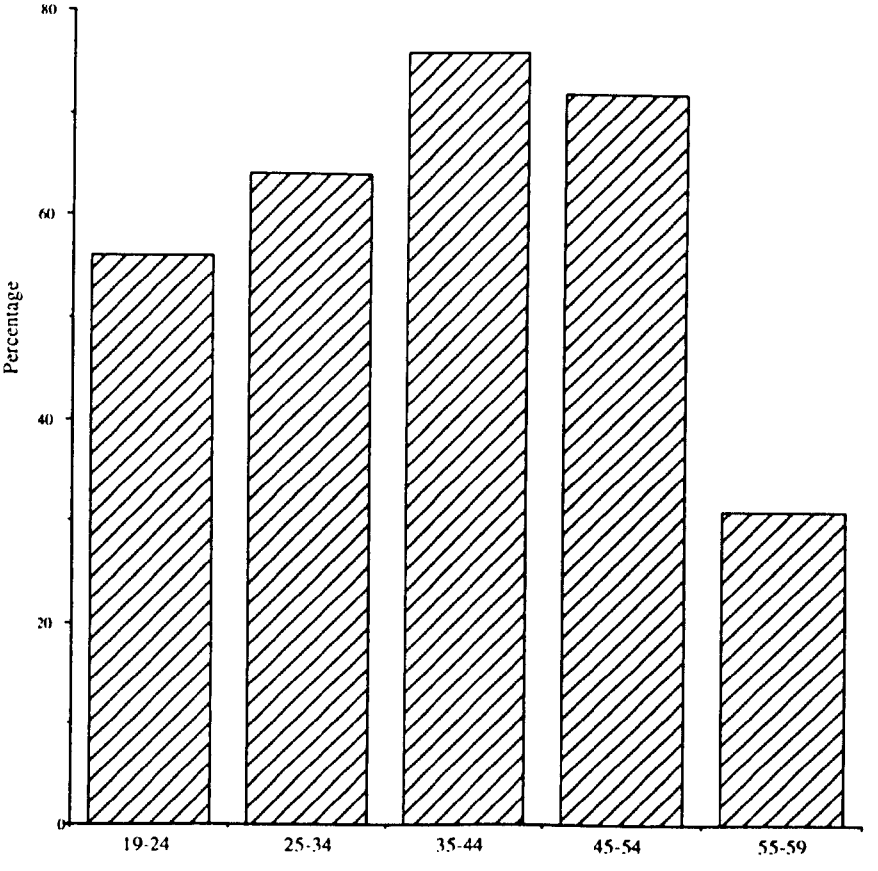


Figure 8.1 Percentage of Car Drivers by Age Group - Working-age Postal Questionnaire Respondeents

What is significant about this issue for women with caring responsibilities, is the additional scheduling problems which are experienced as a result of restricted access to a flexible form of transport. Difficulties, for instance, surround arrangements for taking young children to and from school as well as being in easy reach for an adult dependant in a separate household:

> "... and then that's it then till I have to go and get my daughter ... which is, it doesn't seem far Belle Vale, but if I didn't have the car it's a fair way ... I mean I took her to school this morning on the bus with not having the car. I left the house at half-eight, I got back half-nine so it's an hour isn't it you know? ... I'm not saying miles but with a toddler it is, you know, in the rain and everything isn't it? ... (Early 30s - Looking after home).

> "It's usually my husband that gets roped in ... I can drive actually ... It's just I'm too lazy to take lessons and pass my test so.. It's something that I should do because I think I need to be able to drive now. As I'm saying, not only my Dad getting older, but my husband's parents as well. Yes and I think you do need to be able to drop everything really, you know, if they need you" (Early 40s - Full-time secretary).

A number of these women also mentioned the 'spaces of fear' present in the urban environment and identified by Valentine (1989 and 1990). For instance:

> "It is dark nights walking down that lane - it's frightening isn't it? It's my own fault anyway. I should have a car shouldn't I? ... I should have passed my test a long time ago really" (Early 30s - Full-time clerical worker).

> "... Because I used to walk on my own after 10 o'clock at night and now I get so frightened because there's that many gangs and you get to Halewood Road, you know, they're coming out of the pub. And one night I was attacked so since then ... I've just been too frightened to walk round [to mother's] on my own. So it's when my husband's off that he can take me round, leaves me and then he comes back ..." (Early 50s - Part-time catering assistant).

In contrast, full-time working women in higher-income households often have the use of their own car with all the freedom that affords:

"... you see we run two cars and we know that it's expensive but - I mean you've said before about, 'What would you do if.. ?' and all that. And it gives us, it gives me, both of us, a lot of independence. I don't have to think 'Oh where's Gerry, I need the car' ... Now and if she [daughter] didn't have Down's Syndrome - I suppose going to things like occupational therapy and physiotherapy when she was younger would have been an additional expense. But we tend not to think of it. When you're running a car you don't think of it like that do you?" (Late 30s - Full-time teacher).

8.2.3 The Telephone and Time-space Flexibility

As Figure 8.2 indicates, 36 of the 52 working-age respondents to the overall postal questionnaire who lack private transport can, nevertheless, afford their own telephone. Fifteen women are, however, without access to either of these items which are so important to flexibility in the scheduling of social role activities. Having a telephone makes it much easier, in particular, to overcome problems of geographical distance when supporting an elderly dependant living in another household. For example:

"What I usually do now - I pop in to see her [mother], but I ring her every evening to see that it's OK. And sometimes before I go out to work in the morning depending what's what" (Early 50s - Part-time teacher).

"She [mother] knows that she's got to phone me if she's that bad. So even if Mike [husband] was at work I'd get a taxi round to her and do it that way ... She's got the phone number for work as well. And her neighbour upstairs, she's got my phone number as well, both for home and work (Early 50s - Part-time catering assistant).

Hence, a relatively small demand for *actual* care can become an *effectively* time-consuming activity for women who rely on public transport and have physically to visit in order to check on a dependant.

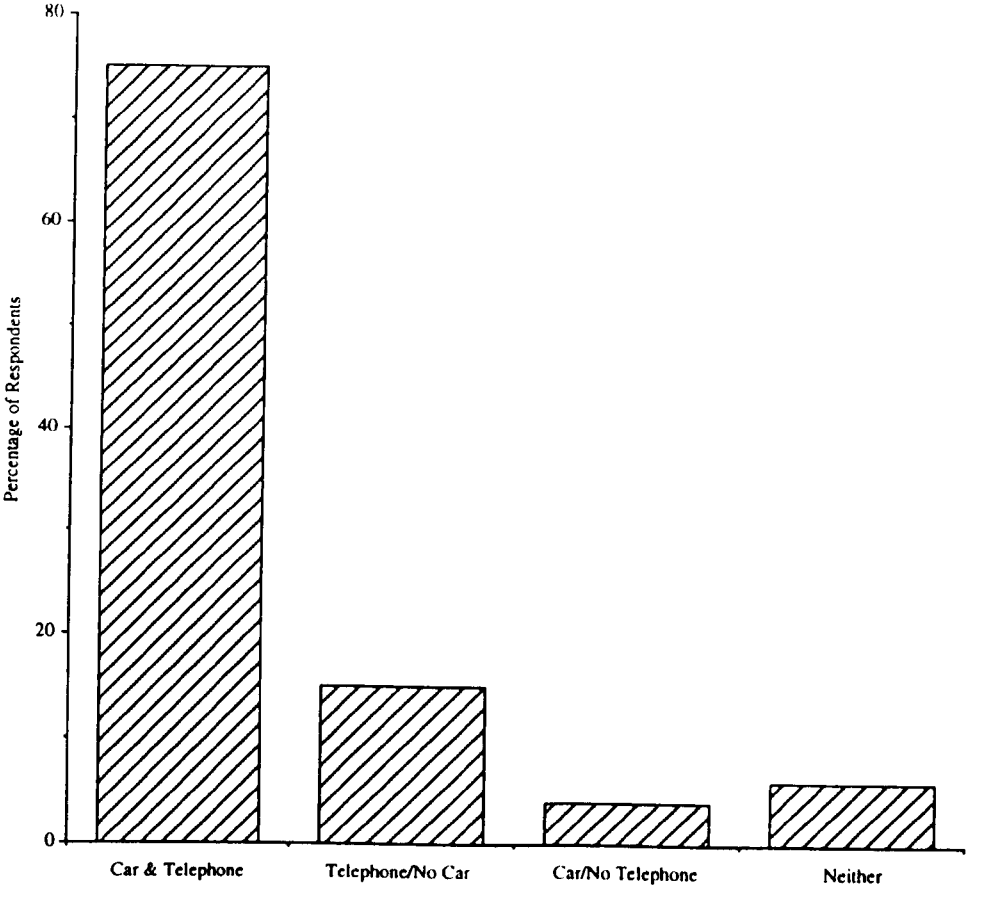


Figure 8.2 Car and Telephone Ownership - Working-age Postal Questionnaire Respondents

It is through the employment of economic resources that women, particularly in higher income households, are able to manage the competing demands and constraints on their time-space flexibility. At its simplest level, this would encompass having easy access to a private car and the flexibility that this affords to scheduling social role activities. It would include possession of a private telephone which can play a further important role in reducing the time-space constraints of

caring. There are also various ways in which financial resources can be directly substituted for women's domestic and caring labour in order to allow time for alternative activities such as paid work. Finally economic resources can be used to ease the constraints on activities and mobility which result from limiting long-standing illness. It is these issues to which the discussion now turns.

8.3 Domestic and Caring Labour - Paying for Flexibility

8.3.1 Substituting for the Caring Role

Another obvious way in which higher-income women are able to ease social role demands, in particular in order to continue in full-time paid work, is through the hiring of alternatives to their own caring labour. For instance, childcare services are important for mothers to cover the critical times in the day when their activities would otherwise be dictated by the needs of their children:

> "I take her [daughter aged 2] to the childminder's about half-past-eight in the morning - it's just round the corner - and then she puts her on the bus. She's bussed to a special nursery ... I think they finish at three - and then she's bussed back to the childminder's" (Late 30s - Full-time teacher).

> "It's an after-school care club, which they pick up by mini-bus and take him [son aged 6] back. He used to go there to nursery from when he was six months old and Luke [older son] did as well ... you can pick them up there up till 6 o'clock. And they also run some holiday care schemes which, of course, takes a heck of a lot of pressure off you because you don't have to worry then about, 'What am I going to do during the holidays?' ..." (Mid 40s - Full-time personnel manager).

In the first example above, the toddler described is cared for by her childminder for two-and-a-half hours each weekday at a cost of £30 per week. The woman referred to in the second example, pays a similar amount for her son to be looked after and sums up, very clearly, the attitude of mothers in this situation:

"We pay £32 a week for after-school care, but it's cheap at twice the price really, you know for the peace of mind, to be honest" (Mid 40s - Full-time personnel manager).

Other comments made by the same personnel manager illustrate how, given sufficient income, responsibilities towards the elderly may also be managed in order to reduce the requirement to provide care personally. When asked how the family might handle her father's imminent need for greater levels of care, she replied:

"... Beyond my mother's capabilities? I think it would have to be a nursing home really. I just don't think any of us - I mean it just would not make sense in terms of our own family and he would not wish it for us to give up our jobs, you know, to care for him for a period of years which would then affect the future. Because one of her [sister's] children is in private education. It would have to change the children's education. We'd have to give up so much and he just wouldn't want it. And, to be honest, I wouldn't want that sacrifice. I'd make a sacrifice for me but not for my children, you know - much as I love my Mum and Dad, they're the most important thing to me. And so it would have to be a nursing home. But financially we would help to make sure. And we certainly wouldn't stick him in there and leave him. Weekends we'd do what we could and make sure we'd visit and all that sort of thing. But I have to say - I mean you've made me sort of face I suppose the question that I don't want to face really - but in truth, I wouldn't give up my job in order to care for an elderly parent" (Mid 40s - Full-time personnel manager).

Of course, most of the women interviewed are unable to make this kind of priority choice because they lack the financial flexibility in managing competing obligations to ensure that a relative would receive satisfactory alternative care. Lower-income women are more constrained, therefore, in their paid employment participation as a direct result of feeling their own personal caring labour is the best an adult dependant can, realistically, receive. At the same time they are drawn into considerable amounts of unpaid caring work.

8.3.2 Paying for Domestic Labour

Economic resources can also be used to hire substitutes to perform domestic labour other than caring in order that women can continue in full-time paid work. This is necessary because, despite the fact that higher-status employees are more likely to talk of their partners 'sharing' the domestic load, they are still, in practice, responsible for the majority of household tasks. Others find themselves having to pay for help with domestic labour which they can no longer perform because of ill health. Illustrations are provided once again by the personnel manager interviewed and by a woman who had recently retired due to ill health:

> "I do have help actually ... In fact, to be honest, it's John's Mum who comes in one day a week and we pay her ... She knows how her son likes his shirts ironing and, you know, it works out really well ... The rest of the time we just, one of us will do it [laughs]. I do most of the cooking. I have to say, as a norm thing, I will come in and do the meal. I don't know what John does as a norm thing, but he's there, he's around - takes the dog for a walk!" (Mid 40s - Full-time personnel manager).

> "When we retired ... we decided we could live on £500 a week ... We reckoned if we had that a week we'd be very comfortable ... And we need that much because we have to save to - any big repairs or any painting or decorating we have someone in so that's all got to be paid for..." (Late 50s -Recently retired from part-time laboratory job).

8.3.3 Using Income to Manage Chronic Illness

The last extract raises the final issue to be dealt with in this section. This is the question of how earnings can be used in higher-income households in order to ease the problems of limiting long-standing illness. For instance, the woman referred to above describes how she and her husband take an extended holiday so as to escape the winter weather which is likely to affect his chest condition:

> "His resistance isn't very good, naturally, so he catches anything that's going - you know, he'll get it. So what we've been doing is - the specialist told him a long time ago that the ideal climate ... would be somewhere like South Africa, you know, dry climate. But naturally we couldn't afford it ... What we do now is go to Tenerife for December and January and miss the worst of the winter ... And I notice, when we're there ... he's a lot better. He doesn't use his [inhaler], he can walk further and he can breathe a bit better. And probably the sea air I think. But the dry climate, definitely - the British winter is a killer" (Late 50s - Recently retired from part-time laboratory job).

This couple had earlier bought a cottage in North Wales in the hope that this would help the husband. As the next extract illustrates, having a higher income also means that they can consider their future and make definite plans for the possibility that both their conditions may worsen:

> "[Would there be any problems if you had to go into hospital?] ... This is one of the reasons I'm trying to think ahead and I've said we might sell up. It's started to go through my mind ... I can see things now that he used to do that he can't do and vice versa with myself. So ... we did think about ... buying one of these warden-controlled, sheltered, purpose-built places ... It would be a lot easier to manage. And if anything happened to either one of us, thinking if I went first, it would be securer for my husband. At least he'd got someone there that can get a doctor or help ... And vice versa, if anything happened to him, it would be easier for me ..." (Late 50s - Recently retired from part-time laboratory job).

Despite the points made here, that it is probably easier for higher-income households to handle the additional requirements of limiting long-standing illness, it should be noted that people on a low-income who have a long-term health problem can receive assistance from the social services. Assistance is, for example, available for home adaptations and transport:

> "... I use taxis a lot. I'm hoping that, when this new award goes through, that they'll give us a three year award so I'll be able to get a car ... [It must cost you quite a bit in taxis] Oh it does. But then, as I say, that's what I've got the award for, you know. But I use

> most of it on taxis like. But it'd be more economical ... if I got the three year or more. They have with the mobility scheme - it's like a lend-lease - you have the car for three years, they have your award and you're fully taxed, insured and everything. And all you've got to do is put the petrol in which would be better because it'd give me more freedom because our Julie's [daughter] got her driving licence and our Ann is having lessons ..." (Late 40s - Registered Sick due to rheumatoid arthritis).

Perhaps it is lower-income people with less restrictive, but still serious, health problems who are the most disadvantaged in terms of time-space flexibility. This is because they are not eligible for help from the social services and also have an inadequate income in their own right to cover the additional costs of managing illness.

As noted in Chapter Four, various studies have shown that, in the absence of available income as a means of managing with time-space constraints, social network resources may be employed in a number of similar ways (Hosking, 1989; Pearson et al, 1993). Without distinguishing income, 236 working-age women replied to the postal questionnaire section about social resources. Of these, 26 percent (61) received childcare and 30 percent (71) received help with transport on a regular or occasional basis. A further 7 percent (16) received other forms of help ranging from shopping and domestic work to 'granny minding' and use of the washing machine. The issue of when and how social network resources are employed is dealt with in the next section.

8.4 Sharing Responsibilities across the Social Network

8.4.1 Social Networks and Paid Labour Participation

The divorced woman in the next example provides an illustration of the major use to which women put their social network resources. That is to provide childcare in order that they may go out to work. The woman concerned works full-time. Her children are cared for during work hours by her mother who stays over and only returns to her own flat at weekends:

> "... I used to have a childminder at one time, but it didn't work out - too expensive ... When I weighed it up at the end of the month it wasn't worth it so ... I think if anything should ever happen to my mother I'd probably have to come out of work altogether ... my Mum takes them to school for me and she picks them up and, most of the time, she'll cook their tea as well for them - say two or three nights a week ..." (Early 30s - Full-time clerical worker).

Part-time workers in low-income households, on the other hand, seem able to call on the social network only as a relatively secondary measure. These women very much set their work hours around school or times when partners are available for substitute childcare. The lack of another alternative is part of the reason why some women who want to work full-time cannot do so. One Netherley mother, for instance, described her application for work in a betting shop as follows:

> "... Well Andy could babysit every second week when he was on the early shift - he'd stay in ... But, for every second week, I'd get Kath [friend]" (Mid 30s - Income Support).

Of course, as the previous section demonstrates, some are fortunate enough to have regular access to social resources *in addition* to a substantial financial income. Other higher-income women rely on friends and relatives simply as a 'fall-back' at odd times, for example, when a paid childminder is unavailable:

> "My next door neighbour's been very helpful ... Otherwise I suppose I'd have to look for somebody else and there are two or three people.

> You develop these type of networks don't you? But there are two or three people in the area I could ask ..." (Late 30s - Full-time teacher).

The resource circumstances of each woman already discussed does, however, stand in sharp contrast to the conditions managed by low-income mothers who either lack social resources altogether or feel that the help they require is too much to ask for. For these women, there is little alternative but to commit the major part of their day to caring and domestic work and not to a paid job:

> "... I did have a job, but I had to pack it in through the youngest - it was too much for my Dad. He was looking after the baby ... I was just a cleaner in one of the schools. But it was like three till six and my Dad just found it hard because as the baby - as she was getting older he just couldn't cope with her ... I'll just have to wait till she starts school or something and look for something then" (Early 30s - Looking after home).

> "... I do have a friend who will occasionally sit in, but then she has two boys herself and so, you know, we don't really like to trouble anybody ... I suppose we are very much on our own with David [disabled son]. The family are OK when they're here and with him, but I think if anybody had to look after him I think it would be a different matter so we don't ask ... It's just that he's getting bigger and he's heavier now and OK you've got to hold him ... so he does wear your energy obviously and most people can't cope with that really ... So we are much on our own ..." (Early 40s - Looking after home).

This lack of help from any social network only serves to compound the financial difficulties in which many families with children find themselves and also contributes to the kinds of feelings of isolation which will be described in Chapter Nine. As one young mother replied, when asked about baby-sitting:

> "Very rare - might go out twice a year. Went out last week on Friday and I had my niece baby-sitting for us ... I've got a nephew as well. He came Christmas when we went out" (Late 20s - Looking after home).

A number of the middle-aged carers of highly-dependent adults also described feeling that it is too much to 'burden' other people with sharing their responsibilities other than for a short break or in emergencies. The next illustrations are taken from interviews with a married woman caring at home for a mother in her nineties and a divorcee who has a twenty-five year-old daughter with Down's Syndrome:

> "Well sometimes they'll [friends] come in and sit with my Mum if my husband and I want to go off for the day. Or there's one friend, a particular friend - I mean she'll say, 'Oh I'll take your Mum down for lunch' ... which is a change for her and a break for us" (Late 50s - Part-time job in school).

> "Julie will mind her or Paul or Sandra [children who have all left home] ... Oh, if I want to go out, I've always got one of them to come and mind her - not that I go out very often I don't" (Early 50s - Recently retired part-time catering assistant).

Each woman, clearly, regards herself as the principle carer and any help from the social network, even from within the family household where it is available, is seen just as a back-up.

8.4.2 The Nature of Assistance in the Social Network

Just as Qureshi and Walker (1989) suggest for the carers of elderly dependants, the interviews carried out in Netherley and Woolton reveal a definite hierarchy of responsibilities within social networks. This hierarchy is based upon gender, generation, the closeness of relationships and whether or not the person likely to be called upon can claim mitigating circumstances which effectively reduce his or her level of obligation. If the woman in the next illustration had to go into hospital, she would, for instance, call upon her mother-in-law ahead of her own father and family before friends:

> "Short-term I think my husband would manage ... I suppose long-term it would be a problem because of all his other commitments ... We would rely on his mother. But, again, we don't like to do that too often because she's getting old - she's in her seventies. My Dad's still living, but he's not much use in the childcare department I'm afraid. He is nearer, but - if I said he was unwilling that makes him sound mean and that - he's not really able ... to look after kids, he's not up to it. He doesn't want to be up to it [laughs], not little kids ... Failing that we'd have to rely on friends, which we have done before, rather than relatives. And, like I say, we're in the catchment area of a Barnardo's Families Project so we do have a Barnardo's Social Worker ..." (Late 30s - Full-time teacher).

When the woman referred to next was younger, it was her mother who helped when the husband was unable to work due to ill health and the family was in financial difficulties:

> "... It was when our son was young and I wasn't working and he [husband] was in hospital and ... it was only a small firm - I mean they couldn't carry on so they had to come and give him his cards you see. Well, I couldn't go to the hospital and tell my husband, you know, 'You haven't got a job', so I went on pretending that I was getting the money each week ... And we were living on love, fresh air and hope. Actually, it was awful. That's when my Mum was very good. She would come to visit and, pride, I wouldn't tell her. But she knew and when she left the cupboard used to be full of food" (Late 50s - Recently retired from part-time laboratory job).

Not only do these interviews illustrate the very practical nature of help from the social network, they also reaffirm previous findings (eg. Pearson, 1991) that a hierarchy applies just as equally to the pool of assistance on which the women feel able to rely as to their own positions of obligation in relation to family and friends.

As is the case for caring responsibilities within households, labour market participation is one of the primary mitigating circumstances for people who might otherwise figure significantly on the list of those to be called upon. One Netherley

mother described, for example, why she cannot ask her mother to help with childcare:

> "I think she works about thirty hours. I don't know if it's considered full-time. She's a barmaid. She does three days and five nights so - difficult isn't it?" (Mid 30s - Income Support).

Conversely, spatial proximity is likely to accentuate the obligations of certain members of the social network above those of people who should, ostensibly, be at the same position in the hierarchy. A clear example comes from a Woolton teacher who provided care to a terminally ill aunt before she died. This woman also looks after her mother and another aunt and, at one point, had to have all three to stay in her house due to illness:

> "Unfortunately, I'm the only sibling living here. My aunt has only one child, or daughter, who lives in Germany. My two brothers, one lives abroad and one lives in Holyhead in North Wales so it's difficult to get through. And my other aunt who died has daughters living in London. I mean, one of them came fairly regularly but.." (Early 50s - Part-time teacher).

Another concrete demonstration of the workings of geography is again provided by the Netherley woman who feels unable to ask her working mother for assistance. She described how the family system of obligations operates from her own point of view:

> "Me, a sister and a brother. [But is it you that goes shopping with your Mum?] Yes. I'm the closest. She only lives round the corner - unfortunately - it's a disadvantage isn't it? [Is it?] Yes. She doesn't return the favour by babysitting. Never mind" (Mid 30s - Income Support).

8.4.3 Reciprocity and Social Support

The last comment brings the discussion onto another important feature of social networks which means that resources in the shape of help from friends and

relatives are critically different from those in economic form. Again, it is consistent with previous research (Finch, 1987a and 1989; Pearson, 1991), that participants in this study talk in terms of the need to reciprocate exchanges across the social network. As the single mother, who is referred to at the start of this section as able to hold down a full-time job because her mother looks after her children, puts it:

> "My Mum's classed as, she has Invalidity. She shouldn't really be looking after my kids but, as we say, it's therapeutic for her, you know. I mean nobody knows she has my child benefit - nobody knows about that. But I've got to give her something, I've got to. I feel we're sort of doing each other a favour, you know. As she says, this money doesn't half come in handy for her bills and I couldn't get anywhere that cheap d'you know what I mean? Six kids - I mean, it's only fifty-five quid a week. I mean, where else could you get anybody to mind six kids for you for that? ... So I'm very lucky. I couldn't work if I didn't have her. It's as simple as that" (Early 30s - Full-time clerical worker).

This woman also aims to return her mother's help by buying her massage oils, vitamin pills and other tablets for her arthritis. She gives her mother money for the bingo and thinks up ways to improve the quality of her diet which she feels would be inadequate without such intervention.

Reciprocation in this sense is direct and contemporary to the help received. There are, however, other sorts of reciprocity which are far less immediate or tangible (Finch, 1987a; Qureshi and Walker, 1989). The active social networks of the single mothers of young children in the interview group, for instance, more obviously contain friends in the same situation as opposed to just relatives. The needs for assistance within this type of network are relatively similar because they centre on the women's children. Although these women are still reluctant to impose on other people, there is an *in-built* sense of social support and reciprocity which

comes from having to cope with the same kinds of problems. In other kinds of social network, a similar feeling of *potential* reciprocity is also an important factor as is the *accumulation* of good-will through an exchange of favours and friendship over many years:

> "My neighbour next-door-but-one, if you need her you can always go to her, she's good that way. But, then again, I've never had to rely on her so. But I know that she's there if, you know, no matter the time of day - same as we're here for her if she needs us" (Early 50s - Part-time catering assistant).

> "... the next door neighbour and her [mother] had lived next door to each other since about 1948. But she - one of the other reasons that she went in a home as well was because the neighbour was moving ... Because she had the key to my mother's house. I mean, you can't expect anybody else who moved in next door to do anything like that, it's unreasonable. But they'd been friends for so many years that she had their key and they had her key and they kept an eye on each other you see ..." (Late 40s - Part-time library assistant).

As the last example illustrates, where a sense of commitment has not been built up between people it is not so easy to call upon the social network for assistance.

So far, in this part of the discussion, only positive feelings of gratitude and commitment have been referred to. However, in the context of inter-generational exchanges between family members in particular, terms such as *obligation* and *duty* have also been used (Finch, 1989; Ungerson, 1987). Children often feel obligated to look after elderly parents in return for the care they received during childhood and feel guilty if they do not 'do their duty' in this way. The single paid-working mother referred to above may also feel duty-bound in future years to help her mother in return for assistance with childcare today. Indeed a number of the middle-aged women interviewed described how they actually combine helping to look after grandchildren with primary caring responsibilities towards an adult

dependant. A Netherley woman explained, for example, why she will not look for another job following early retirement:

> "No, I'm getting too old now, I'm fifty-three. And Mary [adult daughter with Down's Syndrome] takes up too much time. And I've grandchildren now so ... Because their mother goes to work [as part-time school cleaner] so I have them five days a week from half-past-two to six o'clock ... I pick one up from school. One's in nursery of a morning so she's at home and James, he's only two" (Early 50s - Recently retired part-time catering assistant).

Another carer, who looks after her elderly father at home, also described her contribution to the care of her grandchildren:

> "I babysit - you could call it babysitting - a Monday and a Saturday. They go to Asda and leave the children here, so we watch them until they come back ... because you know what youngsters are in the supermarket, they're better without them. Debbie, my granddaughter, the eldest one, she's eight, she likes to sleep here with me on a Saturday night if she can. Andrew's five now - first of all he didn't, but now because our Debbie stays he wants to stay you see. So I usually have one in the bed and I put a mattress on the floor and who slept on the bed one week sleeps on the floor the next week ..." (Early 50s - Invalid Care Allowance).

These then are some of the ways in which obligations are built up between parents and children over the life-course. They give an idea why children feel that it is 'giving something back' if they look after a parent in old age.

Although relationships between carers and elderly dependants can certainly involve very positive feelings, the terms obligation and duty do highlight the fact that there may also be a negative side to caring. If the carer believes that obligations have been 'paid off' adequately already, or were insufficient to require reciprocation in the first place, feelings of guilt may well be lessened. Often, however, guilt is replaced by resentment and, as the next example illustrates, a deteriorating relationship with the person being cared for:

> "[Would you prefer it if your father was in a home?] Yes. I would be made up. I spoke to somebody up at the health centre about it once. She said, 'It's up to you', but she said, 'Don't you think you'd feel guilty?' I said, 'No I wouldn't feel guilty, I've done my duty'. No I wouldn't feel guilty. I've looked after both my mother and father. When my Mum's been ill I've been down there, done everything for her all my life and my father I've got no reason to feel guilty. It's my Dad that should be feeling guilty. He's given me no life when I was young and he's giving me no life now ..." (Early 50s -Invalid Care Allowance).

Since holding a driving licence and access to a private car are age-related, a large proportion of the help which low-income younger women give directly in return for assistance from otherwise healthy family and friends centres on transport provision. If one person in the social network owns a car then they provide lifts to everybody else. For example:

> "[Your Mum and Dad haven't got a car?] No. I'm the chauffeur [laughs] I am. I'm amazed how much petrol I put in the car because I'm always running round for everyone. But, as I say I don't mind because they're always good to the kids ... It's got to work two ways hasn't it, you know? [So what sorts of things do you do for them?] I take my Mum shopping, she goes to library classes on a Friday - I take her there. I take her to my Nan's -she lives in Widnes. Anywhere she wants to go, I'll take her ..." (Early 30s -Looking after home).

As might be expected, a lack of contemporary reciprocity or sharing of the caring burden amongst people at equal positions in the social network hierarchy also tends to cause resentment. This is illustrated by one woman's reply to a question about who would help her parents if they were unwell:

> "... it would be left to me to look after my mum because my sister lives in Grassendale, my brother lives in Halewood village - they don't visit that often, they just come down every time they need something. I resent that slightly because they come down once every blue moon and it's, 'Oh our Sharon was down, oh our Richard was down'. And you think I'm just here all the time, no thanks, nothing. So our Paula [interviewee] was round, 'You didn't pick me this up,

you didn't get me that'. So often I think I'll move, see how she likes it then with no car here - just being a bitch. [She should appreciate it shouldn't she?] Yes. Neither of them do. They are cows the pair of them, his mother and my own. I couldn't in a million years imagine our Sharon bringing a Sunday dinner down for them [Paula does this every week], but oh God she'd think it was lovely if she did, you know one of them ..." (Mid 30s - Income Support).

8.5 'Catch 22' - The Social Security Context

So far, the discussion has outlined the concrete means by which lower and higher-income women handle their different social role responsibilities. The main point to take from the chapter is as follows: regardless of their attitudes about appropriate gender roles, low-income women with caring responsibilities are heavily restricted in their choices for paid work because they have to cope with time-space constraints, primarily, by means of the social network. The aim of the present section is to point out ways in which labour market conditions and the social security system interact to provide the context for managing by low-income women and their families. It reaffirms the findings of others (eg. Garnsey, 1987), that the wages such women can realistically expect to earn in part-time, low-status jobs are insufficient to enable them to give up social security payments.

The next extract, taken from one of the interviews in Netherley, illustrates this situation quite dramatically. Although the partner of the woman interviewed wants them to get married, he does not earn enough on his own to support himself, her and their two children. Since she is unable to find a job which fits in with the children and pays enough to live on, she is forced to continue to claim Income Support without declaring that they live together. The same woman had given up

her nursing training for the sole reason that she became pregnant and could not find a nursery place for the baby:

> "I went for an interview last month and got the job - and the day after I went for the interview, that was when I found out I was pregnant. I had to phone and say 'No thanks'. It was really, really bad wages - it was nights as a care assistant - £2.70 an hour, that's all for nights, twelve hour shifts, £2.70. You'd have to be mental ... So I rang up and said, 'I'm afraid I can't start, thanks for giving me the job and everything but I've found out this morning I was pregnant.' She said, 'Oh well, you can start work if you want.' I thought they must be desperate to interview a pregnant woman and take her on. What sort of job is it? So I never started.
>
> [So that wouldn't be worth it, with losing your benefit?] Oh God no! No, I worked it out. With getting Family Credit and everything I would be worse off working and Family Credit than I am now. I'd lose like they're school meals and uniforms and things.
>
> [You don't get that with Family Credit?] I'd have earned too much. I would have earned £2 too much to get the full Family Credit so I would have had to pay rent as well. I'd have been broke - just the travelling costs. I would have been worse off than someone on Income Support. I mean, they don't make it easy for single parents to find work. I mean, I've got to find enough to cover the rent which I don't have to pay now ... So there's £35 I need straight away. Travelling costs to work, school meals and uniforms and things. I'd have to pick up a hundred and fifty. Where do you find a job these days? And that's without even considering paying someone to pick up and drop the kids and everything. I'd obviously have to pay someone to do that.
>
> [So if you start this job at the betting shop will that be..?] Until I'm fully trained she'll give me that in my hand and then she'll work out with me. I can do full-time or part-time really and in the summer they have all the night races so the overtime's all on the quiet.
>
> [Really?] Yes. I mean, I don't want to stay on Income Support - I want to be able to come off it and work properly and everything but it really is hard to. You're trapped once you're in this situation" (Mid 30s - Income Support).

The woman referred to in the next example also described being unable to find a job because of the need to remain in the local area in order to accommodate

her children's school times. The household cannot survive on the wage her unemployed husband can, realistically, earn in Liverpool's increasingly depressed labour market and is better off if he continues to claim social security:

> "... he wants a sales job with a basic. He doesn't want commission only and that's hard to find ... That's all he's ever done really and mechanics he did when he left school ... But he's got ideas on starting up his own business as well ... It's been twelve months since he's been out of work and he just hasn't got the money to just start it up so he's looking for grants. And he's finding it hard to get onto them because a lot of them you've got to be under twenty-nine, you know, there's all circumstances around getting these grants ..." (Late 20s - Looking after home).

Even more striking comments concerning the income inequalities imposed on households by conditions in the labour market which have led to suppressed wages and an inability to accommodate caring responsibilities whilst working, were made by two mothers of disabled children:

> [Do you get anything extra for your son?] Oh yes I do. I wouldn't be able to manage if I didn't have that ... It's Disability Living Allowance. I mean, that's the only way I've got the car really ... I tried to get it through Mobility, but you've got to have it for so many years ... But with the money that I'm getting I just pay off the car, you know. I would have to do a full-time job if he was a normal child" (Early 40s - Part-time care worker).

> "... I think it's £160 a fortnight he [husband] gets off the dole so that's £80 a week. And then I get David's benefits which is £70, nearly £80 ... We get Attendance Allowance and what's the other one? ... I know there's Disability Living Allowance isn't there? I've got two booklets anyway and then there's Family Allowance but I only get that four weekly ... £10. So that's it [the household income], it's between £100 and £200 a week which isn't a lot really [laughs]. We could do with more ... I mean, as much as we'd like David to be a perfect child - if we didn't have David's benefits coming in I'm sure things would be a lot more difficult, you know, to do because we get that £70 a week that we wouldn't get normally. So it helps keep all the bills on-going, you know, we're not in debt to anybody, fortunately, so that's OK" (Early 40s - Looking after home).

Worryingly, given the last remarks about the contribution of social security payments to economic survival in some households, a significant minority of the women interviewed described long periods of being unaware of the entitlements owing to themselves or their dependant:

> "... I used to have another physio woman ... and I didn't know anything to claim, like Attendance Allowance or any help for James [son age 2], like he had support boots or - I wouldn't have known anything. And only for her, she helped me with all this ..." (Early 30s - Income Support).

Others had been refused payments despite not being able to afford the extra costs of caring. One young Netherley woman lives with her mother and house-bound grandmother who needs intensive personal care, for example, with bathing and dressing. Their council house was about to be demolished and they had asked to be moved to accommodation with a downstairs toilet, specifically, for the grandmother's use:

> "That was another thing ... we had to ask for a house with two toilets in it and like now we've got to pay £10 extra [per week] ... £53 the rent's going to be over in the new house. It's about £33 now in here... We applied for, you know you get so much money if you look after your old people ... and we got turned down for that. They said because my Nan is pretty active for her age - she can do the washing-up and things like that - they said she's OK, she doesn't need any help ... Well, to be honest like my Mum just put in for that money to get things like to help with my Nan ... I said to my Mum, 'We deserve it' ... But my Mum said, like with being turned down, she said, 'I'm not bothering now'. I've tried - I've said, 'Go the Citizens' Advice', but my Mum's not like that ... If someone says, 'You're not entitled to it', she won't reapply ..." (Late 20s - Full-time domestic).

In cases where older women have heavy caring responsibilities towards an adult dependant, they may lose more than an income in the short-term if they give up paid employment in order to care on a full-time basis. One woman in her fifties

described her sister's situation following her brother-in-law's stroke. Not only had she given up her own job and lost his income, she found herself in the position of having to spend their savings before she could claim any social security. She was looking to the prospect of spending her retirement looking after a severely disabled husband on an extremely low income indeed. Another woman caring for her husband said:

> "I'm not going to retire until I have to. You see, I've been stupid, I haven't paid a full stamp ... I won't get a pension until he's [husband] sixty-five and that's in five years ... I only ever, ever worked part-time anyway and about three years ago I went on full-time work in the same place. And when I say to you I've only worked part-time ... I've always worked sixty-odd hours a week and that was at my part-time job ... I've spoilt myself financially pension-wise. Silly" (Late 50s - Full-time care worker).

As studies discussed in Chapter Three note (eg. Groves, 1992; Joshi, 1992) and as the last example illustrates, women are considerably disadvantaged in the pension system. Hence, the economic and social experience of old age is already a gendered one (Walker, 1992). In addition, current government policies view the state retirement pension solely as a residual foundation on which individuals must provide for themselves through alternative means. As lower-status employees, the majority of women are unlikely to be able to do this (Groves, 1992). For all of these reasons, it is vitally important to consider the future implications of caring in the 'community' if the working-age women of today have to forego their long-term pension rights as a result. The discussion returns, in Chapter Ten, to the implications, specifically for carers, of policies of Community Care.

8.6 Summary

In an economically depressed city such as Liverpool, where the burdens of responsibility for health and social care are clearly exaggerated, any understanding of the mechanisms by which caring is managed within households can only be achieved by exploring the role of economic and social network resources. It is particularly important to examine the availability of such resources to the principle providers of that care, namely women. This chapter has aimed to show that the burdens associated with conditions of relatively low per capita GDP and high unemployment, in the study areas and Liverpool as a whole, have an added effect when viewed through the lens of gender relations. For example, in attempting to alleviate the burdens of caring, the particular forms of household social relation surrounding access to financial income and resources such as the 'family' car are critical to women. Also significant are the social relations which structure informal systems of obligation and familial and neighbourly exchange. Embedded social practices in families and local areas are revealed by the in-depth interviews in ways which illustrate both the subtlety of the processes involved and the constitutive role of space in the outcomes for women. Only by exploring the contingent spatially configured and socially constructed circumstances of caring as a process can an understanding be developed of the workings of women's everyday lives and, specifically, the means by which women's own health needs are or are not met. The evidence set out in this chapter and in Chapter Seven, therefore, forms the contextual framework for the discussion which is to follow of women's own health experience and the health-related decisions they make personally and on behalf of family members.

CHAPTER NINE

HEALTH-RELATED BEHAVIOUR: AN ACTIVITY ANALYSIS

9.1 Introduction

As Jones (1989) suggests and as Chapters Seven and Eight have illustrated, the scope for women to overcome temporal and spatial distance does depend, to a large extent, on the degree of perceptual and practical difficulty they experience in scheduling competing daily activities. The aim of this chapter is to illustrate how, in the interview households, such time-space decision-making processes follow through to influence health, illness and health care behaviours. The first part of the chapter distinguishes the various types and divisions of household health-related labour, both conceptually (Section 9.2) and using the interview evidence to expand on the framework described (Section 9.3). Although, clearly, this should be regarded as an integral part of the general task of caring within families, a separate discussion was felt to be necessary for the purposes of the present argument. The chapter then moves on to deal with the various ways in which economic and social resources are employed by households, specifically, in relation to health and illness (Sections 9.4 and 9.5). These first sections set the context for the ensuing discussion of: i) the issues which are of primary concern to the interview participants in relation to their own health and social roles (Sections 9.6 and 9.7); and ii) the position women take in the order of priorities for household health needs (Section 9.8).

In general, therefore, the chapter continues the theme of the links between women's social role demands, the constraints of individual health status and the availability of economic and social resources. It seeks to highlight the ways in which these factors interact, differentially, in the outcomes of decision-making depending upon the type of health care concerned and which member of the family is involved. Overall, it is argued that, on an individual basis, inequalities in the apportionment of time-space and resource constraints can influence women's ability to fulfil their own health-related needs in an adequate manner.

9.2 Health Management in Households - A Definition

By focusing on their role as household health managers, working within the set of constraining and/or enabling circumstances set out in Chapters Seven and Eight, this chapter will examine how women deal with:

i) the health-related needs of the household and wider family;

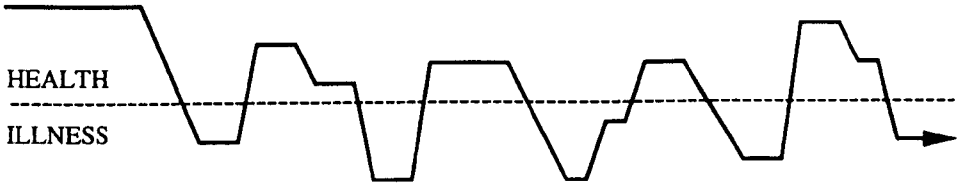
ii) their own health-related needs within that overall framework.

The term health-related is used here to cover the range of health, illness and health care behaviours outlined in Chapter Two. However, it is first necessary to set the context for this stage of the interview analysis by defining, conceptually, what it actually means for women to 'manage' health.

As a starting point to this exercise, we can picture the individual as continually moving between states of 'health' and 'illness' as he or she progresses across the life-course. Such a path is indicated by the arrowed line in Figure 9.1 where health is taken as being the 'desirable' and illness the 'undesirable' state to

be in. Illness may, of course, be a short-term or acute episode or it could be a long-term or chronic condition. There are also varying degrees of limitation subsumed within each category. An individual might have a long-term problem with migraine but this limits their activities for only a few hours or days at a time. On the other hand, he or she may suffer with severe rheumatoid arthritis and experience continuous restriction of activity.

Figure 9.1 Life-path of Health and Illness



Using this conceptual framework, we can now define the management of health-related need as having a number of integrated and complementary elements:

i) the active maintenance of a 'healthy' state and the reduction of susceptibility to potential illness;

ii) helping those who fall ill to get back to health where possible;

iii) preventing the worsening of illness which does occur, whether it be short or long-term.

Placed under i) above would be health behaviours such as eating a balanced diet, taking regular exercise and taking vitamin and mineral supplements likely, for instance, to ward off colds or reduce the risk of osteo-porosis. Health care behaviours in this category might include getting children immunised, accepting Hormone Replacement Therapy and responding to calls for breast and cervical cancer screening. Placed under ii) and iii) above would be personal care within the household and social network and the accessing of interventions from the range of health services. Figures 9.2 and 9.3 illustrate two alternative scenarios in this context. First, the case of a 'generally healthy' person who has occasional episodes of acute illness. Second, that of a person who becomes chronically ill but the condition is 'managed' to remain quite stable. Each category of health management can be applied as much to a woman's caring labour for the family as to how she and other family members deal with her own health-related needs.

Figure 9.2 Occasional Short-term Illness Episodes

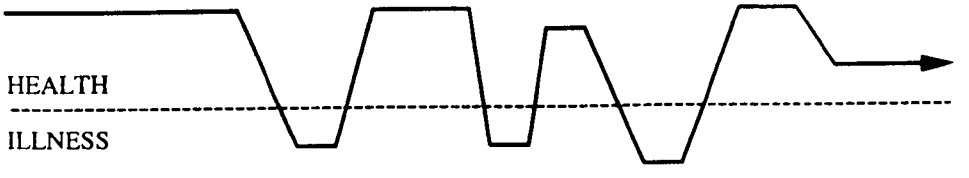


Figure 9.3 Managed Long-term Illness

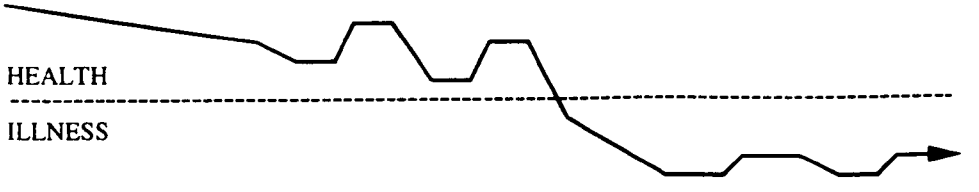


Figure 9.1 is, of course, very much simplified. Not only do individuals begin life at different positions along the vertical axis between health and illness, but position within either state is also not fixed or absolute. In addition, as outlined in Chapter Two, health and illness are subjective concepts. The experience of each is socially constructed along the lines of the wider social divisions of gender, class, ethnicity and age. This means, for example, that certain individuals are freer than others to accept the sick role depending on the nature of their socially constructed roles.

This chapter explores the social construction of women's health, illness and health care behaviours. It does this by placing those behaviours in the context of women's general social roles within the household and wider family network. In particular, the chapter will argue that the decisions women make in their capacity as health manager vary according to the family member involved. First, however, the discussion will expand on the conceptual framework by examining the nature and divisions of health-related labour in the interview households. That labour ranges from measures aimed at ensuring the continued health of family members to the various forms of provision of care to the sick.

9.3 The Nature of Health-related Labour in Families

9.3.1 Maintaining Healthy Lifestyles

Consistent with previous research outlined in Chapter Three (eg. Graham, 1984, 1988, 1992 and 1993), the women in this study described their central role in maintaining a 'healthy lifestyle' for family members. The primary means by

which they do this is through exercising control over household eating habits. For example, when asked if she had altered her husband's diet following his being diagnosed as having high cholesterol, one woman replied:

> "Oh yes, for him yes ... I buy him low cholesterol spreads. He has to take sandwiches to work because of the job he does [docker]. It's sort of take sandwiches or go to the chippy and he can't go to the chippy ... Any chips that we have now are oven chips in sunflower oil ... And he doesn't eat as much red meat as he used to ... And he takes a lot of fruit with him where, beforehand, I would have given him maybe a piece of cake or some biscuits or something in case he needed anything extra ... It hasn't affected the way the rest of us eat ... I buy differently for him" (Early 40s - Full-time secretary).

Clearly, however, women are limited in what they can do given the gendered nature of household power relations:

> "We're just hoping she [daughter] grows out of it [being overweight] and we do watch what she eats ... And my husband is overweight as well. He's getting bigger and I don't know why [laughs] I think he stuffs himself in the daytime when he's at work. But, of a night, I go to bed early and he's always staying down watching telly till all hours and he's just stuffing himself because I end up with all the dishes in the sink when I first get up of a morning ... You can only do so much can't you? I mean, it's up to him then what he eats while he's not here ..." (Mid-30s - Looking after home).

Another means by which mothers maintain a 'healthy lifestyle' for their children is through encouraging them to take exercise. The woman referred to in the next extract still takes her children swimming even though she does not swim herself. When asked if there is anything she would like to do for the sake of her own health she replied as follows:

> "Oh lose weight definitely. Get us all, I mean the kids as well, get them involved in some kind of fitness regime. You know, some kind of routine, something that we could all be doing together. I mean, the oldest three play football a lot ... But I'd like to get Loraine and the twins involved in some kind of - just for us all to keep fit and that's it really" (Early 30s - Full-time clerical worker).

This is just one example of a mother who describes her own efforts to live a healthy lifestyle in terms inextricably linked with the needs of her children. The discussion will return to this important issue later in the chapter.

9.3.2 Managing with Short-term Illness

The necessity to look after a sick family member is another obvious form of health-related caring labour. Mothers of young children, in particular, talk of the extra work that this involves because youngsters do not always understand what is wrong with them:

> "It is [extra work] really because she gets it [eczma] so bad she can't even stand water to touch her skin because it hurts her. So I'm trying to give her a wash or a bath or anything and it's all this kind of - you can't wash her hair and - she just wants your undivided attention when she feels like that. So I have to carry her out and sit her on the kitchen worktop while I do the dishes - comfort her. I suppose it's because they don't see that much of their Dad that they just want their Mum when they're sick don't they? Which is a bit of a pain, but I like it" (Mid 30s - Income Support).

Just as with the sharing of domestic labour described in Chapter Seven, the question of who cares for ill children depends very much upon gender relations in the household. The following extracts illustrate the possible contrasts. The women were asked what happens when a child wakes in the night:

> "If I'm being honest my husband sees to her ... And then if he thinks she wants her Mum I'll see to her. The other night she was really in a bad way -that's when she was on the antibiotics - and my husband ended up getting in her bed, because he'd been with her for an hour and he had to get up for work - and she ended up getting in with me. But I'd do that as a last resort ..." (Early 30s - Looking after home).

> "... He says that's woman's work ..." (Early 30s - Part-time nurse).

Clearly, the differential nature of the paid labour market for lower and higher-status workers follows through to influence household divisions of caring for health in addition to those of caring labour generally:

> "The only worry is as a working Mum, with a younger child particularly, is when they're ill. I mean it's not so bad with Luke now because he's nearly fifteen, but the younger one - obviously you daren't leave them even for a couple of hours. I mean with Luke now I'll work at home a couple of hours during the day if I wanted to. I haven't done this week because his Dad's been off a couple of half days. You know, just sort of mix and match really" (Mid 40s - Full-time personnel manager).

> "[And what happens if you're not able to look after the kids?] Hope my Mum and Dad'd help, you know - that's it. Because, as I say, my husband doesn't get paid if he's off work and there's only his wage coming in. I don't think he could take time off [from factory] really, you know, it's awkward ..." (Early 30s - Looking after home).

It is a similar situation when adult relatives are considered. In comparison with their male partners, the women interviewed had taken on considerable extra caring and domestic tasks during periods of a dependant's illness. For women in lower-status, part-time paid work, employment clearly takes second place. As one Netherley woman explains:

> "She [mother with stomach cancer] didn't want to stay in hospital ... she came home and we nursed her for seven months because they lived right facing me ... I was working part-time of a morning ... and then coming home at one and spending from one till nine looking after my Mum. And then towards the end I took time off work so I could be with her all the time, you know. I took sick leave - I was off with stress due to mother's illness on the [GP's] notes".

> "I used to just do mine [housework] when I could, you know, fit it in. Because it was like, it was running two homes" (Late 40s - Former care assistant).

Women who have access to greater economic resources, by contrast, have more scope to ease the time-space constraints of looking after an ill relative by means other than reducing their paid work participation. In order to manage, when faced with her elderly relatives being sick, the woman in the next illustration brings them to stay with her for periods up to several months. She is fortunate to have a large enough house to manage:

> "... So, say if she's got a cough, she won't go to the doctor's until it's developed into a full blown thing and then - well then we move her in here because we don't want her to cope with it on her own ... And I have a daily that comes in the mornings and I found it easier - I knew that she was sort of looked after and she had access to phones and things very easily. And I also only worked in the school round the corner so I could whizz home at lunchtime and just check that everything was all alright. It was easier than keeping her in the flat and going too and fro".

> "My aunt couldn't move around too much because she'd broken her leg ... My aunt lives in Maghull so again it was easier that she was here because of being stretched working full-time and going over to the Wirral [to visit second aunt in hospital]. You know, there's only so much travelling you can do really ..." (Early 50s - Part-time teacher).

The other context in which male partners were mentioned as being involved in issues of illness was in relation to grown-up or teenage sons still living at home. Two Netherley mothers commented that their sons sometimes turn to their fathers for support over emotional or potentially 'embarrassing' male health problems:

> "When I got in from work Ian [husband] said, 'He's [son] not been well all day' and I said, 'Well, go the doctor's'. And Ian said, 'Oh, I'll take him' and he took him over. And he must have already told Ian that it was something he didn't want to talk to me about. And when Ian came back he said, 'I've got to take him to the hospital right away ... But the doctor said he must have had this for a while and never mentioned it. I think he must have been embarrassed ..." (Late 40s - Full-time administrator).

"It's just our Graham with him being asthmatic. And then it's this job [at Job Centre] he's on, he gets a lot of flack ... And then right now he's on what you call the desk so he takes all the stick as soon as the people walk in the building ... You wouldn't think he'd take it to heart the way that he has. He was even crying this morning. Mind you, he wasn't crying in front of me - it was in front of his Dad" (Early 50s - Part-time catering assistant).

As might be expected from the discussion in Chapter Seven, older children and adult dependants are less of a responsibility generally when it comes to an episode of illness. This is because they are better able to cope themselves:

"[So you'd take time off before you'd get your in-laws to help?] ... if it was something like a cough and a cold and you can't really do much for them ... well, obviously, somebody next-door [in-laws] would pop in on them ... If they were that bad, I'd be staying off work to look after them, you know. I wouldn't get somebody else to do it. And as they were younger, obviously, they wanted their Mum more than anybody - well, I couldn't really ask anybody. It's just that they're getting older now, they're quite happy for somebody else to come in" (Late 30s - Part-time catering assistant).

"[What happens when one of the children is ill?] We have heart attacks. If Sarah's [Age 12] ill - I mean, touch wood, she's never been that ill that we've not been able to leave her. Since Hayley [Age 2] was born really she's looked after herself. If she's been ill and stayed off school she's stayed here and one of us has come back at dinnertime or rung her up, you know, that sort of thing" (Late 30s - Full-time teacher).

9.3.3 Managing Medication and Long-term Illness

Caring for illness in the family does not only mean looking after a child or adult dependant during periods of short-term, or acute, sickness. Amongst other things, it can mean collecting repeat prescriptions on behalf of others and being responsible for making decisions concerning their use of medication. In addition, the women interviewed described it as their responsibility to 'manage' the chronic

illnesses or less serious, but still long-term, conditions of family members. For instance, when asked about her husband's asthma attacks, one woman replied:

> "... If he has a bad one in the middle of the night, which has happened many, many times, the first thing we do is get up and get his pipes and give him that - they're next to the bed - and then open the windows and get a lot of air in and keep calm. Because, I was taught this by the chest specialist, the worst thing he said you can do is panic ... At one time, they were going to teach me to use adrenaline ... But, luckily, it never got to that stage ..." (Late 50s - Recently retired from part-time laboratory job).

Two mothers describe their own roles in the health problems of their young daughters as follows:

> "... I've forgotten the name of it, you know, your little valve at the bottom of the oesophagus used to close before the milk'd land - throw it back up. But, with her being so small, she wouldn't vomit - it'd stay in the top of her throat and she'd choke. So they said if that's not better after a year they'll operate. She just got better the week her appointment was due. I started giving her really thick food - thick Readybrek and stuff like that, baked potatoes with no wet on them or anything. It seemed to do the business, she was better ..." (Early 30s - Income Support).

> "I don't think she's got asthma severe, it's pretty much under control. I only give her inhaler when she's bad, you know ... But I'll only take her to the doctor's as a last resort with the asthma because they tend to give them a lot of the steroids and that and I don't like it. So I try to control it myself, honey and lemon and that, you know" (Early 30s - Looking after home).

As the last extract illustrates, mothers have strong opinions about the appropriateness of medication where their children are concerned. They are unafraid to counter the instructions of the medical profession when they feel this is necessary:

> "And tablets - and I thought they were sleeping tablets so I stopped her taking them. On the instructions thing it said side effects makes you sleepy and tired and all that ... I don't like kids taking tablets and things. And that confirmed it when that doctor gave my

> daughter acne cream and it's gone and given her eczma ... I don't totally blame him for it. I don't know. I'm just annoyed that she's got it from that" (Late 20s - Looking after home).

In addition, a number of participants in the study talked of their own dislike of 'taking too many pills':

> "I just keep getting like recurring boils ... and he's just put me on these antibiotics which I'm not happy about taking because I'm not happy about taking tablets ..." (Early 30s - Looking after home).

> "I had a chest infection in August which didn't clear up and I went back to my doctor ... and he was convinced I'd got asthma which I've never had in my life and he put me on the sprays. And I'm not convinced I have. Anyway, I stopped taking it ... They weren't very happy I'd gone off taking the inhaler but I thought, 'Well, it's me' ..." (Late 40s - Part-time library assistant).

In some cases, this mistrust of medication actually deters women from seeking the help of their family doctor:

> "Because I think, if I go, he's just going to give me some tablets that aren't really going to do anything" (Late 20s - Looking after home).

The woman in the last illustration had asked her sister for her opinion about the tablets her daughter had been prescribed. This point, in particular, and the extracts in this section in general, raise the significance of self treatment and advice-seeking away from the medical profession in many households.

9.3.4 How to Avoid the Doctor?

For non-serious illnesses and simple family health problems, the majority of women in this study described treating the condition themselves. As two Netherley mothers explained:

> "We tend to sort of treat ourselves rather than go to the doctor. Flu, for instance ... I don't think flu in an otherwise healthy person is serious enough to want a doctor's consultation unless you've got other really worrying symptoms with it ... No, I would think I was

wasting the doctor's time if I went because I had flu (Early 40s - Full-time secretary).

"... the eldest one, both the twins eventually, had chicken pox a couple of weeks ago. We just got some Calpol and some Calamine Lotion - just went to work on it. I did take one of them to the doctor's but I thought, 'Well, there's no need to take the others now we know what it is'..." (Early 30s - Full-time clerical worker).

In addition, the women talked of making themselves generally aware of and being willing to try alternatives to 'professional' medicine even under relatively serious circumstances:

"... I'm one of these people who reads articles about things ... So I always think I'm sort of fairly up-to-date with what sort of treatment is possibly available ..." (Early 40s - Full-time secretary).

"My Dad had it [arthritis] severe - so bad that my Dad couldn't walk. He changed his diet and, honestly, he gets it now and again ... He can only eat like white meat, chicken, fish, soya. It's not exiting but, as he says, it's better than being.. [How did he find out about that?] A book, just got a book ... His sister was given steroids for it and she died and that's what put him off. I think that's why we're all so strong about taking medication and that, you know. And he said, 'Well, I'm going to try and cure myself' and he has ..." (Early 30s - Looking after home).

"... I've asked them could we go homeopathy and she said, Well, he's [autistic son] got to have medication'... I've been taking him to Mossley Hill. It's just this chap - he's been giving him tablets ... I mean, I don't know whether it's logical or what but it does seem to have a calming effect on him ... But I just thought, 'Oh well, can't do him any harm'. It's only supposed to be plant remedy, you know. I mean, I bought a book when he was on that medicine and all the side effects of it ... I mean, these drugs you don't know what they do" (Early 40s - Part-time care worker).

The local chemist is the principal source of 'professional' advice away from the family doctor. Women use the chemist for a variety of self-treatment purposes, the most obvious being as a source of over-the-counter medicines. Sometimes, this is even prompted by inadequacies in the conventional health care system:

"... But sometimes I go into the chemist and ask them ... You know, obviously you'd prefer to go to your doctor, but if you phoned up our doctor's on a Monday morning, you probably couldn't get an appointment till the Tuesday evening if you were lucky ... So you've gone all that day getting worse I always think. So you might as well just go and get a bottle of something from somewhere" (Late 30s - Part-time catering assistant).

The chemist can also act as a 'sounding board' to assess whether a trip to the GP is necessary or to get a second opinion about medication already prescribed:

"... the reason I had Paul [son] at the doctor tonight - he seems to be getting like a small eczma outbreak and the E45 cream hasn't been working. So I took him to the chemist on Saturday and said, 'Can you suggest anything that I could use?' and he said, 'Oh, I suggest you take him to the doctor'. So that's how that happened" (Mid 40s - Full-time personnel manager).

"... I remember them giving me Salbutamol or something for the baby and she was only about three months old and I was very worried, you know, about giving it to her so I asked his advice" (Early 30s - Looking after home).

"I know when my Mum was ill I used to go and ask his advice because you're on morphine and they're always very good at explaining things to you ... And when with the prescription the GP'd just say, 'Oh, I've doubled the dosage' and that was all he'd say ... And I think now more so because I have to pay for my prescriptions ... I have done that before, you know, had a prescription and said to him, 'Can I get them any cheaper?'" (Late 40s - Full-time administrator).

The social network is the other main source of information on health and illness. For example, although some dismiss advice from their own mother as merely 'old wives' tales', for others this is a valued source of help. A few take advice concerning their own ill health:

"... I went a week just on salads and things like that because my Mum said maybe it's more fresh fruit and veg. But it's not made any difference at all [to acne problem] ..." (Early 30s - Looking after home).

Others tap into their mother's experience of childrearing and children's health problems in particular:

> "I've asked for the children - you know, when the children weren't well and that she was always there - but not for myself" (Late 40s - Full-time administrator).

Parents are, especially, useful where there is past family experience of a certain illness:

> "... with my Dad having the asthma, I ask his advice - you know, with the daughter with asthma ... " (Early 30s - Looking after home).

A number of older women in the interview group also describe giving advice, wanted and unwanted, to younger family members:

> "... She [granddaughter] was up all night. She [daughter-in-law] said, 'I had a fan on her because she could hardly breathe'. So I said, 'Why didn't you take her the hospital Julie?' 'How could I go the hospital?' Because our Steve [son] works nights, you know, on the taxis. I said, ' Julie, you've got a phone there, you dial 999 and the ambulance men come out and they'll treat her as they get in the ambulance' ... She seems to think she can't go on her own ... I don't think she realises how bad asthma is!'" (Early 50s - Retired part-time catering assistant).

Although they were referred to in the interviews rather less often than family, friends are another source of advice in the social network. They were mentioned by five women in total. The two whose friends are also trained nurses placed particular value on their advice and there is a sense that knowledge which stems from 'professional' experience is more 'bonafide'. When asked where they would turn for advice on health those two women replied:

> "Well probably a friend who's a nurse. I'd probably ask her but that's about all. I think other people just confuse you and they don't really know anyway do they?" (Late 40s - Part-time library assistant).

> "Like I said, my friend a nurse. From time to time I asked her about the ache in my side. Yes, my friend, my friend the nurse" (Late 30s - Full-time teacher).

Some have access to health care professionals other than their own GP by virtue of their position in the paid labour market. For simple matters, therefore, these women can avoid the time-space constraints of primary health care attendance:

> "Occasionally, I have consulted the nurse in work ... I might go down there if I'm feeling grotty and ask her what I should do" (Mid 40s - Full-time personnel manager).

Of course, most women in lower-status, 'flexible' employment are not so well provided for with occupational health services. Access to health services at work is a strategy discussed in more detail later. It might, for example, be used as a means of easing time-space constraints on the uptake of preventative screening.

Having made these points about accessing advice away from the 'regular' health services, it has to be said that everybody does go to the doctor at some time and there are those for whom their GP is always 'the first port of call'. In addition, the women interviewed described playing an important role in accessing health services on behalf of other family members. It is this subject, of help-seeking for others from the 'health care professionals', which is dealt with in the next section.

9.3.5 Talking to the Professionals on Behalf of Others

The most frequent means by which mothers in the interview group are involved in a child's contact with doctors is through physical attendance at the GP's surgery:

> "... I took the baby the week before last and then the other one ... She'd just finished the antibiotics ... I thought she was just jealous, which she was, but she had it and all" (Early 30s - Looking after home).

> "... He'll go to school in the morning time as well and I'll meet him at the bus stop outside the clinic where he'll get off from school ... And then I can put him on the bus again ..." (Early 30s - Full-time clerical worker).

Once again, older children and lower dependency adults are less of a responsibility when it comes to primary health care attendance as the following extracts illustrate:

> "He [son] goes himself now. He doesn't like us going with him now - he's seventeen. I stopped going with him when he was fifteen. I mean, if there was anything serious I'd go with him" (Late 40s - Full-time administrator).

> "Mum and Dad go to the health centre in Whiston. They manage that themselves. The only time they want any help is if either of them are in hospital ..." (Early 50s - Looking after home).

However, women can still find themselves in the position of having to talk to doctors on behalf of these less dependent people and other 'not yet dependent' adults also need help at times. Usually, this means talking to hospital doctors during an episode of more severe illness when it is common for the women to feel that a problem would not adequately be communicated without their intervention. For instance:

> "... He [husband] had this massive coronary and he was in about four weeks. He was home a fortnight and rushed back in again; he was out a week and rushed back in again. That happened five times in nine weeks. So, you see, I had to get him sorted out then because he won't speak up for himself. You know, 'Oh leave it, I'll be alright'. So I had to go and talk to the doctor's to get him seen to properly" (Late 50s - Full-time care worker).

> "I would sometimes be in with the consultants or when she [aunt] came back from operations I'd be there so.. With my mother, I spoke to the doctors independently as well because I was concerned.

> And I also wanted to brief them before my mother went because she would just, you know, she wouldn't say what it was sometimes. So it was just to alert them really" (Early 50s - Part-time teacher).

Another means by which women are involved in family members' contact with the health services is through accompanying them to hospital or, in the case of children, school clinics. A discussion of this kind of health care 'situation' illustrates how fathers' paid work can restrict their 'sharing' of more than the general caring labour described in Chapter Seven. The timing of paid employment, specifically, limits their contribution to caring for children's health:

> "My husband's under a different doctor to us. I put the kids on with me because, obviously, I'd be the one that was going to take them more than what he would anyway. Obviously, if they had to be off school one day and he's in a full-time job, well it'd be me that'd be taking them so I wouldn't be taking them up to his doctor's" (Mid 40s - Part-time cleaner).

> "... I had the social worker last week from the school ... And I always have a social worker from Barnardo's ... Some of them come here and sometimes I have to go up to the school when they have reviews and that, you know, see the psychologist ... Sometimes he [husband] goes if he's off work, but it's not really worth him taking a day off work" (Early 40s - Mother of autistic child and part-time care worker).

Since, however, the data suggest that men take on less responsibility for their children's use of health care whatever the employment status of their partners, it is clear that labour market pressures are not the only processes affecting household divisions of health-related labour (cf. Chapter Seven):

> "[And is it always you that takes your daughter to the physio?] Almost always - it's a bone of contention [laughs] - almost always. Anything to do with Barnardo's or hospital visiting just gets dumped on me - or school, even with the other one - as it is in most families

I suppose" (Late 30s - Mother of child with Down's Syndrome and full-time teacher).

Only in the families described in Chapter Seven, where household labour divisions generally have become more equitable, is caring for children's health care use talked of in terms of joint responsibility:

> "[And have you used the health services for anybody else in the family?] Well, I mean David, we have sort of regular appointments at Alder Hey [Children's Hospital] ... Child Development Centre. And, oh hearing tests. We go to the Family Advisory Centre at Chatsworth Street [in inner Liverpool] with David for hearing tests. I suppose it's mostly with David that we sort of go around different places, you know" (Early 40s - Looking after home and husband long-term unemployed).

Women also accompany adult dependants and other adult relatives to hospital clinics as part of their responsibilities for family health care use. For example:

> "He [father] had two cataracts done. But a couple of weeks ago I had to take him to the Royal because he had like a film coming over one of his eyes ... and they did the new laser treatment on him and it's smashing now ... But I took him to the hospital that day ..." (Late 40s - Full-time administrator).

> "... My Mum's just having heart tests done now. She's only forty-eight my Mum ... She's had a heart scan and she's got to go in for a stress test this Thursday where they'll give her forty-five minutes of exercises and monitor her heart ... I'll go with her - she's a baby - she needs the lift ..." (Mid 30s -Single mother on Income Support).

9.3.6 Accommodating into the Daily Routine a Dependant's Stay in Hospital

Mothers of younger and disabled children feel particularly strongly that they should stay in hospital during a child's treatment. One single mother explained:

> "[Will you have to go and stay with your son in hospital?] Yes, I always do. I never leave because, as you know, Alder Hey's busy anyway ... I couldn't leave him because he wants me all the time. I know that some kids do like, but he does, he's only had me to look

after him so I'm staying with him" (Early 30s - Mother of two year-old on Income Support).

This generates complications in dealing with competing household commitments such as caring for other children. For example:

> "... the eldest daughter [Age 12 now], she was in hospital, in Alder Hey, when she was a tiny baby, three weeks and I had to sleep there with her it was that bad. It was too far - it was all the way in town - it was too far ... But really speaking, I don't know what I'd do now with having the other daughter ... I'd have to ask them if I could keep the baby there and all. I don't know if they'd let you like, but if it's all you could do. Because my Mum works part-time and, as I say, my Dad goes to college and my husband works full-time ... I'd have to see if they'd let the baby stay and all. But I couldn't see them letting you somehow" (Early 30s - Looking after home).

In addition, hospital staff do not always make it easy for families to cope in such circumstances:

> "Hayley [Age 2 now] was in hospital - she was in Alder Hey when she was about five weeks old ... I was breast feeding at the time so we were both admitted and she was in a little isolated ward ... Oh, it was awful, it was really awful. I was sleeping there all the time on this sort of mattress on the floor. I never had a cup of tea off them or nothing. Gerry [husband] was going backwards and forwards to the hospital fetching me sandwiches and drinks and things and we had our daily visit from the doctor and that was it. It was not a nice experience ..." (Late 30s - Full-time teacher).

Only where divisions of household childcare and domestic labour are equitable do women appear to cope with relatively little difficulty or concern. One mother, referred to earlier in this context, described how she and her unemployed husband shared the inconvenience of staying with their disabled son in hospital. The links between a couple's ability to share health care-related caring labour in this way and the male partner's non-participation in the paid labour market are clear:

> "... Don stayed over night with him and then I would go sort of all day ... I'm a terrible sleeper anyway and I couldn't sleep in it so Don said, well the best thing - Don can sleep anywhere, so he had a nice lounge chair by David's cot and he slept there sort of over night and then I came home and slept in my own bed ... I mean, Don wasn't working then so you were able to do that. Had he been working it would have been a different matter, but because he was unemployed at that time then it worked out quite well ..." (Early 40s - Looking after home).

The women interviewed did feel much better able to leave an adult dependant in hospital overnight except in cases of terminal illness. As the next extract illustrates, there is also greater scope to share the visiting task between family members such as siblings:

> "... At the weekend, my sister will go one day, I'll go the other and we take him [father] out somewhere for a walk because he's not in bed. We make sure he gets a visitor every night so it'll either be me or my older sister with or without Mum. Or John [husband] might go occasionally. Again, we just say, 'Who's going tomorrow?'" (Mid 40s - Full-time personnel manager).

This does not, however, mean that women feel under less strain as a result of such demands especially when they have competing domestic commitments:

> "... and it was just all her [elderly mother's] washing really from hospital, because hospitals don't do all the washing. And visiting her, because she was in Clatterbridge [Regional Hospital on the Wirral] so it was a long way from here to visit her. That was hard. I used to go again sometimes from work so it would be the bus to the station. I used to get the train to Bebington and the bus to Clatterbridge Hospital ... and then my husband would meet me after five and bring me home ... If you were full-time, obviously you couldn't ... I went about three days on the bus and train and then another day in the car because I was finding I was getting so tired. You know, when you've been working all morning and you're going straight from work to the hospital and then coming back and when you get home I had to make the meal. It's hard when people are in hospital and she was in hospital for ten weeks ..." (Late 40s - Part-time library assistant).

The last extract points to a number of issues which build upon the themes of Chapters Seven and Eight, namely the importance of fitting health-related caring around the time demands of gendered social roles and the constraints on time-space flexibility imposed by women's lack of access to private transport. Later sections will discuss these issues, specifically, as they affect health-related behaviours.

9.3.7 Managing in an Emergency

This research shows that, as with childcare and looking after sick, elderly or disabled adults generally (see Chapter Seven), women are responsible for the more routine tasks of caring for health and illness in the family. Only in the case of *emergency* attendance at the casualty department were 'traditional' gender divisions of caring labour overturned. One woman, for instance, described the several occasions when her sons have broken a bone. The difference between the actual emergency situation and follow-up attendance at the hospital is clear:

> "[Did you both take the kids?] Yes, we both go. Yes, normally we both go don't we? Then I went, obviously, to get Adam [son] checked each time ... but that was just to the clinic - to the fracture clinic - and they'd just do an x-ray and check everything's going the way it should be, you know" (Late 30s -Part-time catering assistant).

Emergencies are also one health care situation where the necessity for access to transport and/or a telephone is immediately apparent. This point further introduces the issue of how economic and social resources are used by households, specifically, in relation to health, illness and health care use. Before moving on to discuss that topic, however, the main ideas which should be borne in mind from this section on the nature of health-related labour will be summarised.

9.3.8 Summary - Health-related Labour

The points to emerge from the discussion so far are as follows:

i) confirmation that households are responsible for carrying out a significant amount of health-related labour on their own behalf;

ii) the view that health-related labour is an integral part of the general task of caring within families and social networks;

iii) endorsement of the view that the majority of health-related work within families is done by women in their capacity as household managers and family carers;

iv) the sense that much health-related labour which takes place in households and social networks may actually go unseen by the conventional health services.

The next two sections deal with the employment of household economic and social resources around health, illness and health care use. The first looks at issues of actual physical mobility focusing on the importance of access to a private telephone and transport (Section 9.4). The second examines the ways in which women also use resources as a means of accommodating personal and family health needs into their general social role responsibilities (Section 9.5).

9.4 Using Resources - Issues of Mobility and Family Health

9.4.1 Time-space Flexibility in an Emergency Situation

In the interviews, women were asked to consider a number of hypothetical scenarios/vignettes as discussed in Chapter Five. What would happen, for instance, if a child or adult dependant became ill in the middle of the night or had an accident requiring hospital treatment? In many cases, the vignettes prompted women to recall actual situations from the past which illustrate the importance of economic and social resources for managing in emergency situations.

The telephone is one type of economic resource which, clearly, increases the flexibility of a household to respond at short notice. It avoids the necessity, for example, to rush to hospital because women can ring their own GP for advice before doing anything else. When asked what would happen if a family member was unwell in the middle of the night, one woman replied:

> "I'd just ring the doctor's up ... You ring your own health centre and they put you through to the main switchboard or something for all Liverpool. All I know is our Susan is the one that suffers with asthma and we've had to do that with her like" (Early 50s - Invalid Care Allowance).

Another said:

> "... I would possibly ring the GP first and say, 'Such and such a thing has happened. Are you going to come and see her or should I take her to the casualty?' ..." (Late 30s - Full-time teacher).

The availability of a telephone also means that women can be contacted more easily in situations which require a quick response. It affords routine peace of mind, for example, to the mothers of school-age children and allows adult dependants to call on their carers for help:

"If I'm not [contactable] then my husband is and if we're not, somebody is. I mean everybody that might need to contact us - the school, the nursery - has got a list of about six numbers finishing off with my sister's car phone ... I have been called up to say the eldest isn't well and I'll just go" (Mid 40s - Full-time personnel manager).

"Well Mum called me at three-thirty in the morning and she said, 'I think your father's having a heart attack' ... So we went to Whiston to pick Mum up first of all but the ambulance was there outside their house then ..." (Early 50s - Looking after home).

The next extended illustrations speak for themselves on the contrasting experiences and management mechanisms of women who do and do not have access to a telephone and, as importantly, private transport. The extracts are from interviews with higher and lower-income mothers who describe what would happen if a child had an accident or became ill. First, the higher-income mother from Woolton who is able to plan quite confidently for an emergency:

"I'd go with my instinct. If I really thought it was bad ... I wouldn't hesitate to either phone the doctor or go straight to Alder Hey [children's hospital] I really wouldn't ... I went to Alder Hey recently with my sister's little girl who had a very high temperature and the doctor was a bit worried about meningitis and they were superb ... I mean, I thought at the time I wouldn't even think twice about bringing a child here if I had any worries with or without the doctor's help. I'd do whatever I thought was quickest. If I really thought they were ill and it was quicker to just get in the car and go up there, I'd go up there" (Mid 40s - Full-time personnel manager).

Next, the lower-income women, both of whom are single mothers from Netherley. They describe much more complicated arrangements which depend on a certain degree of luck as much as on prior planning:

"It's very hard. Like a few months back before Christmas he [disabled two year-old] was very ill ... so I had to leave my daughter in the house while I ran to the phone ... That phone was out of order - I had to run right down, all the way down Brittarge Brow [on

opposite side of council estate] ... And so I had to ask my mate to take the call for me from the doctor and I had to run all the way back again so I was exhausted. Then he was getting worse and the doctor never came till five-past-eleven. And that was from half-seven, eight o'clock so I was disgusted by that - I was getting all fidgety. So that's what happens ... I was like, shall I send my daughter out to go to the phone or whatever? And then I always think - well, it's like say someone grabs her? ... I'm on edge with leaving her but what can I do? Another time he was really ill ... I didn't want to take him out because he was getting dehydrated but there was no one around. You know what I had to do in the end? ... I had to just take him [to GP] and say, 'Look, you'll have to see to him now because he's really ill' ... Lucky enough the other kids were at school because it was daytime. But lucky enough a neighbour was coming past and seeing my Mum so I had to ask my Mum and Dad would they go and pick the kids up for me rather than drag him out again ..." (Early 30s - Income Support).

"... And this night I was on my own with the kids and the eldest lad fell outside and gashed it [leg] really badly. Well I was frantic trying to get somebody. My Mum wasn't here, their Dad wasn't here ... So it was - I'm not on the phone anymore - it was running round to the phone box and all this, you know, it was terrible. So eventually I got somebody about two hours later to come down ... So we got to the hospital about seven o'clock I think ... and there was a nurse ... And she said,'And why didn't you come as soon as it happened?' ... So I said, 'I was waiting for my babysitter to come and mind the other kids' ... And she looked at me like that and I was getting really annoyed ... I suppose I could have got anybody to mind them and run there but you can't because you're thinking what's back at home - what if anything happens if there's somebody under age minding them? ... My cousin came from Halewood. And again, there's no car and the buses are only every hour now once it's turned teatime from there to here. [Did you have to get a bus up to the hospital?] No, I got a taxi. Yes, I had some money for a taxi. That's why it's frightened me. That's why sometimes when I've got no money I think, 'I can't imagine anything happening now', you know" (Early 30s - Full-time clerical worker).

Overall, these extracts illustrate the degree to which low-income households have to rely on social networks in order to cover for their own lack of mobility resources. There are also other examples of women in the interview group, not just single mothers, who have to call on friends and relatives for the health-related use

of a telephone and transport. This applies in routine health care situations such as attendance at the out-patient department as well as in emergencies.

9.4.2 Collecting a Prescription at Night

Few women have problems getting a prescription made up before 8 or 9 pm because there is usually a chemist near the GP surgery which is open until that time. In contrast, the only chemist open late at night in Liverpool is located in the city centre around eight miles from Netherley and Woolton. This also causes difficulties for women with caring responsibilities especially if they lack access to a private car. Once again, social networks are the primary means of overcoming the constraints. For instance, when asked to consider the hypothetical necessity to collect a prescription after 7.30pm, two women replied:

> "I'd get my daughter to go - one of my daughters - they've got cars" (Late 50s - Full-time care worker).

> "... When we didn't have a car it was difficult because you had to get the bus down and it's a long way ... if I had to go, my Mum would always come over and mind the children. Or I'd have to bring somebody in to mind them. I have done it where I've had to have a friend come and mind them while I've gone" (Late 40s - Full-time administrator).

Those without responsive social networks tend to rely heavily on a doctor being able to supply enough medicine to last until morning:

> "[What would happen if you got a prescription later on, say if you called the doctor out?] Oh, I'd have to wait till the next day yes. I did call the doctor out to Susan [daughter] ... I think it was about nine o'clock he came out. But he gave me.. when I started moaning, you know, he had a sachet of calpol and a sachet of - what is it? - penicillin, something like that - and the medicine he prescribed was the same as the sachet he gave me so.." (Early 30s - Income Support).

In addition, as with the general issue of mobility outlined in Chapter Eight, it emerged here that women are restricted in their choices by fear of unsafe spaces. The household referred to next was the only one in the interview group where it was the male partner who was unable to drive. He could not, therefore, go for the prescription instead of the woman herself:

> "[What happens if you get a prescription late?] I'd have to go the next day. Because I think the only all-night one now is in town and I wouldn't go to town ... [Even if it was for your kids and it was really serious?] It's a difficult one that isn't it? I'd want someone with me in the car [laughs] ... I don't like going to town on my own in the car - not on my own ... [But you would go?] I suppose I'd have to go yes, as you say. [But only for the kids?] Yes, it wouldn't be for me. No, it wouldn't be for me [laughs]. No I'd do without, I'd wait, you know" (Early 30s - Looking after home).

This extract provides another example of the differential priorities exercised by women in relation to family health needs. This is a subject discussed in more detail later.

9.4.3 Travelling to Routine Health Care

Another advantage afforded to higher-income women, by virtue of their access to a private car, is greater scope to travel to a GP of their choice:

> "So it seems a long way from here doesn't it? But ... when we were first married we lived in Halewood because I had a job there and they were the local doctors ... And, despite him telling me that we are very stressful, we do get on with them very well. I like them - both of them - and we stayed with them over the years ..." (Late 30s - Full-time teacher).

By contrast, a nurse working part-time described how she changed from the GP she had had since childhood simply because of the difficulties involved in taking her children several miles to the surgery by bus. Even the time-space constraints around attendance at the local GP surgery are greater for women who lack their own

transport. Another household in the interview group had only recently acquired a car which was old and had since broken down. The woman interviewed was able to compare her situation now with that in the past:

> "... If I didn't have the car, I've got to be honest, I wouldn't go the doctors unless I really, really have to yes - I wouldn't myself or the kids no ..." (Early 30s - Looking after home).

Clearly, routine health care attendance can also be affected by the gendered nature of transport mobility within households. One mother described how she manages:

> "Well my son's got the opticians so I'll make his appointment - I'll try and get it in the morning time while I can take him in the car, get him seen to, get him back to school. It really depends a lot on his [partner's] shifts and when I'm mobile. Because it takes twice as long getting the bus doesn't it? ... I try and do everything while I've got the car" (Mid 30s - Income Support).

Another woman had actually been deterred from attending a hospital clinic, specifically, as a result of the time-space constraints of her social roles. Her multiple commitments could not be accommodated using public transport. She was asked about any concerns she might have for her own health:

> "Gall stones ... And he said I couldn't have the laser because with me being relatively young they'd just come back so I've got to have them out. I mentioned it to my GP but he said, 'Well you're too much overweight no wonder they won't operate!' ... So I'm on pain killers. They sent me to the dietician at the hospital but I just couldn't afford the bus fare because you'd have to get the bus down to the Five Ways [approximately 5 miles], then a bus along and then walk you know. It was eighty pence that way and eighty pence the other way. And then of course, when I was going there ... I was looking after Mary [adult daughter who has Down's Syndrome], going to work - I was also round there every day seeing to my mother because she was bad and she wouldn't go and live with me or anyone and the doctor said, 'No while your mother keeps going just keep her there'. So really I had to go around in a vicious circle" (Early 50s - Recently retired part-time catering assistant).

The last extract raises the issue of the second use to which women put economic and social resources for the benefit of family health, namely to enable them to continue with their general paid and unpaid work responsibilities at the same time as household health-related needs are being fulfilled. It is this topic to which the discussion now turns.

9.5 Using Resources - Accommodating Health and Conflicting Social Roles

9.5.1 Substituting for Women's Caring Role in Health and Illness

It was implicit in the earlier discussion of household health-related labour (Section 9.3) that social networks play an important role in covering for women's general caring responsibilities when a health situation requires a quick response. This is spelt out even more clearly in the following extract where a Netherley mother describes an occasion when her husband cut open his fingers on a car engine:

> "We got a taxi down there [Broadgreen Casualty] ... The kids were at school but his auntie lives in the square so I just called in hers and said to her, 'When the kids come home will you take them into yours? I'm going with him' ..." (Late 20s - Looking after home).

She also said that, if one of the children needed to go to casualty, the others would be left with her father next door whilst her husband drove them to hospital.

Relatives can also provide assistance in more routine health care situations. Examples include enabling a mother to stay with her youngest child in hospital and easing the problems of taking more than one child to sit in a GP's waiting room:

> "... my Mum's going to mind the two of them rather than the both of them be split up ... But with it [son's operation] getting back dated, what I keep thinking now is.. My Mum and Dad generally

> have their holidays you see and I thought, if they go away, what am I going to do? I'm going to be stuck. But I suppose I'll have a few words and see if we can sort something out again. [Will there be anybody else you can rely on?] Well, not really because ... there's my brother which is younger, he works - you can't just sling him kids. As for my sister who lives in Bellevale - she's got four girls - her house is not even big enough to have a girl and a boy.. She would, but I just couldn't put that pressure on her" (Early 30s - Income Support).

> "[What happens when you go to the doctor's?] ... When I took the baby the eldest one was at school and when I took her my Dad came over to mind the baby. I was lucky because sometimes you can be in the waiting room for up to forty minutes and when you've got the baby running round everywhere, you know, it's a pain" (Early 30s - Looking after home).

On this evidence, it is clear that the hierarchy of responsibilities within social networks, which was identified in Chapter Eight (Section 8.4.2), follows through to influence who women feel able to ask for health-related assistance. Building on another theme from Chapter Eight (Section 8.4.3), we see that social resources can be less enabling in terms of time-space flexibility than women might wish.

> "[And does it make it inconvenient if you have to sit and wait?] Yes. Well, my Dad's sitting waiting with the baby and, as I said before, she's a handful and I don't like putting on him really ... I tried to make this one ... about four o'clock thinking, well if I pick her up [from school] at half-three, walk up for four o'clock and I could be home for my Dad, you know, about twenty-past-four. But it just didn't work out like that waiting for the buses, waiting for the appointment ..." (Early 30s - Looking after home).

There is also the issue of reciprocity:

> "If my Mum and Dad were ill? Yes, I'd go right over like and sort something out for them, definitely yes. Because they're always there for me and the kids, you know, so I would yes ..." (Early 30s - Looking after home).

As might be expected from the discussion in Chapter Seven (Section 7.6), whatever their employment status, women in paid work invariably said that caring responsibilities take priority if a child is ill:

> "... I just said, 'I'm off sick. If you've got to take pay off me, I'm here for my son - but I'm not coming in and that's it' ... I just thought, 'Well, if you lose your job over it, tough', you know, because your children come first don't they? ..." (Late 30s - Part-time catering assistant).

> "... Even in this job I'd say, 'Right, I'm going to get her'..." (Late 30s - Full-time teacher).

Having said this, mothers do tend to make a judgement about the severity of the problem before they take time off in order not to 'antagonise' an employer too often:

> "We'd try and work round it. I try not to take too much time off work if I can help it ..." (Late 30s - Part-time catering assistant).

In addition, the nature of some women's employment makes it much easier for illness events to be accommodated by household members. If, for example, a mother works in the evening and her partner does so during the day, there is no need at all for a third party to look after their sick child:

> "... As I say, I used to work evenings before so it was OK ... I was here all day if.. I've only been doing this just over a year so I haven't really had to take time off, you know" (Early 40s - Part-time care worker).

This case stands in sharp contrast to that of another mother who works full-time. She feels under considerable pressure not to let her family 'get in the way' of her job:

> "... I think they feel sorry for me, you know, single mum with six children -struggling. They get this picture, you know, this mental image. Although I never play on it. I want them to treat me as

> equal as they do the man who works there who's married and his children are grown up. That's why I don't want any favouritism or don't want them to think, 'She's a bloody woman', you know, 'more domestic problems' ... I mean, there's times I'd like to be with the kids, you know, the dentist's or whatever and my Mum says, 'No, you go to work, I can do that'. So I'm sitting in work sometimes and I think I should be there at the dentist but that's just the way it goes isn't it?" (Early 30s - Full-time clerical worker).

A different equation seems to apply for older women who combine paid work with responsibilities towards an elderly dependant. In general, carers felt it was less acceptable to take time off except in the most serious of circumstances:

> "... You don't take time off at school very easily but they were very good about that because it was an emergency ... I mean it was only a couple of days anyway. It was the couple of times she [aunt] had the operation and then, obviously, the day she died ... [Would you have been able to take time off if they'd needed longer care?] Well no, no I wouldn't have done because it would have been hard to explain that it wasn't a mother or a husband or a child, you know, I was directly involved so.." (Early 50s - Part-time teacher).

For women in paid employment, children's health needs provide a specific example of the role which social networks play in substituting for women's caring so that they can continue working for the household in other ways; that is bringing in income. Not only do relatives take children to the family doctor, they also provide care during illness:

> "They were off a while ago with chicken pox and I couldn't have any time off work. I didn't ask for it because I knew I was too busy you see. But my Mum will - yes, she steps in. She's always here kind of thing, you know what I mean? She's sort of - it's the extended family at work I think really, you know. She is, she's just part of life" (Early 30s - Full-time clerical worker).

> "Hayley's had dysentery in the last three weeks from the nursery ... so she had to go to my mother-in-law's for two weeks ... She stayed there. We couldn't really trek backwards and forwards, it's two hours down the M62. It's not an easy journey really in the week" (Late 30s - Full-time teacher).

As the mother referred to in the last illustration also said:

> "... it was so difficult because, obviously, no childminder wants to look after her if she's got dysentery because she might infect all the other kids ... it's very, very difficult to find someone to look after a sick child. It's very difficult" (Late 30s - Full-time teacher).

9.5.2 How do Families Care for the Carer?

What happens when the principle domestic labourer and carer in the family is herself ill and, therefore, unable to carry out her usual tasks? Here, again, women's management strategies are strongly linked to overall gender relations in the household and the level of dependency of those being cared for. Two married woman explain:

> "If I knew I was going into hospital then I'd run round like a lunatic for a week or two before sorting everything out - making sure there was plenty in the freezer and that all the washing and ironing was done [laughs]. If it was sudden then I think they're big enough to look after themselves. They'd have to come at visiting time and say, you know, 'What shall we do about this? - When shall we do that?' But I think they'd cope, they'd look after themselves - they're quite grown up now. I hope they'd look after themselves! [laughs]" (Early 40s - Full-time secretary).

> "... Because I've been so used to his support, if it was Don [husband] going into hospital then things would be a lot harder on me obviously ... If I was in hospital, I really don't think it would be any problem for Don ... I mean, Don is so used to seeing to David [disabled son] anyway, all his needs, that I don't think it would be much of a problem ... Oh, he would say he's fed up, you know, once David had gone to bed ... But, in general, looking after David and cooking and the house, I mean he could manage quite well really. I'm really lucky in that respect" (Early 40s - Looking after home).

In general, women turn first to their partner for assistance during sickness although older children can also help out. The mother in the next illustration was asked what would happen if she needed to convalesce:

> "... the kids are quite good because they understand what migraine's like with having it themselves. And so if I have a migraine then they're very good about turning their music off and creeping in, 'Mum can I get you anything?' and stuff like that - because they know what it feels like. So I think they would be quite good actually" (Early 40s - Full-time secretary).

If a partner does help, it has considerable repercussions for the scheduling of his daily activities. In general, it is men in higher-status employment who are best placed to accommodate women's needs in this way. Two wives were asked what happens if they are ill:

> "[Laughs] Then it all falls onto the husband. [Pause] I was just thinking when I have been ill. I strained my back about three weeks ago ... and I had to lie on the floor for three days ... so, obviously, I couldn't run around after them. But my husband had to do it ... He didn't take time off when I hurt my back - he came home at lunchtimes ..." (Late 30s - Full-time teacher).

> "I had a fortnight off work [following removal of benign lump] and he stayed off for a week - he had a week's holiday - because my arm had been in a sling for about two days so it just made life a bit easier ..." (Late 40s - Part-time library assistant).

Clearly, what happens when women are ill is another example of how the hierarchy in the social support network operates. It shows, once again, that paid labour participation is the primary mitigating circumstance which prevents individuals being asked for assistance. This is particularly the case in low-income households where a consistent salary from the male partner is often so important. In circumstances of low income, therefore, it is other women in the household and wider network of family and friends who are called upon to help because they are

less likely to be in full-time work. The following extracts serve to illustrate these issues:

> "[Who would look after your mother if you went into hospital?] I've got friends in the parish are very good. [Would your son be able to help?] No, he's full-time - he's training to be a chartered accountant so he's quite occupied really" (Late 50s - Part-time job in school).

> "Then my Mum would probably take time off work. My Mum and my sister would probably do it between them so that he [partner] could still go to work ... I couldn't afford him to take time off really ... " (Mid 30s - Income Support).

For single mothers, the situation is complicated still further by the limited availability of their children's father:

> "[If you did have to go into hospital, how would you cope?] ... Well, it'd depend on my Mum and their Dad if they could sort it between them, you know, come to some sort of amicable arrangement ..." (Early 30s - Full-time clerical worker).

9.5.3 Paying for Health Support and Flexibility

Private insurance can mean that, in terms of preventative health care, women in some higher-status professional and managerial positions are far better placed than their counterparts lower down the social scale. A manager with an insurance company illustrates the point thus:

> "This BUPA annual medical is something that my company does for managers, for all managers every year. It's compulsory ... the full treatment. They have you on bikes, walking up pretend hills, lecturing you on your diet, you have to fill in diet sheets, examinations. I mean there's not a bit of you they don't stick something up or down" (Mid 40s - Full-time personnel manager).

Access to economic resources and hence private health care, also opens possibilities for hospital treatment to be timed to fit in more conveniently with other commitments than if a woman has to wait her turn on an NHS waiting list:

"We'd been in BUPA quite a while ... I waited because my mother was still in hospital at this time and I said could I just put it back a bit until my mother's out of hospital? So as she went into the nursing home I went into hospital and had it [benign lump] removed. Because my arm was in a sling just for a couple of days and it was sore for a while so I knew I wouldn't be able to do very much to help her. I had to get her sorted out before I had my operation" (Late 40s - Part-time library assistant eligible for BUPA through her husband's job).

"... I went to the Women's [hospital in central Liverpool] first and then after that I went to the Lourdes [private hospital] ... I needed to fit in with my work programme really because I was at school permanently at the time and I wanted it done anyway right away ... Well I fitted it in when it was convenient ..." (Early 50s - Part-time teacher).

For those women to whom the flexibility of private health care and economic resources generally are unavailable, caring and paid work commitments pose far greater constraints on their own health-related behaviours. In cases where levels of social network support are also minimal, the scheduling problems created by women's own or a dependant's ill health are further magnified. Three groups stand out particularly. First, older, low-income women who care for people across the family generations. Despite having their own caring responsibilities, they are still the ones most often called upon to give rather than to receive social support. To use Brody's (1983) description, they are 'women in the middle':

"Mary [adult child with Down's Syndrome] has had a few asthma attacks ... and the doctor had come out in the night ... And he said, 'I think she should go away'. I said, 'Oh doctor, do you really? - Can't you leave it a bit?' Any road, my doctor came out about ten the next morning - but she'd settled down ... He said, 'The locum said you refused to send her'. I said, 'I didn't refuse to take her away. I just said could we wait? Because doctor I've got to stay in the hospital with her'. And he just looked at me. And my Mam was alive then, you know ... that was a big problem. You see, I'd have been on pins either way because I couldn't have left her in the hospital ...".

> "I've done it before today - left Mary in bed, run over, grabbed their two and run back home, you know, when one of them's [grandchildren] been bad or anything" (Early 50s - Recently retired part-time catering assistant).

Second, the mothers of still-relatively-dependent teenagers whose low-status paid employment is vital to household economic survival:

> "I never feel anaemic until they tell me and then I feel really tired [laughs] ... That first time, when I went I saw the doctor, he kept saying, 'How do you feel?' I said, 'I feel fine'. And, you know, I came out feeling as though he thought I should be crawling on my hands and knees or something ... But afterwards, whether it's mind over matter, afterwards I felt really tired and I think it was because I'd been told there was something wrong with me. I mean, I'm fine, just tired. But then everybody gets tired" (Mid 40s - Two part-time jobs in catering and cleaning).

Finally, the single mothers who have to manage on their own on social security. As one woman from Netherley, supporting her two primary school children and physically disabled two year-old declared:

> "No, I've no time to be sick, honestly I haven't" (Early 30s - Income Support).

The next sections look at this issue of women's own health-related needs in more detail.

9.6 Health Gain or Health Strain? - Social Roles and Well-being

Chapter Four showed that the interactions between health and social role participation are complicated and multi-directional. Not only have paid and unpaid work been shown to influence an individual's mental and physical health experience and sense of well-being (Arber, 1991; Graham, 1984a; Popay et al. 1992), health status also exists independently and, in its turn, helps to determine social role

participation. This latter, more obvious issue, of the restrictions placed upon the domestic and paid labour of women with a limiting long-standing illness, has been dealt with already in Chapter Seven (Section 7.4). The current section will, therefore, concentrate on the following general questions raised by the research cited in Chapter Four:

i) in comparison to the social isolation of domestic labour, does paid employment facilitate social participation and, hence, a feeling of well-being?

ii) how does taking on the dual roles of paid and unpaid worker impact upon women's health?

In the latter context, previous studies have been able to examine both mental and physical health issues. Ungerson (1987) and Sandford (1975), for example, both found physical and psychological problems amongst the carers of elderly dependants. However, when the women interviewed in Netherley and Woolton were asked about the impact of social roles on their health, only a very few described physical problems. These were women who had, for example, worked as care assistants and had not been trained to lift correctly. Virtually without exception, questions were answered in terms of problems which can broadly be described as 'stress and strain-related'. The discussion will, necessarily, focus upon this aspect of the debate and it is interesting to note that all of the findings are consistent with trends which emerged from the studies reviewed earlier.

9.6.1 The Pressures of Taking on Dual Roles?

Significantly, for this research, a number of the women who combine paid and unpaid labour do report health-related problems as a result of having to schedule multiple tasks. Just as Martin and Roberts (1984) noted in their extensive survey, such feelings are most evident amongst women looking after young or disabled children at the same time as working in a demanding full-time job:

> "And I think I get lots of sort of general aches and pains just from stress ... When you read my diary you'll see why [laughs]. I must be at it from half-past-six in the morning till about seven o'clock at night with work some days and then you come home and see to this lot. I do too much really, too much" (Late 30s - Full-time teacher).

Those with older, healthy and, consequently, less dependent children report far fewer problems. So, too, do the full-time paid-working carers for adult dependants since they tend to be helping a person at the lower end of the dependency scale to live separately. One woman had worked as a full-time teacher until just prior to the interview. She now does temporary supply jobs. Her case illustrates how it is easier for part-time workers to accommodate heavier forms of caring responsibility into the day:

> "[Is it easier to cope working part-time] Yes, it is really because I can chose, you know. I mean, if a situation arose now like it did last year [when mother and two aunts came to stay because they were ill] I'd have no compunction about staying off - I'd say, 'Well look, I can't come in now.' Whereas before I had a commitment to the school and I had commitments here ..." (Early 50s - Part-time teacher).

The situation is not as simple as task overload alone, however. Problems are very much associated with pressures, already noted in Chapter Seven (Section 7.6), to cope with and 'make a good job' of *all* the conflicting demands. Part-time

workers, therefore, can also feel under strain from their social roles, especially if they have strong attitudes in favour of prioritising domestic and caring labour but are forced to work in order to boost the household income. When asked if she felt under more strain before giving up her part-time job to have another baby, one mother, for instance, replied:

> "Yes I did because I thought I was like neglecting my house ... I mean, three hours doesn't seem much but then I'd be rushing out of a morning where now I can come back when I drop my daughter off at school and do things in the house - clean up or whatever, where before I couldn't. I had to like either come back and it's all rush - I'd have an hour in the house and then go to work. I was rushing around everywhere ..." (Mid-30s - Looking after home).

9.6.2 Variations in Demands across the Caring Groups

For all of the women, whatever their employment status, worry and strain increases in line with caring need. First, the younger and/or more dependent the person being cared for, the greater the pressures perceived. Disabled youngsters, in particular, require extra work and cause more concern:

> "... Like when my son went to [school name] ... sometimes he'd be a real pain and he'd have tantrums and things and you'd get some dirty looks off some of the mothers ... I used to think, 'Well why have I got somebody like this? They don't understand, just because their children are so normal'. You know, all this sort of thing goes through you head and that - you think, 'Oh God, why me?' ..." (Early 40s - Mother of autistic child and part-time care worker).

> "... I don't like to look too far into the future because we had him very late in life and I just - I just worry what will happen to him when we're not here because there's nobody really ..." (Early 40s - Looking after home).

The necessity to combine multiple *types* of caring responsibility is the second cause of additional stress levels:

> "[Do you ever feel under strain?] Oh God sometimes, yes, sometimes. I was saying to someone the other day, I've been in this house twenty-four years and the last two years - that's since my Mum died - is the longest I've spent in this house. Because with looking after her and Mary [disabled daughter] and going to work, I was never in the house ..." (Early 50s - Recently retired part-time catering assistant).

Much of the pressure for carers of elderly people, male and female, stems from difficult relationships as opposed simply to the tasks of caring:

> "... And when Dad decided he was going to move, yes, I was under a lot of stress with it then. Because he's like a lot of old people now, he focuses in on something now ... And I'm getting all this on the Saturday" (Late 40s - Full-time administrator).

> "I've only got to be five minutes late and her face is down and, 'Where do you think you've been till now?' ... So she sits and sulks then for about an hour so you just sort of ignore her. Just, it gives her a taste of her own medicine, then she soon comes round" (Early 50s - Part-time catering assistant).

Despite the fact that she can actually cope on her own, the mother referred to in the latter extract even puts pressure on her daughter not to go away on holiday for a break. The carer concerned feels very much taken for granted in the help she gives.

Evidence also emerged from the interviews of the sorts of stresses, outlined by Mullender (1983) and Qureshi and Walker (1989), which result from the altered order of dependency relationships between children and parents in these circumstances:

> "... She was very active and very bright and she's not my Mum anymore. That's hard to cope with really ... She can remember things, what she did when she was young, but she can't remember what she had for lunch. So it's hard" (Late 40s - Part-time library assistant).

In cases where such difficulties exist and the carer and cared-for parent also live in the same household, this can be the catalyst for even greater family conflict:

> "... And sometimes he's sitting there and the grandchildren'll come in from school about four o'clock and soon as he hears this door opening and he says, 'Close that door, there's a draft' ... I never argue with my Dad, but I've had two arguments ... I said, 'Dad, those children are scared of you, the way you speak to them.' But basically I'm an only child and I can't say to my Dad, 'Do this, do that and you're not having that on the tele, listen ..." (Early 50s - Invalid Care Allowance).

Much less apparent conflict exists in households where the person being cared for is a husband or partner. Although these relationships, too, have changed as a result of the dependant's need for care, they are differently configured to begin with in terms of a 'correct' order of dependency. Rather than arguments, therefore, the stress of caring would seem to result from limitations placed on the couple's activities and an inability to express any extra worries and concerns:

> "I get fed up sometimes [whispers]. But then it passes, you know, because he's so good. He never complains and he could but he doesn't" (Late 50s - Gave up job to care for husband).

> "... Yes, it worries me, it worries me a lot because he's frightened to do a lot of things that he used to do before. Like we couldn't go a long distance in the car, where he used to drive a lorry, he used to drive a taxi and go for distances ... I mean, it worries him because he gets depressed over it, you know, because I'm working and he can't" (Late 50s - Full-time care worker).

Another aspect of the contrasting effects of relationships between carers and different types of dependant is the fact that women with children often talk of the pleasure that they gain from caring. This was very obviously less the case for those women looking after an adult. Caring for an adult dependant may give purpose, as

Ungerson (1987) noted and as the next extract illustrates, but it was not as often described as rewarding:

> "It was an awful funny feeling when my Mum died because I'd been with her that much time and that much of my own - how can I say it? Because she was like a constant thing all the time and when there was no caring to do I didn't know what to do with myself ... I thought, 'I'll have to go back to work because I'm really getting that boredy feeling'" (Late 40s - Full-time administrator).

9.6.3 The Benefits of Paid Work

As again anticipated in Chapter Four, full-time workers across all the carer groups are much more likely to describe their paid employment *per se* as demanding and stressful. Notably, however, such feelings of dissatisfaction are generally weighed favourably against the personal satisfaction, prospects of promotion and other social rewards of paid work. Part-timers, too, report benefits to their general sense of well-being even when working in low-status jobs which they would not chose other than to accommodate family responsibilities:

> "... I enjoy helping other people. It does make me feel better to sort of help ... Because a lot of them are lonely and one of them like used to sit and talk. I mean, sometimes I'm the only person that goes into them all week ..." (Early 40s - Part-time care worker).

In a variety of different caring circumstances, women felt that going out to work actually reduces conflict in the household and helps them to manage caring responsibilities:

> "[Did you ever feel pressure from your job?] No, we used to have a laugh in work ... I think that break used to do me the world of good. I know I was going to work like but, you know, the break" (Early 50s - Retired part-time catering assistant caring for adult daughter with Down's Syndrome).

> "... when you had that time when you were apart it was ... it sounds terrible saying it was necessary, but it helped, you know, because

you didn't get on each other's nerves and you had your own space ..." (Late 50s - Recently retired from part-time laboratory job).

"... I suppose the job may cause more strain - but then I think to myself, 'If I didn't have the job I couldn't go on social security.' ... I need to be occupying my mind during the day as well if only to be a better Mum to the kids at the end of the day. I find I'm more placid and more approachable because I'm out at work all day" (Early 30s - Full-time clerical worker).

9.6.4 Contexts for Social Isolation

Conversely, and as the last extract indicates, women whose sole occupation is to look after the home do describe considerable feelings of boredom and social isolation. These sentiments are expressed most strongly by the lower-income mothers of young children, particularly those who want to work but are restricted from doing so:

"... I feel fed up a lot of the time. I think that's just boredom through being in here [at home]. I feel like - the routine of things gets to me and that ... Just bored and fed up. Constantly being hounded by my daughter. She never stops talking. Sometimes I feel like just going away somewhere on my own, you know, like the weekend when she's home from school [laughs]" (Late 20s - Looking after home).

Consistent with their feelings of social isolation, a number of these mothers describe the considerable strain they feel from having to carry out domestic tasks. When asked, for instance, if she had visited the doctor concerning her own health recently, one woman replied:

"Last year I did. It was depression and anxiety. It was all different things ... the washing machine was broke down and I was doing all the washing by hand. Have you ever tried that? - for the three of us. And it was just all different things breaking down in the house and I was just getting nowhere ... It was during the school summer holidays. I had all the kids round the door running round. And then we were nearly getting divorced ... And that's when I broke down

> ... I did get some tablets. I don't know what they were called, they calm your heart down ..." (Mid-30s - Looking after home).

Of course, as previous studies have also noted (Focas, 1989; Martin and Roberts, 1984; Jones, 1989), single mothers have to cope with the additional isolation and activity scheduling problems which stem from a lack of other adult company and support:

> "[So do you ever feel under strain?] ... Yes, definitely, especially being on your own and you're picking the kids up and doing the same thing. And I don't know ... like once my kids go to school, once I've done my house, the washing's clean, everything's done, I just go out and visit my friend's. Because I think if I sit here, that'll be it, your life just sink under you won't it? ... But I'm OK. I'm just one of them people that just get on with it, otherwise you'll sink under won't you? And sometimes when I'm on my own at night and I think - I feel really lousy and I think I'm alright though. I get up the next morning, that's it, you've got to play your role back again haven't you? - so I'm OK" (Early 30s - Income Support).

The mothers described here tend to be the ones in the interview group with least access to private transport and the most restrictive income when it comes to social activities. Their social world is, as a consequence, even more confined to the local area and this only serves to exacerbate the kinds of feelings described. When asked what she does for relaxation, another young mother replied:

> "Go the bingo [laughs] - boring. Yes, nothing really apart from that ... I get out now and again, me and my friends, but me and my husband don't go out a lot. Well, it's the finances, we can't afford it really, you know, to go out. That's the main reason" (Early 30s - Looking after home).

For women in households where only the male partner is in paid work and caring labour is 'traditionally' divided, the situation is often further compounded by the fact that leisure time away from the home is also shared unequally:

> "[What do you do to relax?] Watch TV I suppose. I can't think of anything else - or fall asleep, or have a nice long bath.
>
> [Does your husband feel under stress?] Probably [laughs], if he's working six days a week he does feel stressed. But he goes jogging of a night and that to relax so ... Miles away I don't know, he goes out for about an hour" (Mid 30s - Looking after home).

The other circumstance, mentioned in the interviews, which directly brings about feelings of social isolation is the presence of limiting long-standing illness. This can, as the next case illustrates, severely restrict time-space flexibility:

> "... And physically going out, I don't go out. It's been like that for a few years now. A lot of places it's difficult to get access to with your sticks and that. Plus you haven't got the income to be going out a lot like ..." (Late 40s - Registered Sick due to rheumatoid arthritis).

This extract is an important reminder that the processes linking social roles, health and well-being are very much two-way. Not only does paid and unpaid work participation affect women's health status, it can also influence their response to illness and the ways in which they access health services. Considering the differential apportionment of paid employment and caring responsibilities amongst women, which was described in Chapter Seven, the next section assesses the mechanisms of constraint and enablement in operation.

9.7 Links between Social Roles, Illness Response and Health Care Use

9.7.1 Paid Work and Illness Response

The interviews in Netherley and Woolton illustrate that a significant proportion of the women, who combine caring responsibilities with paid work, ignore health problems as a direct result of their social roles. In addition, they

describe the difficulties in terms of pressures on time. This is true across the whole scale of employment status as the following illustrations show. The women were asked if they ever ignore symptoms of their own:

> "Yes, all the time I think ... I mean, I think I have got arthritis in my hands ... For years I've always had pains round my elbows but I have got pains now all up there [indicates shoulder] so I don't know ... I mean, half the time it's just getting round to the time to go the doctor's isn't it? I suppose I should go but what could they do anyway if it's arthritis? They could only give me pain killers can't they?" (Early 40s - Part-time care worker).

> "My friend's a nurse and I've got a pain in my side nearly all the time - but it's not a sharp pain, it's not this terrible pain, it's just something I'm like aware of - and she says, 'Something to do with one of your ovaries that you know? ... And I say haven't got time for that - I'll go in the Christmas holidays ... " (Late 30s - Full-time teacher).

Having said this, it is clear that women in distinct segments of the paid labour market confront very different circumstances in terms of illness. The following extracts are from women in the primary labour market:

> "I think we have six months on full pay and another year on half pay or something like that ... And then if you're still not well we have this long-term disablement scheme which you can stay on forever ... It's a pretty good organisation from that point of view" (Mid 40s - Full-time personnel manager).

> "... You get eight weeks full pay and then you'll go onto half pay until you've had a medical. And if you're medical says you're still unfit for work you go back on full pay and you can be off for twelve months with some sort of pay ... I mean, financially I don't suppose I'd be any worse off" (Late 40s - Full-time administrator for Local Authority).

This contrasts with the situation in the 'flexible' labour market:

> "I don't think I would get sick pay to be quite honest because I do three jobs and two of them are temporary contracts and, because they're temporary contracts, they don't usually pay sick pay ... The only one that is a permanent contract the hours are too short and

that's the five hours with the school" (Early 40s - Full-time secretary).

"Up to three months you're alright and then six months they give you the push. I would get pay because I work twenty hours so I'm classed as full-time. But most of the others are there only fifteen hours so they just get a fortnight's pay, maybe a month at the outside and then that's it then - nothing" (Early 50s - Part-time catering assistant).

Of course, not all women in higher-status jobs are well-placed to take time off for their own health needs. It is, however, much more unusual for this kind of situation to exist:

"... I'm under pressure not to take time off ... The person I work for now, he's the sort of person who never takes any time off himself no matter what and he doesn't think that anybody else should take time off. And when I strained my muscle in my back and I really couldn't walk and I was trying to go to work because I knew he'd have a face on and I couldn't even dress myself - it was terrible ..." (Late 30s - Full-time teacher).

9.7.2 Managing Paid Work and Health Care Attendance

The contrasts are similar if we consider the affects of paid work participation on the ease with which women can decide to access health care. The woman referred to in the first extract below is a manager herself and works 'flexitime'. Her case and those following illustrate the differences between: i) 'being your own boss'; and ii) having an 'understanding' or 'awkward' person in charge:

"... I'd just say, 'I'm going to the doctor, I'll be late', or leave early ... I mean, you can go to the doctor and the dentist on company time - there's no rules about it" (Mid 40s - Full-time personnel manager).

"I think the home help organiser's pretty good that way because she says, if you've got a hospital appointment or anything yourself, just have the day off -you don't have to book it as a holiday or anything" (Early 40s - Part-time care worker).

"[Would you have problems taking time off for a smear test?] Oh yes [laughs], you wouldn't take time off for anything like that. He'd expect you to do that on a holiday" (Late 30s - Full-time teacher).

Previous research (eg. Grieco and Pearson, 1991) has shown that women in part-time jobs often find it easier, than those working full-time, to attend health services. This is because they have 'free time' which coincides with, for example, GP surgery opening times. The interviews in Netherley and Woolton confirm this picture:

"... I try not to go in the morning because it's silly when you're part-time - you have got the afternoon ..." (Late 40s - Part-time library assistant).

They also reveal the comparative ease with which part-time workers can chain trips in order to accommodate health care attendance:

"... I used to get the first appointment at eight o'clock and then I used to have my traction for half an hour and then go into work for quarter-to-nine ..." (Late 50s - Recently retired from part-time laboratory job).

Full-time workers in paid employment did describe having greater problems combining a job with health care use. Routine and preventative services, in particular, were afforded lower priority:

"I think they do Well Woman things, breast screen and things like that and weight and cholesterol ... But I've never really had time to go because I think it's a Wednesday afternoon and I never used to go then when I was working full-time ..." (Early 50s - Part-time teacher).

"... it's the time of day business again because I don't want to take time off work ... They have a surgery during the day and a surgery sort of after work time - 5 o'clock onwards. And if you ring and say can you have an appointment in an afternoon surgery, it's like four

> or five days away and you think, 'Oh, I'll be better by then', so you don't bother" (Late 30s - Full-time teacher).

Lower-income women, who lack access to private transport, illustrate the time-space disincentives of full-time paid work even more clearly:

> "[Does feeling that you can't have time off work put you off going to the doctor?] I think it does ... If I visited my doctor during the day time, it would always be just pm - late pm. But I think if I had a car ... I could get there and back in half an hour. That might make me I don't know ... The old system's the best, you know, just walk in and ask who's last and you go in after that person ... To be able to just go when you felt sick and when you could find the time ... I mean, I find the appointment system just doesn't work for me so.." (Early 30s - Full-time clerical worker).

9.7.3 Caring Responsibilities, Illness Response and Health Care Use

Paid employment is not the only social role which constrains a woman's health care use and reaction to illness. Those who see their role as solely that of carer also describe ignoring 'simple' symptoms. They, however, talk less in terms of direct time constraints and more in terms of the necessity to 'carry on' for other people. This is hardly surprising since their paid labour participation has often been restricted by the very fact of having heavier caring responsibilities. Two women who look after an elderly parent explain:

> "I just struggle on and look after them all really" (Late 50s - Part-time job in school).

> "Well the thing is I couldn't lay in bed could I? I had to get up and give him his breakfast ... (Early 50s - Invalid Care Allowance).

In part, it is also the nature of the caring role that women do not want to worry their partners or those they care for by telling them about their own health problems:

"I don't even tell my Mum because she'd tend to panic anyway so.. Because I never told her about when I had the cyst. Because that was about the time my brother was dying and I thought, 'Well, I can't give her that to worry about', so I just kept it to myself" (Early 50s - Part-time catering assistant).

"I don't ... Well, in case I worry my husband, you know ... he's that type" (Late 50s - Gave up work to care for husband).

Those with heavy caring responsibilities must also accommodate the demands of that social role as part of the decision framework for their own health care attendance. For instance:

"[What do you do with the kids when you go to the doctor's?] Either my daughter will sit in the house with the five year old. Or either could be at school when I do go so that's OK and I'll just take the youngest with me ... or they could be at the little youth club that they go to ... So I pick the times, you know. When they say to me, 'We've only got this time', I go, 'Well OK then, I'll have to have it the next day'. I either suffer when I'm really ill, I'll make it like to go the next day to suit the kids. You think to yourself, 'Another night of illness - put up with it'"(Early 30s - Income Support).

Some attempt to overcome time-space constraints by booking combined appointments at the GP:

"I'd sometimes make consecutive appointments, one for me and one for the kids. They've got a notice up at the surgery saying, 'An appointment is for one person only', so ... I've said, 'Give me two appointment times, one for the child and one for me'. I've done that" (Late 30s - Full-time teacher).

More likely than not, however, the necessity to attend to a dependant's needs takes priority:

"... I've been there coughing my guts up and everything and my file hasn't been there and I keep thinking, 'Should I ask him?' And I've thought, 'No, I haven't come for me today'. This is it, you don't know when you're going to be sick do you? ..." (Early 30s - Full-time clerical worker).

Clearly, the difficulties outlined apply as much to women who are full-time carers as to those who combine paid work with caring responsibilities. For some, the long-term consequences for their own health needs may be quite serious:

> "[They wanted you to go to a dietician did they?] Yes, well I did go ... every week and I lasted out for about two months. But after that ... I just didn't have the time because, eventually, my mother was in a wheelchair ...".

> "And I'm still trying to get down there to have another smear test because the doctor's sent for me about twice - but with minding Alison's [daughter] kids [5 days/week 2.30-6pm]. Half-past-nine in the morning is one [clinic] till ten - well, I can't go with Mary [adult daughter with Down's Syndrome] because her bus is at half-past-nine so that's out. And one's from twelve - I'll have to try and get down there for that one - twelve till two ..." (Early 50s - Recently retired part-time catering assistant).

The issues raised by the last extracts prompt a consideration of the circumstances under which women are most likely to neglect their own health needs. The main point is that they afford differing priorities to their own personal health-related needs as opposed to those of their family. The next section focuses, first, on two aspects of the management of health care in relation to illness: i) attendance at the GP surgery; and ii) calling out the doctor. Second, it examines the circumstances under which women ignore personal symptoms and, third, it describes the limits on many women's opportunities to maintain a 'healthy lifestyle' in the context of their various social roles and resource constraints.

9.8 A Woman's Place in Household Health Priorities

9.8.1 Calling in the Medical Profession

One of the clearest indications of the different priorities for health needs within families, is provided by contrasting mothers' attitudes to their own and their

children's symptoms of acute illness. First, how serious do symptoms have to be before women feel the necessity to attend the GP surgery? Various examples show variations in the threshold for decision-making:

> "... I used to suffer with my throat, like tonsillitis. It has to be really bad for me to go ... I'd say I go more with him [disabled toddler] than anything, with his chest or anything. But they go more than me, the children, they're first" (Early 30s - Income Support).

> "... I'm a regular tonsillitis - I'll get that once a year but I'll just ignore that ... If they get sick, I'll watch it for a day ... If they're no better the next day, I'll take them the doctor's. I won't wait for an appointment either. The way our health centre's really busy - you'll ring for an appointment say Monday and they'll say, 'Come in Thursday'. Well, by that time, depending on what's wrong with the child, they could have rapidly deteriorated. So I just march down there like a battleaxe and wait until all the other patients have been seen and then I'll go in. I won't let them wait more than twenty-four hours if they're sick" (Mid 30s - Income Support).

Second, what does it take to prompt a request for the doctor to make a home visit? Once again, it is dependants who take priority in women's decision-making and this is the case across all the caring groups. Responding to an hypothetical scenario, one mother of otherwise healthy children expressed the choices as follows:

> "[Say if your daughter [Age 3] woke at two in the morning with a temperature and pains what would you do?] Call the doctor out. [Right away?] Yes. [Wouldn't think twice?] No. [How about if it was the older boy?] Well, he can communicate a bit better than Laura. You say, 'What's wrong?' with Laura and it's just, 'I'm sick'. If I said to her, 'Is you hand sick?' she'd say, 'Yes' - 'Is your head sick?' So I can't really get much sense out of Laura. I'd ask Tom where's he sore? If he was sore with like stomach cramp I'd think, 'Something he ate'. If he had an extremely high temperature and really didn't look well I'd call the doctor out ... [And how about if it was your partner?] I'd just say to him, 'Do you want me to call the doctor out or can you wait till morning?' If it was me I'd wait. If I was half dead I'd still wait till morning ..." (Mid 30s - Income Support).

Other mothers described actual illness episodes which show that, although the GP is not contacted lightly in any event, there are differences in what is regarded as serious enough for a call out depending on the family member involved. For instance:

> "That has happened to us. Hayley's woken up and she's had stomach pains or a temperature ... if she seemed to be really ill I would call him out ... When I did my back ... I was in absolute agony - I couldn't walk ... I did wonder whether I might have slipped a disc or something - whether I ought to call him out. I haven't and we didn't call him out in the night ... I did call him out the next day ..." (Late 30s - Full-time teacher).

Those with disabled children feel even more justified in calling the doctor out because there is a 'legitimate' reason for doing so:

> "... Oh I wouldn't think twice about calling the doctor out if there's anything wrong with David ... because you don't know what other underlying things there are, you know ..." (Early 40s - Looking after home).

This is also the case if women are caring for a dependent adult:

> "... I had the doctor out about three times in three weeks ... And the first time it happened he wanted to know how did I justify bringing him out? I said, 'Because she's my mother and she's so ill!' ... And he just said, 'Well, what do you expect? She's eighty-two years of age'. I felt like smacking him one ... It's not as if we get him out if she sneezes or anything like that, you know, but to literally collapse in my arms ... And then he said how do you justify getting him out? - arrogant sod!" (Early 50s - Part-time catering assistant).

The contrast between these women's reactions to their own ill health and their attitudes to illness in their dependants is similar to the differences identified for mothers and children:

> "... If it was my husband bad I wouldn't hesitate to bring an ambulance out. I wouldn't bring the doctor out to him because you'd wait too long. If I was sick myself I might send for the doctor but

it would all depend what was wrong with me" (Late 50s - Full-time care worker).

"... I just thought I was able enough to go over there and sit and wait my turn. I just don't believe in abusing doctors. [What would you bring them out for?] If I couldn't walk. [And your husband?] Oh for my husband, yes. [What would you bring them out for?] Well, you know, if he took a funny turn like. I don't know, but I wouldn't hesitate in bringing them out for my husband" (Late 50s - Gave up job to care for husband).

What becomes obvious from these extracts is the differential power relationship which exists between women and the medical profession. This is most clearly expressed by one Netherley mother:

"You know my attitude when I've had to call a doctor out like when my daughter's been ill and say it's been three or four o'clock [in the morning]? I apologise for bringing the doctor out and I shouldn't really ... I always say, 'Can you hang on to say seven?', or something like that. But you can't if they're ill like you've got to bring them out haven't you? But you feel uncomfortable having to bring the doctor and you shouldn't really should you?" (Early 50s - Retired part-time catering assistant).

Such considerations intervene sharply in women's decision-making where response to illness symptoms is concerned and the threshold at which they feel the health services can, legitimately, be involved differs markedly between family members. The level of need which women perceive on their own behalf is often very much less than for a child or adult dependant.

9.8.2 Ignoring Personal Symptoms

When asked to answer hypothetically, most women did say that they would not ignore more 'worrying' personal symptoms such as a breast lump or severe, inexplicable pains:

> "No I wouldn't do that [put off going to doctor about lump], it's very foolish isn't it? I mean, if there's anything wrong with you, you might just as well face up to it. It's not going to get better on its own and you're going to worry about it and the anxiety's going to make it even worse isn't it?" (Late 50s - Part-time job in school).

In practice, however, many had not wanted to 'bother the doctor' for a whole range of symptoms from the 'simple' to the, potentially, 'very serious':

> "... I go to the doctor's when I've got to go ... Like my bowels [diverticulitis], I wouldn't have gone if I could have sorted it out myself ... It's not that I don't like doctors. It's just that if I can sort it out myself then I will because I think they've got enough to do with people that are really ill, you know" (Late 50s - Full-time care worker).

> "I suppose with the heavy periods - some months they were really bad and the girls in work said, 'Why don't you go? What does your doctor say?' 'Oh I don't go near him - I'm alright - I don't feel not well. To me it's just a normal thing'. But I know other people who've gone and ended up with hysterectomies because they had heavy bleeding ... I thought, 'I'm not that bad, why worry the doctor?' (Late 40s - Full-time administrator).

> "I think the lump [breast cyst] that I've got, I think I ignored that at first ... It played on my mind a bit about what it could be. But, as for going the doctor's, I think I thought it would go away ... But I don't bother the doctor that much ..." (Late 20s - Looking after home).

9.8.3 Maintaining a Healthy State

Graham (1992 and 1993) has already described the complex budgeting strategies which women in low-income households use in order to balance individual health and household economic survival. Cutting back on basic necessities, of which food is the major expenditure, is identified as the best way to control overall out-goings. The evidence from Netherley and Woolton confirms the view that, in this area of health maintenance as well as illness response, women afford lower

priority to their own health needs than those of their family. In the interview group, it is mothers on benefit who have to make such sacrifices on a routine basis:

> "I used to get dole when I'd given up [work] after the baby. First thing I'd do, I used to get £28, I'd go and cash my giro and go straight to the chemist and get two week's worth of baby food in, you know the tins. And I thought well at least if we've got nothing she's alright" (Mid 30s - Part-time shop manager and mother of two).

Diet is not, however, the only element of maintaining a 'healthy' lifestyle. Health promotion messages also stress the importance of factors like taking adequate exercise. Women with multiple social roles often have difficulty fitting such 'extra' activities into their daily routine. That is, unless it is tied into the needs of children or a dependant. The women in the interview group were all asked a general question about what they might do for the sake of their health. Two women living in Woolton show that the dilemma is much the same across the range of income groups. The first is a part-time cleaner who holds down two different jobs. She is the mother of three school-age children and also helps out her own elderly mother who lives nearby. The second is a manager with an insurance company and a mother of two:

> "What could I do to improve my health? Probably exercise, because I virtually do no exercise. I mean, I think I'm doing enough by all the rushing round I'm doing but I don't actually do exercise, you know" (Mid 40s - Part-time cleaner).

> "I don't do as much exercise as I should - nothing like. I know I should join an exercise class or go swimming or something but, unless I take the kids, I don't ... We've got a static caravan up in the Lakes and we go there probably every other weekend and that's relaxing because we do nothing really, you know, we just go walking and things like that ... But I haven't got time for me. I haven't got any time that is set aside just for me at all ..." (Mid 40s - Full-time personnel manager).

In reply to the same question about improving their general health, a number of other women also mentioned trying to stop smoking. For the mothers in the interview group, however, this was again tied in with the needs of their children or the household generally rather than, specifically, their own health:

> "[How come you gave up?] Because we wanted a car. That was the only way we could afford it and we put the money towards tax and insuring the car and we both stopped together ... And I do feel healthier. I did a little aerobic course and, like, I felt healthier doing it - where when I used to do it when I smoked I was out of breath, you know, I was really out of condition but I didn't connect it with the smoking. [So you won't start again?] No, I hope not. I really hope not. For the kids [Age 5 and 2] as well because the eldest one's got asthma. That's the other reason why I stopped, you know, it's not fair on them ..." (Early 30s - Looking after home).

> "... I mean I gave up [for 6 weeks] because the kids [Age 8 and 3] were starting to go, 'Oh you stink' and all this and I thought, 'Well that's not fair, I'll give up' ... That was just for the sake of the kids, it really was ... 'Course my boyfriend doesn't smoke and I'm getting the same from him, 'You're polluting these kids' lungs' and everything. Started going outside and sneaking one but they could still smell it so I just went back on the ciggies" (Mid 30s - Income Support).

The women with caring responsibilities to adults were less likely to talk of giving up smoking in terms of the health of others. As in Graham's (1988) study of low-income mothers, however, women across the carer groups described smoking as one of their few luxuries and as a strategy for managing in stressful situations:

> "... It's the only vice I've got and I may be killing myself - well ..." (Late 50s - Full-time care worker also helping long-term sick husband).

> "... I must admit I've had a couple [of cigarettes] this week in work ... It's just because it's been so manic in work this week ... I shouldn't smoke, I know I shouldn't smoke. I wish I could pack them up ... I just enjoy it. I just enjoy a fag now and again and, 'Why not?', I suppose. I mean I know all the things are against you aren't they? And I've had a few members of our family have died

> of cancer as well - I don't know ..." (Late 40s - Full-time administrator with adult children living at home).
>
> "... See I can't give up smoking 'til I've lost my weight and I can't lose my weight if I stop smoking ... I need to smoke while I'm losing weight otherwise I'll just - I need something in my mouth all the time. It's psychology really isn't it? It's mind over matter really - I should do without the two of them, do without food and cigarettes, but I can't" (Early 30s - Full-time clerical worker and mother of six children)..

The important implications of this issue of perceptions of the relative benefits of personal healthy lifestyle behaviours will be discussed in more detail in Chapter Ten.

9.9 Summary

The evidence put forward in this chapter supports the view that women are the health managers in the majority of households. It shows that this aspect of their activity for the family has to be viewed in the context of their wider social roles in paid and unpaid work. Household gender and wider social relations are, therefore, a vital element in women's health, illness and health care decisions and behaviours. In particular, the double burden of caring and paid work makes it difficult for them to fit non-urgent health care use for themselves into their daily activity schedule. It also complicates arrangements for women to respond to health promotion messages which emphasise certain aspects of lifestyle, for example exercise, in the maintenance of health.

There are certain circumstances, however, which make it more likely that constraints will be overcome. First, if the person involved can be deemed by women to take priority in household health needs. This might include a partner,

children and other dependants. Second, there can be little doubt that those living on a low income are more constrained than higher-income women. Although help from the social network can be substituted for a lack of economic resources, it is much less enabling in terms of time-space flexibility. Women in their role as household health managers employ resources and their own labour in order to achieve the best possible overall outcome for the family. They must, however, work within the everyday 'realities' and this has an effect on the degree of choice they can exercise. In circumstances of scarce available time and few resources, therefore, their own health needs may be neglected. In particular, as Graham (1988) has already argued, behaviours which look 'irrational' or 'unreasonable' to health and social care professionals may have readily understandable origins in the complex social structures described in this chapter.

Given what the research has so far shown, there are clearly implications for the ways in which curative and preventative health care for women is designed and delivered. There are particular problems associated with the movement to a market driven model of need in a framework which de-contextualises the marketplace. Women are seen as clients and patients; sources of demand. Such a view is, however, insufficient to recognise the complex contingent 'realities' which constitute their everyday lives. By adopting the perspective of this thesis, approaches which, for example, blame individuals for not availing themselves 'appropriately' of the services provided could be avoided. The next chapter turns, specifically, to the sphere of policy and provision. It examines existing structures in the light of the findings of the thesis so far.

CHAPTER TEN

POLICY AND PRACTICE REVISITED

10.1 Introduction - From Theory to Policy and Practice

As noted in Chapter One, it is one of the major criticisms of medical geography that it has failed to recognise the full implications of contingent, spatially configured social relations for individual health and access to health care. This thesis has aimed, from a realist perspective, to add such a dimension of social relations and, therefore, contribute to ongoing theoretical debates in the sub-discipline (Dorn and Laws, 1994; Mayer and Meade, 1994; Kearns 1993 and 1994). Although it has privileged issues of gender, the thesis has also explored the impacts of those significant differences *between* women which arise from their differential resource, cultural and life-course positions. Overall, the thesis has aimed to offer a critique of traditional approaches to time-space adopted by medical geographers in relation to health care. These have focused on broad allocative systems and the examination of access by people divorced from the context of the structural inequalities inherent in society.

The route into this has been the extension of perspectives previously adopted in time-geography or activity analysis (eg. Tivers, 1985 and 1988) in a manner which attempts to take account of important criticisms outlined by Rose (1993). Those criticisms centre on the fact that time-geography has traditionally failed to address the central role of the domestic sphere in the social construction of time-space. By expressing agency as a pathway it has, for example, regarded individuals

as totally rational beings devoid of emotion or feelings of attachment to others. Like medical geography, it has also under-emphasised the great diversity amongst women in terms, for instance, of class, ethnicity and age. In other words, time-geography as it is traditionally applied ignores the importance of different subjectivities and the differential nature of meaning attached to time-space. From the perspective of this dissertation, therefore, time-space is seen as essentially negotiated within the domestic sphere and in the context of caring responsibilities in particular. It is constructed and reconstructed by real experience, conditioned by and contingent to all those systems of social and spatial relations, in the household and society, which the women in Netherley and Woolton described (Chapter Seven and Eight). As the interviews showed, perceptions of time-space are different for particular groups of women and for the same women in different situations.

Recognising that this social construction of individual time-space is a highly complex and evolving process, this thesis has attempted to provide a framework with which to evaluate the constitutive elements of the whole. This has focused on a framework for understanding the day-to-day scheduling of women's activities with the family household defined as the primary context in which activity decisions are negotiated between individuals. Figure 10.1 reproduces the decision-making framework set out in earlier chapters. In this, the household as a unit is located along conceptual scales which can be thought of as representing the overall resource levels and the total collective time expended by its members on paid and unpaid labour. Health status in the household context would be included under the category for caring need.

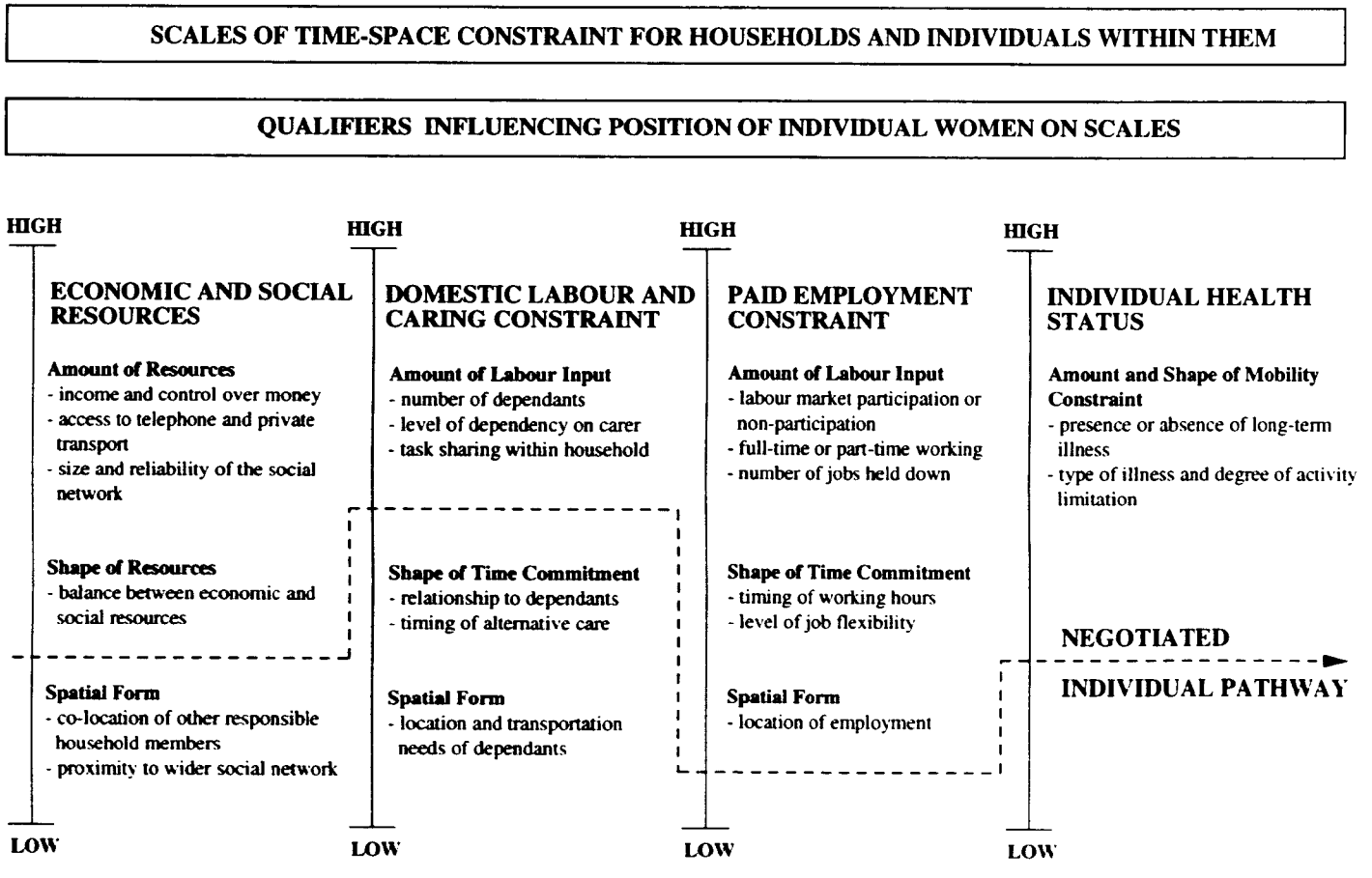


Figure 10.1 The Time-space Decision-making Framework Revisited

It has been argued that the position of the household overall will depend on its composition in terms of the wider social relations of class, gender, race and generation. Poor health and low income are, for example, associated with lower social class and advancing age (Blaxter, 1990). Significantly, however, the constraints faced by individual women depend not only on the relationships of households to wider social structures in society, but also on the ways in which the same social relations are played out on the smaller intra-household scale. Constraints felt by individuals additionally depend on the nature of personal relationships between family members. The scales in Figure 10.1 can, therefore, also be thought of as locating individual women who must negotiate a pathway through the framework of constraints which they face within the household context. Those individual scales will be configured on the basis of practical and emotional qualifiers such as those shown in the diagram. Personal perceptions of time-space flexibility can, therefore, be seen to depend upon the outcome of interactions between all of the decision factors illustrated and the combination of women's positions on each of the four scales. It is the primary argument of this thesis that women's health, illness and health care behaviours are integrally dependent on this overall decision-making framework. Those behaviours are, therefore, heavily influenced by the differential perceptions of time-space constraints which surround them (Chapter Nine).

Specifically, the evidence put forward supports the view that women are the main health managers in the majority of households. It demonstrates that neither this aspect of their everyday activity for the family nor their own health can be

understood without reference to women's overall position in wider structures of social relations. In particular, women's levels of participation in paid work are currently increasing, while they remain the primary carers at all stages in the life-course. For most women, it is that evolving caring role which represents the major constitutive factor in the complex frameworks of practical and perceptual constraints and opportunities which they face in their everyday decision-making. Decisions in this context relate not only to the negotiated 'partnership' between household members in terms of general social role responsibilities but also, specifically, to the ways in which family health-related needs are differentially met; often to the disadvantage of the women themselves.

The choices and decisions that are made are influenced by women's own feelings about and perceptions of themselves. Outcomes are, therefore, both reflective and constitutive of individual identities. A strong thread running through this framework of choice and self-identification is women's access to economic and social resources. In general, higher-income women are less constrained than others by the household division of caring and domestic labour responsibilities and their participation in higher-status, full-time paid employment tends to reinforce this position. Such paid work participation and a higher personal income level enables different forms of self-identification, role substitution and power relations within the household context. Although both economic and social resources can be used to manage the time-space constraints of role responsibilities generally and specifically in relation to health, it has been argued that social exchange affords less flexibility in decision-making. Women in lower income households tend, therefore, to be the

most socially isolated and spatially constrained. The perceptions of their own position and the power structures within the household and family are reflective of this.

All of these considerations have profound effects on the attitudes of individual women to their own *personal health* (Graham, 1984, 1988 and 1993). Although the implicit overall assumption of health care policy appears to be that potential service users operate on a 'level playing field' of opportunity, this thesis has aimed to demonstrate, both conceptually and empirically, that in the vitally important area of day-to-day choices in the household management of health such equality of access and action does not exist. Not only are women differentially placed in relation to men and to each other in society, they often occupy very different positions in the order of priorities for health needs within particular households. All women are facing increasing responsibilities for health and social care and a changing picture of service provision in the light of the recent reforms. However, bearing in mind the inequalities in everyday decision-making frameworks revealed by this research, it is clear that different groups are unequally placed to respond to those policy changes. The present chapter aims to highlight the important implications, both for policy and practice, of women's differential means to perceive and meet their own health needs (cf. Young, forthcoming).

The chapter, therefore, proceeds with a description of on-going changes in the provision and planning of health and social care services in Liverpool (Section 10.2). This is the current response of the policy-making and practice communities

to health-related needs in the city and it follows the general thrust of national policy described in Chapter Two. The main emphasis of the discussion is on the implications for health planning and purchasing of the general conditions of women's social roles and access to resources in the context of social exclusion on Merseyside. In the light of these considerations, the chapter moves on to explore how current national and local thinking might be informed by the findings of this research (Section 10.3). The discussion focuses on the issue of potential household responses to the policy and practice agendas described in Section 10.2. The aim is to suggest lessons for national perspectives which can be taken from the Liverpool experience. This involves arguing for a more 'bottom-up' approach to be adopted to change if the health and social care services are to become truly responsive to the needs of the people they profess to serve. There is a critical need for decision-makers to take a holistic view of the processes which contribute to health particularly in areas of social exclusion such as Liverpool's outer estates. Such an approach can only be informed by the fostering of community networks for change.

10.2 Provision of Health and Social Care in Liverpool

As discussed in Chapter Two, the period since the early 1980s has seen considerable changes in the ideological and policy context for health and social care. A major thrust of policy has been to expose the NHS and statutory sector providers of social care to the discipline of the market place. This has entailed the creation of an internal market for health purchasing and the requirement on local authorities to develop and manage a mixed economy of social care (Wistow et al, 1994). Overall, there is much greater emphasis on health promotion and preventative

screening and the individual is held increasingly responsible for his or her own health. In the context of delivery, these changes have relocated the emphasis of provision away from hospital-based and institutionalised care towards primary health care and care in the community. A number of changes have taken place in Liverpool in the light of this overall rationalisation of structures of health and social care.

10.2.1 Primary Health Care

In 1993, a new joint approach to the planning and purchasing of health services was adopted in Liverpool. The District Health Authority and the Family Health Services Authority now work together to purchase services as Liverpool Local Health Authorities (LHAs). Planning activities are increasingly being focused on the fourteen Neighbourhoods (Figure 10.2) which consist of wards grouped together on the basis of their similar levels of deprivation. The LHAs recognise that there is often a mis-match between the present provision of primary health care services and the level of need based on deprivation comparisons. They also recognise that differences in deprivation exist within the Neighbourhood areas they have defined (Liverpool Health Authorities, 1993). The fourteen Neighbourhoods have each been paired and the resulting Neighbourhood Pairs all have a general practitioner representative whose role it is to provide an informed local view to the overall planning and purchasing process. The objective of this approach is to use the insights of primary health care teams to ensure that joint purchasing decisions and, hence, resource allocation are as sensitive as possible to local needs; or rather, needs as they are perceived by the health professionals.

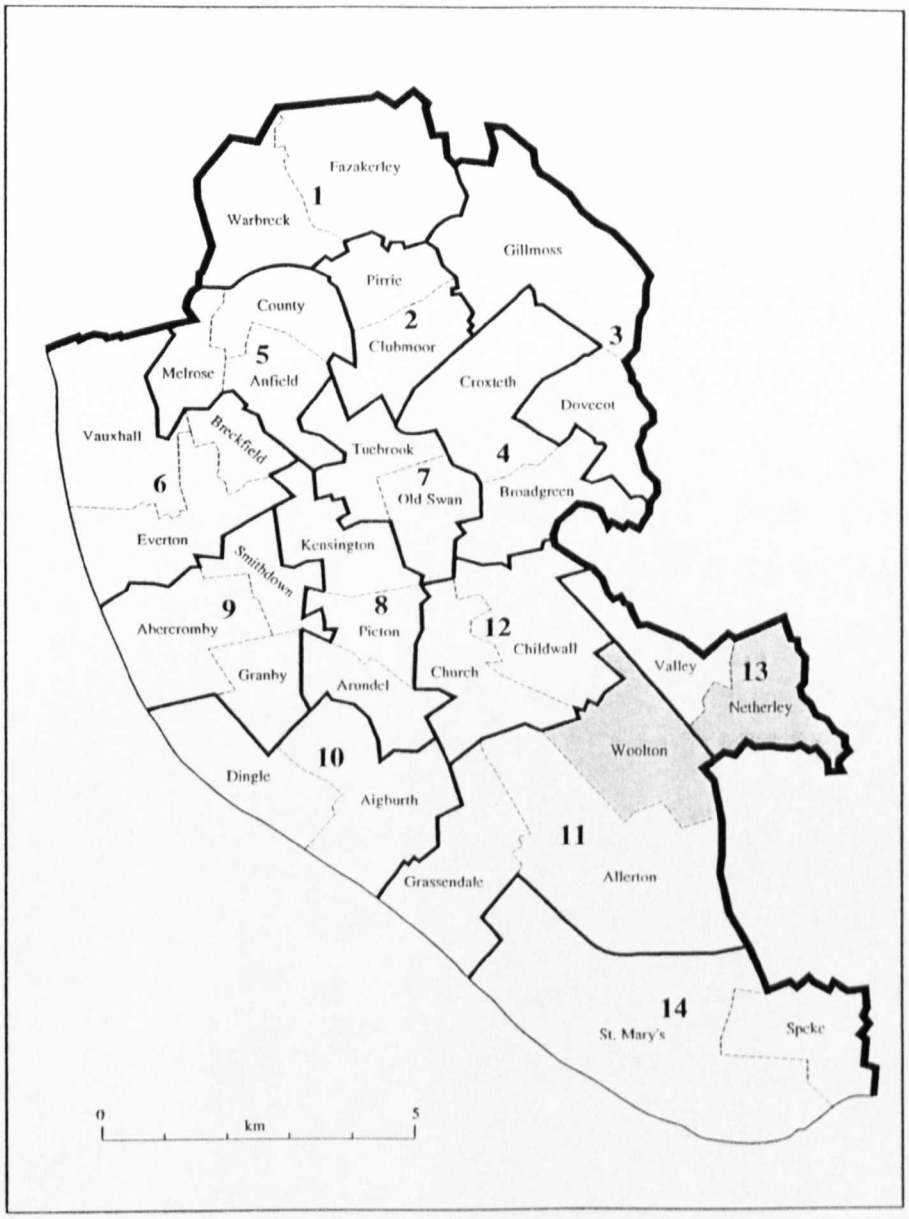


Figure 10.1 Neighbourhood Planning in Liverpool

A corollary to this is the goal, which reflects national policy, of taking a greater range of services into the primary care setting; in other words the local area. There have been a number of relevant developments in Liverpool during the period of this research. These include the opening of primary care resource centres to

provide an extended range of services along the lines outlined by the World Health Organisation (1993, cited in Ashton et al, p.66). Those services include day and late evening surgery opening, consultant out-patient sessions, a minor injuries service and, perhaps in the future, short-stay beds. There are also "plans for a phased introduction of counselling services in primary care in areas of greatest need/deprivation in the city" and "Health Promotion Officers will now be attached to specific Neighbourhoods and work closely with primary care teams" (Liverpool Health Authorities, 1993, p.5). In the Mersey Health Strategy, adopted as RHA policy at the beginning of 1994, this increased health promotion function is the one highlighted for primary care in future:

> "*Primary Care* should ensure provision and access to the promotive, preventive, curative and rehabilitive services. The general practitioner Health Promotion Contract is a central element of the NHS contribution to achieving key *Health of the Nation* targets. Programmes of prevention should be directed at groups with the combination of risk factors that are most likely to lead to acute and chronic illness" [original emphasis] (Ashton et al, 1994, p.23).

The strengthening of primary care is the chief means by which it is hoped to pursue government policy which aims to reorientate the NHS away from its role of curing *sickness* towards one which focuses on the maintenance and promotion of *health*. However:

> "One of the central difficulties of reorientating the health system towards primary care is that within the limited resources which all health systems must operate, the only way of building up primary care is by freeing up resources from hospital and specialist centres" (ibid, 1994, p.67).

10.2.2 Hospital-based Services

The Mersey Health Strategy for secondary and tertiary care has been summarised as follows:

> "*Hospital Based Services (Secondary and Tertiary Care).* Higher risk, complex emergency care and major trauma services will be increasingly provided from a regional or very small number of sub-regional high technology hospitals. However, hospital services will be developed to ensure that lifestyle and prevention advice is offered to all patients, who should also be informed about the range of options for care available and are involved in taking decisions about treatment and care they need" [original emphasis] (ibid, 1994, p.23).

Again, the emphasis here is on health promotion with added moves towards the rationalisation of services on the basis of economies of scale to release resources for use elsewhere. In many cases, however, additional savings are being made by the use of day-patient and out-patient treatments as alternatives to over-night and longer-term in-patient stays.

The aspect of the current debate of most relevance to the concerns of this dissertation is the plan for the centrally-situated Royal Liverpool University Hospital to provide the majority of acute and accident and emergency services for the centre and south of the city. Although such an overall reduction in services is necessitated by the falling population of Liverpool, the policy is not necessarily of universal benefit. For the people of Netherley and Woolton, for example, it means the necessity to travel further for casualty treatment. This is because, since August 1994, the local Broadgreen Hospital has closed its accident and emergency department between 9pm and 8am. The alternative proposed by the Health Authority is the setting up of Primary Care Emergency Centres in Garston and Old

Swan (Figure 10.3). It remains to be seen how successfully the public will be made aware of those services and if people will be able to access them as intended.

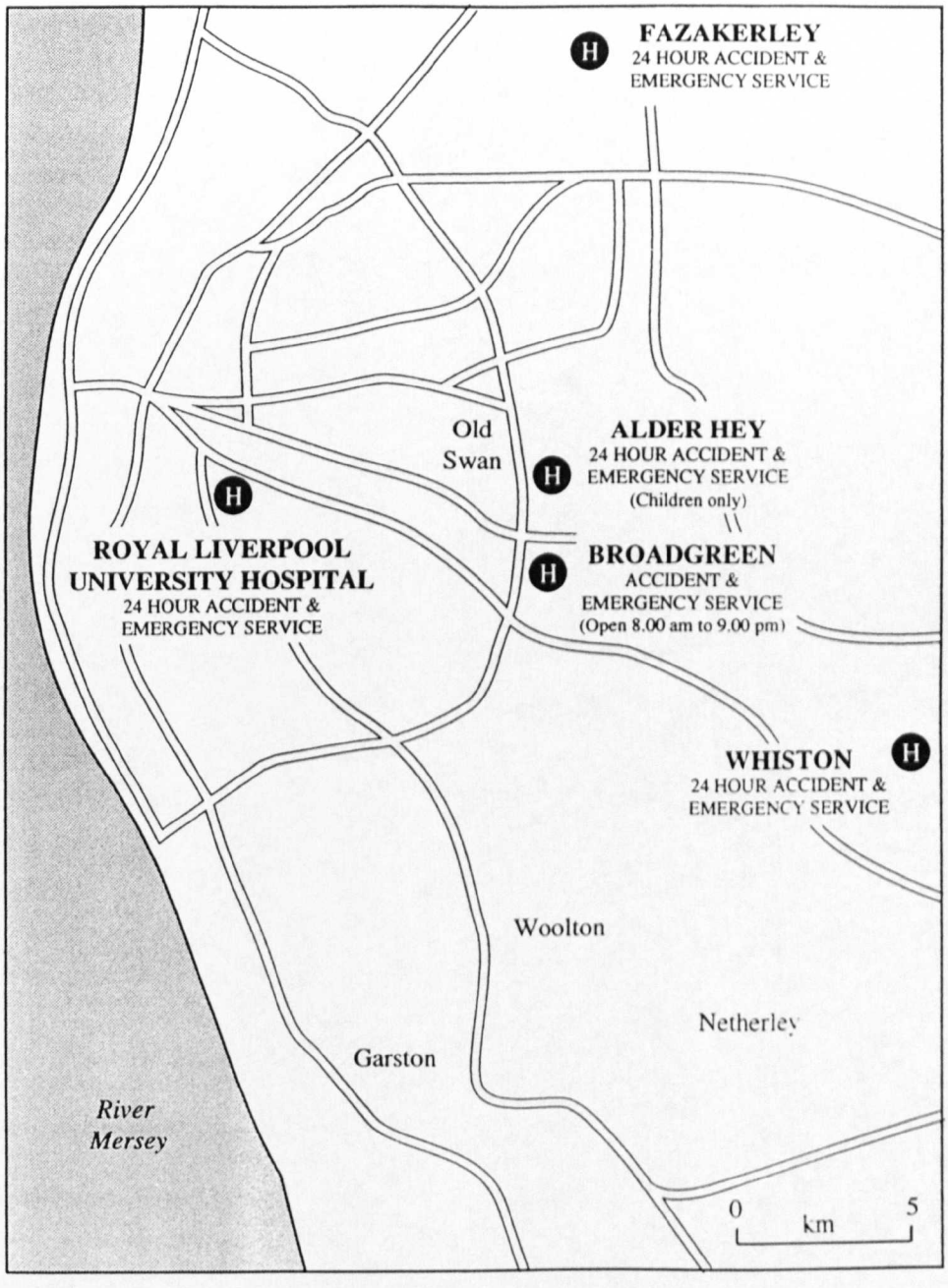


Figure 10.3 Location of Hospitals Providing 24 Hour Accident & Emergency Service

10.2.3 Community Care

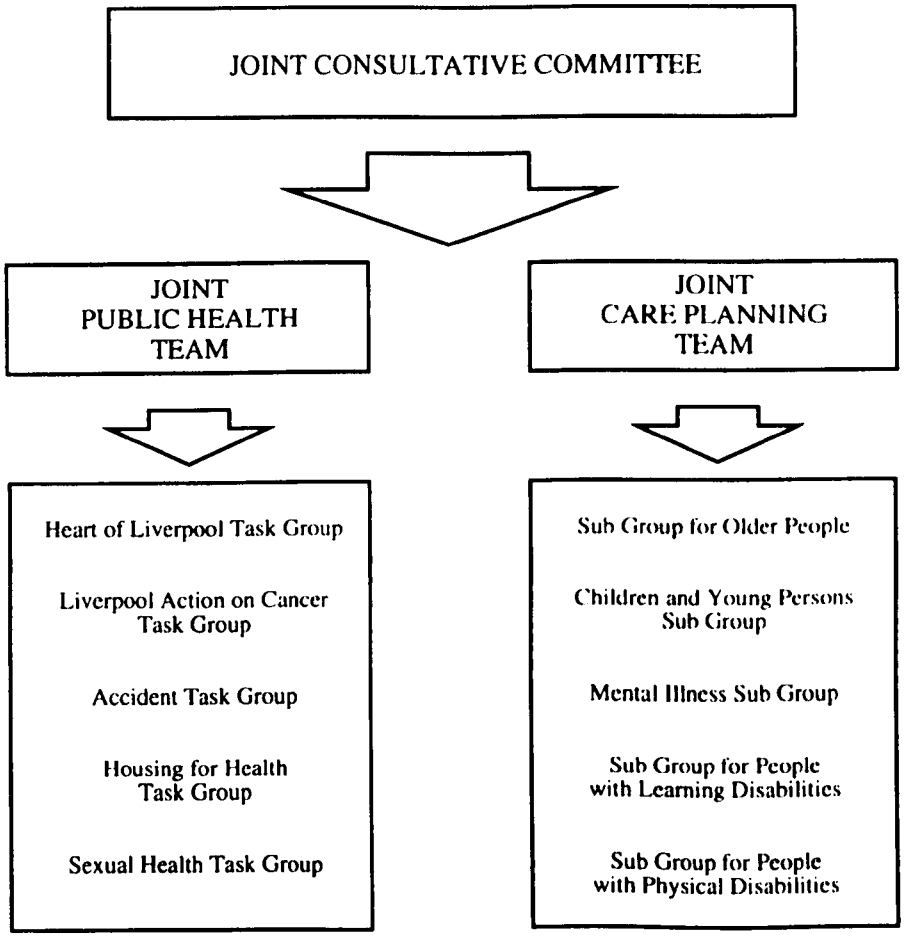
In terms of social care, the Local Authority has assumed the role outlined for it in the NHS and Community Care Act, 1990. In April 1993, therefore, it took primary responsibility for the planning and purchasing of community care in Liverpool. As noted in Chapter Two, in contrast to internal market moves in the NHS, the Local Authority has been charged with developing and managing a market *external* to statutory sector provision. Although the authority continues to provide certain home care services directly, the intention is that informal carers should be supported by voluntary or private sector providers where appropriate. The key role of the local authority is to assess need for residential or nursing home care or for help at home on an individual basis at the same time as maintaining a general overview of services. Although a Community Care Plan was drawn up for the city to cover the period 1993/96, Liverpool is no exception in the spending restrictions its social workers now face. As critics argue, even those authorities which made a promising start to the implementation of community care are now floundering in the light of budgetary limits and the cost of many of the packages of domiciliary care (eg. Wistow, 1994).

10.2.4 Joint Planning - Meeting the Challenge in Liverpool?

In addition to increasingly integrated planning *within* the health and social care services in Liverpool, recent moves have aimed at a greater balance *across* the boundaries of planning authorities. The structure of the new strategy is outlined in Figure 10.4. Briefly, the Joint Public Health Team (JPHT) and its Task Groups operate in parallel to the Joint Care Planning Team (JCPT) and its Sub-Groups.

Both these bodies feed into the Joint Consultative Committee of Liverpool Health Authorities, the City Council and various voluntary organisations. JPHT Task Group members, for example, include managers from the Health and Local Authorities, representatives from the voluntary sector, health promotion and community groups as well as the Trades Council, the Chamber of Commerce and Community Health Councils. Each Task Group has a two year remit to produce a strategy which will build into an overall City Health Plan for Liverpool and inform the purchasing of services by the LHAs and the Local Authority as well as the service plans of local providers. The overall aim is to identify and set targets for health improvement in line with the Health of the Nation strategy.

Figure 10.4 Structure of Planning for Health and Social Care in Liverpool



The ultimate aims of this and the joint approach to purchasing and planning implemented by the LHAs have been defined as follows (Liverpool Health Authorities, 1993):

i) integrated care in the context of localised accountability and responsibility;

ii) more effective management and use of resources;

iii) a greater emphasis on outcomes of care;

iv) empowerment of and greater choice for the individual.

Add to this a number of the general principles behind the Regional Health Authority's overall strategic re-orientation of health care and the possibilities which exist to increase the flexibility and responsiveness of health care services are clear. Those principles are (Ashton et al, 1994):

i) achieving a shift towards the prevention of illness;

ii) involving the public;

iii) shifting investment to the most accessible and responsive points;

iv) integrating primary, community, priority and hospital services;

v) providing more support for informal carers.

However, there are clearly issues which national policy makers, in particular, have not yet adequately dealt with in relation to Liverpool and places like it. This means that local planners are restricted in the improvements they can hope to make to overall levels of health through the implementation of the kinds of changes described above. For example, how does the policy rhetoric of health promotion, most prominently expressed in *The Health of the Nation*, begin to

address the underlying causes of health realities which result from a background of eighty or more years of accumulated urban deprivation in Liverpool? How do policies hope to counteract those health-threatening environments and behaviours which can fairly be described as 'mechanisms for managing' by people on low incomes whose lives are constrained by more than their own unwillingness to address health issues?

This thesis has revealed a number of key issues of relevance in this context which emphasise the importance of access to flexible resources to meet women's own personal and household health, illness and health care needs. Not only does this mean the opportunity of access to an adequate income to budget for day-to-day necessities such as food, it also means the ability to exercise greater choice in the use of time. Substitute sources of labour to cope with ascribed social roles, suitable transport and/or a telephone can each transform the range of women's choices whether they are privately purchased or publicly available in the local area. Such individual and household access to economic and social resources and time-space flexibility stems in turn from the existence of suitable employment opportunities and a living environment which is safe, secure and healthy. It might also be heavily dependent on access to education and sources of personal empowerment to achieve some adjustment of systems of household gender relations. Positive action for women's mental and physical health would, therefore, entail an amelioration of those stresses which many experience in their everyday social roles as paid and unpaid workers. It would mean affording women the ability to exercise greater

choice and control over their own lives both generally and, specifically, in relation to service use and lifestyle options for health.

As the Liverpool Director of Public Health has pointed out, the Local Health Authorities and Local Authority are faced with a vicious circle in which they continue to lose funding in the light of the city's declining population[15] and yet the picture of social exclusion and polarisation continues unabated (Hussey, 1993). As she argues:

> Improving health against this background is difficult and any Health Plan must emphasise the importance of employment, good housing and education as major influences in people's lives" (ibid, 1993, p.1).

Society has a responsibility to consider these needs of the increasingly socially excluded. Clearly, there has to be less emphasis on health and health care provision and behaviours per se if the underlying causes of health realities in Liverpool are to be adequately addressed. The next section explores this issue of how changes in the national and local policy and practice of health and social care do not meet the needs of women who are inadequately placed to respond. It moves on to outline a future agenda in order that decision-makers might address the processes which contribute to health in the holistic manner described.

[15]There has been a 26 per cent fall in the population from a figure of 608,503 at the 1971 Census of Population to 449,560 in 1991 although a proportion of this can be accounted for by boundary changes in 1974 (Shepton, 1994).

10.3 Implications of the Research for Health and Social Care

10.3.1 Women and Household Health Management

Several lessons can be taken from this study. Some relate to the inadequate assumptions of a health care philosophy which resorts to sweeping generalisations about 'level playing fields' for individuals in society. Others more simply relate to the appropriateness of systems of local health and social care delivery. Above all, it is vitally important that both policy and practice take account of the complexities of people's everyday lives and the characteristics of particular places when addressing local health needs. At present, only where recognisably coherent groups of people with problems of access are found in localised geographical areas are they targeted by health service providers. This is because targeting mechanisms can be developed without necessarily compromising cost efficiency considerations and economies of scale. The Somali and Chinese communities in Liverpool are examples of such distinct populations. There are, however, comparable but far less visible individuals and groups living in dispersed social situations which do impose heavy access problems but who are not generally recognised as needing targeted help. For example, a considerable proportion of young single mothers and middle-aged women carers do not have a paid job and live on an income too low to afford a telephone or private car. If they also lack the social network support to substitute for low levels of economic resources these women will be considerably restricted in terms of their time-space flexibility. Although they may exhibit high levels of health-related need, they may not actually be in a position to access health care or respond to health promotion messages which emphasise certain aspects of lifestyle, for example exercise, in the maintenance of health.

Health and social care providers should not be blind to the difficulties of these less visible 'excluded' groups. It must be borne in mind that for low-income households the balance between the financial and social costs and the perceived benefits of seeking health care may be different from those assumed by a health service which has been shown to be predominantly oriented towards middle-class values. This has been highlighted locally by the case of the Liverpool family who it was reported in the local newspaper, were struck off their doctor's list for making too frequent call-outs at awkward times of the night (Critchley, 1994). Viewed more sympathetically, an unmarried mother with a sick toddler, no money for a taxi and no one to call on to look after her older children whilst she goes to hospital with the youngest probably has no alternative but to call out the doctor at night. As Pearson et al (1993) point out, for these reasons it may be that preventative and routine primary health care are beyond practical reach for most low-income families. In particular, the present study has also demonstrated the difficulties of scheduling competing activities where paid work or multiple caring responsibilities are part of the equation.

Most importantly, in their general roles as paid and unpaid workers and as household health managers in particular, women employ available resources and their own labour in order to achieve the best possible *overall* outcome for family members. In the stressful circumstances of scarce time and few resources it is quite understandable that their own health needs may be neglected. In addition, the evidence shows that moves away from public provision by changes to welfare benefits and the reduction of subsidies may actually have augmented the

distributional inequalities within households. This was demonstrated, in the research reported here, by the comments of one particular woman living in Netherley whose husband had received a pay rise of just £5 per week. The rise meant that she had lost her entitlement to Family Credit and, most significantly, the free prescriptions and dental services which went with it. The routine preventative health care needs of her and her husband were clearly being overlooked as a direct result:

> "We're on a very tight budget ... I don't go to the dentist because we can't afford the dentist anymore. I go with the kids because their's is free but my husband and I don't go anymore because we simply can't afford it. I've waited for glasses for two years. The last time we both got glasses was when I was on Family Credit. Then we could get money towards them so we both got them then ... We simply just can't afford them now so we really don't look after ourselves as much as we should. Same as prescriptions really. Going to the doctor is a nightmare because ... if my husband goes and they put his inhalers on and he needed something else for his chest and then say it was three items £12, that's a heck of a lot out of your money. I mean this is probably why we shy away from the doctor's because we can't afford it half the time. Neither of us has been to the dentist for at least twelve months because of all these changes - I mean it's just a nightmare if you want anything doing now" (Mid 40s - Mother of three looking after home).

10.3.2 Mechanisms for Service Delivery

In attempting to address these issues, more flexible delivery arrangements could, at the very least, be brought into place in order to encourage uptake of primary care by women who do not have the economic or social resources to easily overcome the time-space constraints of their social role commitments. Such measures are of particular importance in the context of the rationalisation of hospital care and some community clinics and the moves towards a primary care led service described in the last section (Department of Health, 1994). The simple provision of additional surgeries out-of-hours and non-emergency surgeries on Saturdays

might, for example, enable more women to attend when family members are available to provide substitute care for dependants. Some might find it more convenient to make combination appointments for themselves and children in order that more than one health care task could be accomplished at each visit. As others (eg. Beckham, 1993) have also shown, some service users see the necessity to make an appointment as a barrier between them and their GP. They prefer systems which offer the additional flexibility of open-access slots. Still greater scope for accessing primary care and offsetting 'unnecessary' home visits might be achieved by an organised and well publicised system of telephone contact with the surgery (Hallam, 1991 and 1992). Finally, there is also considerable potential to utilise time away from home commitments by means of the expansion of paid workplace-based screening programmes for a generation of women increasingly being taken into flexible forms of employment (Burton, Erickson and Briones, 1991). There might also be scope to utilise the premises of leisure-based services such as bingo halls. At present, however, the emphasis of policy in this area is once again on health education and the encouragement of individuals to take action on healthy lifestyle behaviours (Health of the Nation Workplace Task Force, 1994).

Each of the above measures relates to the physical and perceptual accessibility of curative and preventative primary health services in terms of time and place. However, the women in Netherley and Woolton also raised the issue of adequate access to care in terms of the nature of social exchange in the primary care setting. They emphasised the significance of availability of information in their freedom to make informed choices. In particular, they talked of the impact of a

doctor's manner being sensitive and appropriate and the need for an adequate explanation of diagnoses and treatment. As one woman put it:

> "I don't just want a bottle of medicine - I want to know why" (Mid 30s - Income Support).

As in other studies (eg. Cooke and Ronalds, 1985; Graffy, 1990; Hooper, 1989), participants commented on the particularly important role of women GPs and practice nurses in perceptions of and ease of access to preventative advice and screening. For example, having previously refused Hormone Replacement Therapy for brittle bones from a male GP, one woman said:

> "... I didn't want to go into it, you know, because it was a man and he was only young. But when it was the woman and she said, 'I think it would help your bones', and things like that so I could talk to her" (Late 50s - Recently retired).

Another described her feelings about cervical cytology screening at a surgery with no woman GP:

> "I prefer the nurse because it's only women have smear tests and I think only another woman can understand how you're feeling at that time. So it's easier, it's far more relaxed with a woman doing it. I'd probably feel that way if there was a female doctor. Yes, I know I'd feel happier with a female doctor ... It doesn't really bother me just at normal everyday things - I get a bit worried about seeing a male doctor when you're talking about purely female conditions ..." (Early 40s - Full-time secretary).

10.3.3 The Social Relations of Health and Social Care

However, service providers do not necessarily assume that current health care facilities and opening times and social care services are convenient for every potential user. The malfunctioning of the system which has been identified is often less a function of lack of understanding than of historically derived power structures in the health service and society in general. These are male dominated and

particularly male consultant dominated within the health service (Roberts, 1985). For example, while large numbers of mothers have been drawn into the paid labour market in recent years, the ascribed role of women as carers means that it is generally assumed that they will be easily available during the middle of the day to take children to immunisation appointments or check-ups. The fact that a significant proportion of health promotion clinics are held at GP surgeries during the daytime was a further issue noted in the last chapter. An indication of the scale of the problem is provided by the responses of surgeries in Netherley and Woolton who replied to the GP questionnaire. The three surgeries were providing a total of 27 health promotion clinics at the time of the field work. Just one, admittedly a Well Woman Clinic, took place in the early evening between 4-7pm. Pearson and Spencer (1989) showed, however, that Well Woman Clinics are poorly attended in the early evening because this is one of the busiest time periods for households with children.

As noted in Chapter Two, the same historically-derived power structures have further implications for women in the area of social care because policies carry an explicit, ideological statement about which family members should support dependants. This has consistently been translated into a lack of formal support from the health and social services particularly for middle-aged, married women carers compared to men (Parker and Lawton, 1994). In the view of Land (1991), the present proliferation of professionals in the formal social care sector and the moves for local authorities to become 'enablers' rather than providers, will cause systems of care to become even less flexible to the needs of women carers. That opinion

is corroborated by the growing body of evidence on increasing unmet need amongst informal carers (Brown and Smith, 1993; Dobson, 1995; Nolan, Keady and Grant, 1995; Philp et al, 1995; Poole, 1993a and 1993b; Warner, 1994). In particular, problems are emerging because of difficulties coordinating multidisciplinary care packages within existing structures of health and social care and the emphasis now being placed on financial efficiency and constraints (Bull, 1995; Gostick, 1995).

This picture of increasing unmet need was also demonstrated by the present study. Particular problems were associated with the changing nature of local authority home care services whereby home helps have become home care assistants. They have reduced their provision of help with domestic tasks and increased their levels of personal care work formerly undertaken by the district nursing services. The following interview extract illustrates the outcome from the point of view of the service provider:

> "... Whereas the home help department used to be - everybody used to think it was like a cleaning service for the elderly - that's very low on the priority list now because we've got a lot more personal care. I mean we get people up, we wash and dress them, feed them. Sometimes we'll go into people three times a day, seven days a week ... District nurses used to have a bathing service so if anybody was incontinent or things like that they'd send nurses in to bath them ... Now they'll only go out to bath or wash down if there's a medical reason ... So it's coming onto us ... and less people are getting a housework service - that's one of our main problems. I mean, at the moment, I've got sixty on a waiting list for housework service because they don't need personal care ... If I haven't got a home help free [for user needing personal care] I have to take housework cases off - put them on the waiting list" (Liverpool Social Services Home Care Manager interviewed 1994).

In addition, the number of local authorities charging for non-residential social care services has increased enormously since 1993 and this may deter some service users from seeking help (Harvey and Robertson, 1995).

As Land (1991) predicted, for the carer at home, these moves mean a much less personal and comprehensive service and more "patching and piecing together" (p.17) of their own time and labour input. Of course, it is those who can afford to pay for alternative, more flexible services who are experiencing the least disruption (Warner, 1994). In particular, carers across all the groups interviewed in Netherley and Woolton described not receiving or losing the small amount of formal support they did receive if they, as the woman in the family, appeared to be coping:

> "Well she [mother] used to have a home help regular every Monday and now with them cutting down that much that she's lucky if she gets them once in three weeks ..." (Early 50s - Part-time catering worker).

> "If he [father] was on his own he'd get a home help wouldn't he? Well he doesn't need a home help because I'm here .." (Early 50s - Invalid Care Allowance).

> "[Do you ever use respite care?] I would do if I could get any but we can't get any. There just isn't enough to go around and I think our social workers perceive us as capable people so we tend to get shoved at the bottom of the list for it ... We wouldn't want much - just a weekend every six months would be enough really" (Late 30s - Full-time teacher and mother of Down's Syndrome child).

As another Netherley woman explained, moves towards increased financial efficiency in the health service which centre on shorter stays in hospital and greater levels of aftercare in people's own homes, also have implications in the everyday household context. In particular, expenditure restraints which have required

reductions in formal support such as district nursing services have meant a decline in, what for many people, are essential back-up services:

> "I don't like it - when you go and have an operation now they send you home far too quick. I mean you're in having an operation one day and say two days later you're not even being looked at. I mean that's where the problems set in, you know when people are ill, they don't get over it do they? ... I had to go into hospital last year for tests on my stomach and do you know I had to come home with a tube up my nose and into my stomach and they never told me what to expect. Now a couple of years ago if you had to go in for tests they'd keep you in for a couple of days, do all the tests they had to do on you and then send you home. My daughter nearly passed out when I came out the door with the tubes in ... They had to be in twenty-four hours and I had to go back the next day and when you've got something up your nose and into your stomach and its going down the back of your throat can you imagine how uncomfortable it is? You feel as though you're choking don't you? So I said to the nurse who put it in 'Well in the meantime if I feel as though I'm going to choke what happens?' And she said to just pull it out! Now I didn't know how to pull it out so I just sat up in bed all night and made sure and I just kept sipping water all night! But she said just pull it out! ... And our mate she had a big op last year. She had cancer and they took all her throat away. Now she was home six weeks and she still had her stitches in. Her daughter had to ring the hospital and ask why her mother's stitches hadn't been removed and they said oh those stitches should have been removed five days after the operation!" (Mid 50s - Looking after home).

A final concern to emerge here, in relation to how the situation of informal carers may be being exacerbated by rationalisation of health and social care services, is the issue of potential differences between the needs of the carer and those of the cared-for. Those differences are exemplified by the following comments from the interviews:

> "[Could you do with any help?] Not really, it's not help I want, it's a break - to get away from it and I just can't. And, as I say, I'm not the type to say, 'Dad, you're going in a home and that's it'... [Can he not get respite care at all?] Well I haven't tried that because it's just the sort of person he is. [He doesn't think you need a break?] No - not interested" (Early 50s - Invalid Care Allowance).

> "... And she's so independent my Mum. She didn't like the idea of a home help anyway. Because when I used to go round and do her windows - those stupid little square ones - and I hated doing them God forgive me. But, as I say, when the home help comes and she says, 'Oh no, our June'll do that and our June'll do this'. Mind you, I just get on with it" (Early 50s - Part-time catering worker).

As well as increasing demands on time, there are also financial consequences for the women on whom the policies of care in the community depend (Crossroads, 1993). In particular, research highlights the problems of those who experience greater financial dependency as a direct result of providing informal care (Glendinning, 1992). As local authorities have been required to manage rather than provide packages of care it is important to consider where that will leave women who provide care to the family. The issue remains as to how care managers should identify the client on behalf of whom care packages are being managed. Is it the carer or the person being cared for or both? How are their possibly conflicting needs and preferences to be reconciled?

This is an issue which also needs to be addressed at a level wider than simply the provision of direct support from social care services. For example, although some now recognise the employment policy issues relating to women's dual roles as mothers and paid workers, there is little acknowledgement in policy of problems encountered by middle-aged women who may wish or need to combine a paid job with caring for an elderly relative (Furst, 1990; Henwood, 1989). The only official statement was issued two years ago and that took the form simply of *advice* to *individual employers* (Department of Health, 1993). What is significant is that although there are parallels between childcare and caring for adult dependants there are also significant differences as this study has illustrated. Responsibility for

a child typically decreases with the years whereas with older people the level of dependency often increases. Another crucial difference is the lack of predictability of care needs in comparison, for instance, to an employee's requirement for leave following childbirth. As Henwood (1989) argues this:

> "... has implications for both employment policy and practice ... If carers are to be workers too, then their work will need to be adaptable to their home circumstances to a much greater extent than is currently the case. For some, new technologies may facilitate the expansion of home working. But the scope for this should not be overstated: the technical sophistication of such work will mean it is not accessible to all, nor would it be ideal for many of those caring for someone within the same household ... Career breaks need to become similarly responsive ... in a way which is of much greater use than ad hoc arrangements for compassionate leave of absence to deal with domestic crises" (ibid, 1989, p.3).

Above all, it is clear that the time input and considerable skills obtained by women through *informal* caring are consistently devalued in the paid labour market and by the emphasis on mechanisms formally to acquire caring knowledge such as in nursing (Land, 1991). When women are faced with the necessity to return to paid work they often face insurmountable barriers such as those highlighted by the case reported in the following newspaper extract:

> "[One carer] ... had more than 20 years' service as a senior finance officer for an education authority but was forced to give up her job in order to look after her mother who had Alzheimer's disease. Six years later, after her mother had died, she was left with no savings and poor pension entitlements and by then she had few contacts and no confidence to restart her career. Her employer had no career break scheme or any retraining arrangement" (Furst, 1990, p.1).

In addition, the health and social care reforms seem only to enhance this value placed on 'professional' skills, for example by making social workers into care managers.

The issue is, therefore, much wider than simply the introduction of flexible paid-working practices by employers. It involves re-conceptualising the boundaries between formal and informal care and providing health and social care services which offer non-sexist alternatives to family support (Croft, 1986). As Henwood (1989) continues:

> "The interconnections between employment and social policy exist both at the level of service and principle. In service terms, more day care, domiciliary services and other support will be required if carers are to have opportunities more fully to participate in society - including within the labour market. More generally, community care today depends heavily on the availability and willingness of individuals to take on major caring responsibilities. The future [however] is uncertain ... As more and more women who have benefitted from higher education, career opportunities and expectations of continued employment enter the caring stage of their life cycle, the willingness simply to give it all up may be much less than in the past ... Imagination will be needed if solutions are to match the needs of individuals. Questions of rights and responsibilities loom large. The appropriate balance between family and state; home and work; employer and employee; carer and cared for; and between men and women must all come under scrutiny. Without clear thinking and planned strategies, a minority of citizens will increasingly shoulder an inequitable burden of care ..." (ibid, 1989,p.4).

What the present study has argued is that not only is this increasing burden likely to be shared unequally between men and women, it will also be shouldered inequitably amongst women themselves. Henwood (1989) talks of those women who have benefitted from higher education and career opportunities being unwilling to become informal carers. She does not mention women in socially excluded groups in places such as Liverpool whose resources to choose their social role responsibilities are severely limited. As Croft (1986) maintains, 'care' in itself may be an unhelpful organising concept for women in developing an understanding of and responding to social need. Instead the emphasis should be on their social and

economic exploitation as the predominant carers in society and the inequalities amongst women themselves in susceptibility to that exploitation.

What is clearly needed in the so-called consumer-responsive climate of health and social welfare services is for truly user and carer-led changes which recognise that the interests of the cared for and the carer are by no means identical (Poole, 1993a; Ungerson, 1995). So far, however, it is proving difficult even for much more visible groups than carers to contribute effectively at a basic level to service planning. This is highlighted by representatives of disabled people who are hampered by a lack of resources in conveying the needs of their constituencies to the planning committees for Community Care (Glendinning and Bewley, 1994). Often the disabled people and members of community groups who do sit on the relevant committees are co-opted by managers and do not actually *represent* the views of other service users (Mayo, 1994). It is vital that women, and carers in particular, be empowered to voice their own concerns at the outset as opposed to responding or merely accepting and 'getting on with' changes as they happen to them. The needs of carers are as valid as those of the people who they look after, but the potential mis-match between their requirements is only now beginning to be perceived by service planners (Ellis, 1993). Although some GP practices in the local context, for example Netherley Health Centre, are involving patients by means of satisfaction surveys and have instigated changes as a direct result, such action is not widespread (Netherley Health Centre, 1992). There is an urgent need to build on these ad hoc measures in order to develop more effective feedback mechanisms than exist at present in the health and social care services. Local people should, for

example, have as much voice as their GPs in the Neighbourhood planning process of the Liverpool LHAs. For this to come about it is vital that the internal power structures and workings of the services evolve from a flow of information which is predominantly 'top-down' to one which is 'bottom-up' with women no longer viewed as pawns in the hierarchical system. As Oakley (1993b) argues, the necessity for health education programmes which promote healthy lifestyles is more than matched by the need for professionals to be educated in what women *already* know about health and social care.

Equally, for such a reorientation to occur in the micro-spatial and gender aspects of health and social care, there is a need to develop the abilities of current and potential service users to contribute to planning. This must mean bringing together otherwise isolated carers, both male and female, to form self-help networks in the community (cf. Dominelli, 1990). Campion et al (1988), for example, demonstrate the potential of this mobilisation of community resources to address needs which remain unmet by the statutory health and social care services. At the very least, therefore, there is a need to build on outreach programmes for information provision and training begun by voluntary groups such as the Women's Health, Information and Support Centre (WHISC) in Liverpool which is run by women for women. At a very basic level, WHISC volunteers offer support to women who are concerned about their health in the confidential and informal setting of a city-centre drop-in point. The group's 'health bus' also goes into targeted areas taking information to women who find it difficult to get to the city centre. Childcare facilities are provided so that women are free to take full advantage of the

opportunities the bus provides. In 1993, the health bus was used by North Mersey Community (NHS) Trust in order to raise awareness of breast and cervical screening services in low-income areas where women had been invited to attend by their GP but where response to screening is generally low. WHISC also offers workshops and courses for women who are disadvantaged in terms of their access to health care in their own community settings with opportunities to take up services where applicable. There is also an established programme of training courses sponsored by Liverpool University which helps women to return to the labour market and develop careers in the area of health promotion. By taking an holistic view of health and health care WHISC aims to improve the well-being and hence the health of all women in Liverpool.

The following extract from an interview in Netherley dramatically illustrates the potential benefits for women of such a holistic approach:

> "I joined a local women's group ... and we used to have a couple of women doctors who came in and explained things. It was all women and they explained things that you didn't like asking the GP about ... It started off - when we first moved up on this estate we used to have a lot of high rise flats. It was like Colditz ... and there was nothing for people living in them with young children and they started a home-link group. And it was in one of the flats which was converted ... the children had a creche downstairs but upstairs in the three bedrooms they had women's groups and it was groups of interests. I had Steve [son now aged 17] - he was only a couple of months old and I was back at work of a day and Ian [husband] was away [working abroad]. I used to finish work at one and Steve - there were no nurseries for his age see and this group was only over there and I just strolled in one day and took him ... And so I did two O Levels there and then we did Women's studies, a history of women in Liverpool, you know interesting things like that. It was sixteen years ago when I joined ... Lots of the girls on the estate went and have gone into further education through that - because that's what I did when I went. Because before I'd never have thought of going back to education and I wasn't really particularly interested. I was

> quite happy with my little job in the nursing home and I was quite happy, you know, being at home. It was only when I went there and started looking at the way different people were working and I thought, 'I can do that', and I can can't I?" (Late 40s - Full-time administrator).

Importantly, however, Campion et al (1988) note that only six of the thirty-two groups they studied were specifically concerned with working-class localities. In all of the other groups, membership was overwhelmingly middle-class. Of the groups organised by volunteers:

> "... the majority [were organised] from private homes in medium and higher income owner-occupier areas and were thus dependent on the organisers' hidden resources of time, money, effort and accommodation ... Lacking these resources, those groups in poorer areas concerned with general health issues were unable to function effectively without special funding" (ibid, 1988, p.454).

The European Community is increasingly recognising the potential of community empowerment and a holistic approach to issues of quality of life and social and economic regeneration in areas of social exclusion such as Liverpool. The Commission acknowledges, for example, the links between ascribed caring roles and the social exclusion particularly of low-income women. Specifically, a recent discussion document noted that community projects which offer jobs to local women are only viable once problems of caring arrangements had been solved (European Commission, 1995). Overall, the Commission is increasingly recognising that the service sector, particulary child and eldercare, is one of the areas with greatest potential for future employment generation. It acknowledges, therefore, the potential beneficial links between the significant and continuing rise in the numbers of women who wish to take up paid employment, the growing caring needs of an expanding elderly population and the applicability to paid employment of skills

which women acquire through informal caring. Given the emphasis of this dissertation on the need for an holistic approach to local and individual health needs, the potential which this type of approach holds for improvement to health and well-being is clear. In the context of the prevailing philosophy of health and social care, therefore, such an approach calls as much for general empowerment as it does for changes to structures of service delivery per se.

10.4 Summary and Reflections on the Role of Research

Holistic viewpoints on health engage not just with health per se but with all the other elements of social relations operating in society. The re-organisation of health and social care has, however, been founded on a particular ideology - that of the marketplace - in which 'needs' are primarily represented as 'demand'; a decontextualised measure of revealed individual utility for a good or service. When considered in relation to the social construction of caring, need equated with demand and utility loses much of its real meaning and context. That context is one which it is critical for health care providers to take into account if they are to meet the inherent inequalities encountered by women in their everyday lives. For example, although the principal aim of the reforms has been to shift provision away from institutionalised services onto primary and community care, the resources needed to support the stated objectives in a manner which would benefit service users have not been forthcoming. The provision of centralised hospital services has also been set within a strong agenda of efficiency and cost-saving to the service but often with added costs to the service user. In particular, market model notions of a 'level playing field' of opportunity, for example to access services and adopt healthy

lifestyles, are uninformed by real social conditions. Where this leads to blaming the victim for 'inappropriate' behaviours, it can only be disabling to the effective working of health and social care.

The main point is that health and social care continues to be provided in a manner which is male-dominated and focused on the perceived role of the caring professions. For women, this has produced and reproduced an inaccessibility based on social and cultural mores and issues of self perception and identification. 'Flexible' provision is part of the framework for modern health care policy. There are, however, many flexibilities and this thesis reveals some of those of particular value to women in the outer suburban context. Engagement is what is required. Women and carers in particular, must be engaged in debates about flexibility and concepts of need. They must be asked for their views about appropriate provision of health and social care and health promotion strategies. 'Bottom up' is of itself not sufficient; health needs will only be met appropriately and the health status of the population will only improve if women are allowed a voice.

As Kelly, Burton and Regan (1994) note there are different viewpoints on the role, specifically, of research in this empowerment process:

> "... Whilst one version of feminist practice recommends listening, recording and a non-judgemental stance, there is another possibility which is to raise/offer different ways of understanding experience ... If we accept that conducting and participating in research is an interactive process, what participants get or take from it should concern us. Whilst we are not claiming that researchers have the 'power' to change individuals' attitudes, behaviour or perceptions, we do have the power to construct research which involves questioning dominant/oppressive discourses; this can occur within the process of

'doing' research, and need not be limited to the analysis and writing-up stages ..." (ibid, p.39 and p.40).

McDowell (1992b), however, asks if it is appropriate to endeavour to empower actual participants in this way as that in itself may:

> "... reveal contestable notions of domination ... A more appropriate aim may be to provide the means towards empowerment ..." (ibid, 1992, p.408).

In this context, there is clearly a need:

> "... to focus attention on difference as a means of more fully representing the complexities of the social world. Where issues of social policy are concerned, it becomes all the more necessary ... that these policies, often 'formulated on the macro level' should 'translate effectively on the microlevel of individual and group experience ..." (Opie, 1992, p.53).

It is by reporting on the implications of the micro level, or differential 'everyday' context for health-related behaviours, that I hope this research in Netherley and Woolton will contribute in some positive way to policy-related change.

APPENDIX 1

POSTAL SURVEY OF GP SURGERIES

30th September 1992

SURGERY ADDRESS

Dear Dr XXXX,

As a post-graduate in the above department, I am working on an ESRC-funded project entitled:

Social Roles and Uptake of Health Care: A Case Study of Women in Liverpool

My supervisors are Dr Maggie Pearson, in the Faculty of Medicine and Mr Richard Meegan, in the Department of Geography. At the moment, I am waiting for the Ethics Committee to approve the research. I have also contacted Dr Robert Barnett, Secretary to the Local Medical Committee, who suggested that you may help me.

I enclose a brief outline of the project for your information. As you can see, I will be interviewing a sample of women, contacted via the Electoral Register, in order to establish how work and household commitments influence their use of health services.

In doing this, it would help me a great deal to know exactly what services are available in primary care in my study areas of Netherley and Woolton. I realise that you are very busy but, as yours is one of only a small number of practices in these areas, your support is important. If you could complete the enclosed one-page questionnaire and return it in the envelope provided I would be very grateful. If possible, could you also send me a copy of your practice leaflet.

Perhaps we could arrange a meeting so that I can tell you more about the project?

Thank you very much for your help.

Yours sincerely,

Ruth Young (Ms)
Graduate Research Student

Encs

GP QUESTIONNAIRE - NETHERLEY HEALTH CENTRE

1) WHAT ARE THE NORMAL HOURS FOR GENERAL SURGERY AT THIS PRACTICE?
In the following table, please specify times for morning and afternoon surgeries and tick to indicate if this is on an open surgery or appointments basis, or a mixture of the two systems.

DAY OF WEEK	MORNING SURGERY TIMES	IN THE MORNINGS, IS THERE OPEN SURGERY, AN APPOINTMENT SYSTEM OR A MIXTURE?			AFTER-NOON SURGERY TIMES	IN THE AFTERNOONS, IS THERE OPEN SURGERY, AN APPOINTMENT SYSTEM OR A MIXTURE?		
		OPEN	APTS	MIX		OPEN	APTS	MIX
Mon	to				to			
Tues	to				to			
Weds	to				to			
Thur	to				to			
Fri	to				to			
Sat	to				to			

2) THE FOLLOWING IS A RECORD, OBTAINED FROM LIVERPOOL FHSA, OF THE HEALTH PROMOTION CLINICS BELIEVED TO TAKE PLACE AT YOUR SURGERY:

CLINIC	WEEKDAY	TIME
Asthma/Chest	Mon	Afternoon
Diabetic	Fri	2-3pm + Occas extra clinic
Dietetic	Second and fourth Tues	
Dieticians	Alternate Tues	9.30am-12.30pm
Hyperlipidaemia	Fri	9.30-11am
Hypertension	Weds	10.30am-12.00pm
Well Person	Tues Thur	2-3.30pm am
Well Woman	Weds	1.30-3pm
No Smoking Awareness	3 One off days	

Please could you fill in the gaps on the above table and amend the clinic list, weekday and times as appropriate. Please specify any other clinics in the space below.

OTHER CLINICS _____ WEEKDAY AND TIME _____

APPENDIX 2A

POSTAL SURVEY OF WOMEN - QUESTIONNAIRE

The University of Liverpool

Ruth Young
Department of Geography
LIVERPOOL L69 3BX

Tel: 794-2874

USE OF HEALTH SERVICES BY WOMEN IN LIVERPOOL

NETHERLEY

ALL OF THE INFORMATION YOU GIVE WILL BE KEPT COMPLETELY PRIVATE

PLEASE PLACE A TICK IN THE BOX WHICH BEST FITS YOUR ANSWER OR WRITE THE ANSWER IN THE SPACE GIVEN

SECTION A: HEALTH AND USE OF HEALTH SERVICES

YOUR HEALTH

A1 In the last two weeks, have you cut down on the things you normally do because of your health? YES ☐ NO ☐

If YES, what was the matter with you? .....

A2 Do you have any health problems which have troubled you for a long time? YES ☐ NO ☐

i) If YES, what is the matter with you? .....

ii) Does this limit the things you can do, compared with most people your age? YES ☐ NO ☐ DON'T KNOW ☐

YOUR USE OF HEALTH CARE

A3 Are you registered with a GP (family doctor)? YES ☐ NO ☐

A4 During the last 6 months, have you talked to a GP **about your own** health? YES ☐ NO ☐

If YES, can you remember roughly how many times? ..... (times)

A5 In the last 6 months, have you talked to a doctor about the health of anyone else who **lives with** you (eg. children)? YES ☐ NO ☐

A6 In the last 6 months, have you talked to a doctor about the health of anyone who does **not live with** you (eg. elderly parents, in-laws etc)? YES ☐ NO ☐

A7 Have you ever had a cervical smear test? YES ☐ NO ☐ DON'T KNOW ☐

If YES, how long ago was your last one? (months or years) .....

A8 During the last year, have you been to hospital? YES ☐ NO ☐

If YES, please tick whichever of the following boxes aplied to you.

IN-PATIENT (stayed over night or longer) ☐ OUT-PATIENT with appointment ☐

CASUALTY patient ☐

A9 During the last year, have you used any other health services **not** mentioned already (eg. well woman clinic)? YES ☐ NO ☐

If YES, please state which. .....

SECTION B: HOW YOUR TIME IS SPENT

OTHER PEOPLE

B1 Who normally lives with you (eg. daughter, husband/partner, mother) and how old are they?

RELATIONSHIP _____ AGE _____

_____ _____

_____ _____

_____ _____

_____ _____

B2 Do you look after any of the people who **live with** you because they are permanently sick, elderly or disabled? YES ☐ NO ☐

If YES, please state who. RELATIONSHIP _____ _____

B3 Do you help anyone, who does **not live with** you, to look after themselves? YES ☐ NO ☐

If YES, please state who, how old they are and where they live (eg. Bootle).

RELATIONSHIP _____ AGE ____ WHERE THEY LIVE _____

_____ ____ _____

B4 Do friends or relatives, who do **not** live with you, ever help you out by childminding, giving car lifts or in other ways? YES ☐ NO ☐

If YES, is this occasionally, regulary or never? (please tick whichever boxes apply to you)

	OCCASIONALLY	REGULARLY	NEVER
Childminding	☐	☐	☐
Giving a lift in car	☐	☐	☐
Other (please specify) _____	☐	☐	☐

YOUR EMPLOYMENT

B5 Do you have a paid job? YES ☐ NO ☐

If YES, please answer B6 i) - iv) and B7 **If NO, go to B8**

B6

i) Is your job ? FULL-TIME ☐ PART-TIME ☐

ii) What kind of work do you do? (job title, regular duties/responsibilities) _____

_____

iii) Are you ? WORKING FOR AN EMPLOYER ☐ SELF-EMPLOYED ☐

iv) Do you have to do any of the following? (please tick whichever apply to you)

WORK AT HOME ☐ OVERTIME ☐ ON CALL ☐ SHIFT WORK ☐

B7 If you have small children living with you, who normally looks after them (eg. childminder, husband/partner, yourself, relative, friend, nursery, creche)?

i) When you are **not at** work _____

ii) When you are **at** work _____

B8 If you are not in paid work, please tick which of the following apply to you

REGISTERED UNEMPLOYED ☐ LOOKING AFTER HOME ☐

RETIRED ☐ REGISTERED PERMANENTLY SICK OR DISABLED ☐

OTHER ☐ (please specify) _____

SECTION C: GENERAL INFORMATION

C1 How old are you? _____ (years)

C2 At the moment are you?

SINGLE AND NEVER BEEN MARRIED ☐

LIVING WITH HUSBAND/PARTNER ☐

WIDOWED/DIVORCED/SEPARATED ☐

C3 How would you describe yourself? (please tick a box or fill in as appropriate)

BLACK CARIBBEAN ☐ BLACK OTHER ☐

BLACK AFRICAN ☐ (please specify) _____

INDIAN ☐ PAKISTANI ☐

BANGLADESHI ☐ CHINESE ☐

WHITE ☐ ANY OTHER ETHNIC GROUP ☐

(please specify) _____

C4 Is your home?

OWNED/MORTGAGED BY YOU AND YOUR FAMILY ☐ RENTED ☐

OTHER ☐ (please specify) _____

C5 Can you drive a car? YES ☐ NO ☐

C6 Does anyone in your house have a car? YES ☐ NO ☐

If YES, who uses the car most regularly (eg. yourself, son etc.)? _____

C7 Do you have a telephone? YES ☐ NO ☐

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE IN THE STAMPED ADDRESSED ENVELOPE PROVIDED

I WILL BE CONTACTING SOME WOMEN FOR THE SECOND STAGE OF THIS STUDY AND HOPE YOU WILL FEEL ABLE TO TAKE PART

THANK YOU AGAIN FOR YOUR HELP IN FILLING OUT THIS QUESTIONNAIRE

APPENDIX 2B

POSTAL QUESTIONNAIRE TO WOMEN - FIRST MAILING

3rd February 1993

Dear

I am a student at Liverpool University working on a project about how women's family or work commitments affect their use of health services. The results will be made available to the local health services to show how opening times of GP surgeries and health clinics could be improved to suit more people.

You are one of a small number of women being asked to take part in the study. Your address was chosen randomly from the electoral register.

A short questionnaire is enclosed with this letter. The answers will give me a general picture of how women's time is spent and which local health services they use. Any information you give will be kept strictly private. The questionnaire has an identification number only.

I hope you feel able to complete and return the questionnaire in the enclosed stamped addressed envelope, as any information which you can give me would be very helpful.

If you do not wish to take part in the study, please return the blank questionnaire to avoid being sent a reminder.

If you have any questions at all I would be happy to answer them. Please write or phone. The number is 794-2874. If I'm not in you'll be able to leave a messsage.

Thank you very much for all your help.

Yours sincerely,

Ruth Young

APPENDIX 2C

POSTAL QUESTIONNAIRE TO WOMEN - SECOND MAILING

The University of Liverpool 15th February 1993

A fortnight ago I sent a questionnaire to you, asking about your use of local health services. Your address was chosen randomly from the electoral register. If you have already completed and returned the questionnaire, thank you very much for your help.

If not, it would be really helpful if you could return it as soon as possible. I have only contacted a small number of women so your reply is very important to me.

If you did not receive a questionnaire, or it got misplaced, please phone me (794-2874) and I will send you another one today.

Yours sincerely,

Ruth Young
Geography Student

APPENDIX 2D

POSTAL QUESTIONNAIRE TO WOMEN - THIRD MAILING

3rd March 1993

Dear

A month ago I sent a questionnaire to you asking about your use of local health services. The number of completed questionnaires returned so far is very encouraging. However, I do not appear to have received your questionnaire as yet.

Your reply is very important to the accuracy of my study because those of you who have not yet responded may well make different use of available health care than those who have. Even if some of the questions don't seem to apply to you I will still be interested in your answers.

In case my other letters did not reach you, I am sending a replacement questionnaire. It would be very helpful if you could complete and return it in the enclosed stamped addressed envelope as soon as possible. The questionnaire has an identification number only. Any information you feel able to give will be kept strictly private.

Again, if you do not wish to take part in the study, please return the blank questionnaire.

Please write or phone (794-2874) if you have any questions at all. If I'm not in you'll be able to leave a message.

Your contribution to the success of this study will be greatly appreciated.

Yours sincerely,

Ruth Young
Geography Student

APPENDIX 2E

POSTAL QUESTIONNAIRE TO WOMEN - ACKNOWLEDGEMENT

The University of Liverpool 17th February 1993

I am writing to thank you for filling out and returning the questionnaire, which I sent to you a fortnight ago, asking about your use of local health services.

If I contact you for the second stage of the study, I hope you will feel able to take part.

Thank you again for all your help.

Yours sincerely,

Ruth Young
Geography Student

APPENDIX 3

CORRESPONDENCE AND HAND ANALYSES TO LOCATE IN-DEPTH INTERVIEW PARTICIPANTS - POSTAL SURVEY VARIABLES

Variables were configured on the basis of the decision-making framework shown in Figure 4.1.

A) TIME COMMITMENT TO SOCIAL ROLES

i) Paid Labour

QB6i) 0 NO JOB
1 PART-TIME
2 FULL-TIME

QB6iv) Y/N WORK AT HOME
Y/N OVERTIME
Y/N ON CALL
Y/N SHIFT WORK

ii) Unpaid Labour

QB1 Primary responsibility for children/grandchildren distinguished by school-ages - Interested in time implications of different school opening times not number of children at this stage.

Y/N PRE-SCHOOL (Age 0-4);
Y/N PRIMARY SCHOOL (Age 5-10);
Y/N SECONDARY SCHOOL (Age 11-15);

QB2 Y/N SICK, ELDERLY OR DISABLED PERSON AT HOME

QB3 Y/N LOOK AFTER SOMEONE IN ANOTHER HOUSEHOLD

B) PERSONAL HEALTH STATUS

QA1 Y/N LIMITING LONG-STANDING ILLNESS

QB8 Y/N REGISTERED PERMANENTLY SICK OR DISABLED

C) ACCESS TO ECONOMIC RESOURCES

QB5 Y/N PAID JOB

QB6ii) Paid job description assigned to Socio-economic groups (SEGs). The abbreviated version of the full SEG classification adopted for the coding scale was based on the following (cf. OPCS and General Register Office for Scotland, 1992, p.41):

1,2	EMPLOYERS AND MANAGERS
3,4	PROFESSIONAL WORKERS
5	INTERMEDIATE NON-MANUAL WORKERS
6	JUNIOR NON-MANUAL WORKERS
8,9,12	MANUAL WORKERS (FOREMEN, SUPERVISORS, SKILLED AND OWN ACCOUNT)
7,10	PERSONAL SERVICE AND SEMI-SKILLED MANUAL WORKERS
11	UNSKILLED MANUAL WORKERS
13,14,15	FARMERS AND AGRICULTURAL WORKERS
16,17	MEMBERS OF ARMED FORCES AND INADEQUATELY DESCRIBED OCCUPATIONS

None of the women in the respondent group actually fell into the categories of SEG 8,9,12 or SEG 13,14,15. The latter was omitted from the final coding because it comprises a variety of mixed income groups.

QB8 Category if not in paid work.

Y/N REGISTERED UNEMPLOYED
Y/N INCOME SUPPORT
Y/N LOOKING AFTER HOME
Y/N STUDENT
Y/N REGISTERED SICK OR DISABLED
Y/N RETIRED

QC4-C7 Indicators of income and access to private transport

QC4 1 HOME RENTED
2 HOME OWNED/MORTGAGED

QC6 Y/N ABLE TO DRIVE

QC6	0	NO CAR IN HOUSEHOLD
	1	SOMEONE ELSE HAS MOST REGULAR USE
	2	CAR USE SHARED WITH MORE THAN ONE OTHER
	3	CAR SHARED EQUALLY WITH ONE OTHER
	4	CAR USED BY RESPONDENT MOST OFTEN
QC7	Y/N	TELEPHONE

In addition, because for timing reasons the social areas used for stratifying the postal questionnaire were based on the 1981 Census of Population, it was decided to create an income variable from 1991 Census of Population data available later. In order to do this, respondents' postcodes were assigned to an Enumeration District (ED) using the April 1991 Central Postcode Directory (CPD). Those postcodes which were missing because they had been created after the CPD were located on an ED map using grid references. Using the 10% sample of the 1991 Census on SASPAC[16], the relevant ED proportions of heads of household in SEGs were obtained. EDs were then grouped on the basis of these characteristics using cluster analysis on SPSS-x (Everitt, 1974; du Toit, Steyn and Stumpf, 1986). It was these groupings which were used as an additional income variable in the analysis. SEGs were used because data were unavailable at the time to match postcodes to Social Class. However, because of reservations about attributing the characteristics even of small areas to actual women and because inaccuracies existed in the census data such that SEG percentages did not always add up to 100%, the ED SEG variable was treated with considerable caution.

D) ACCESS TO SOCIAL RESOURCES

QB4	0	NO HELP FROM FRIENDS AND RELATIVES
	1	OCCASIONAL HELP OF WHATEVER SORT
	2	REGULAR HELP OF WHATEVER SORT
QC2	Y/N	OTHER ADULT IN HOUSEHOLD

[16]SASPAC is a computer software package designed for the interrogation of the 1991 Census of Population Small Area (SAS) and Local Base Statistics (LBS) (Local Government Management Board and London Research Centre, 1992).

APPENDIX 4

IN-DEPTH INTERVIEW SCHEDULE

DIARY KEPT FOR A FEW DAYS PRIOR

1) Establish shape of household roles - woman and partner etc.

2) Discuss typical diary day in relation to time-space.

3) How caring tasks are handled - children, other dependants, general household tasks.

4) Woman's own health and reasons for health care use on the postal questionnaire. Any other health care use by woman since postal questionnaire was filled out. Health and health care use by and for other family members and dependants.

5) Time-space in relation to health care + vignettes.

1) ESTABLISH SHAPE OF HOUSEHOLD ROLES

I realise some of the questions I'm going to ask you were covered on the questionnaire, but I'd like to check if things have changed since then. If there are any questions you don't want to answer just say.

- Do you currently work?

  Full or part-time?
  What hours on what days?
  Where do you work ie. how for from home?
  What type of work?

- Or are you registered unemployed, registered permanently sick or disabled, looking after the home, other etc?

  What was your last job? When?

- Who else lives with you?

  Children How many? Ages?
  Are they pre-school, primary school, secondary school, FE, HE, YT Training, employed full or part-time?

  Other relatives Who? Ages?
  Are they working full or part-time, registered unemployed, disabled, elderly.

- Does your husband/partner currently work?

  Full or part-time?
  What hours on what days?
  What does he do?

- Or is he registered unemployed, registered permanently sick or disabled, looking after the home, other etc?

  What was his last job?

- Do you or your partner or others do work at home, overtime, shiftwork or are you on call? When usually?

- Do you look after anyone you live with because they are permanently sick, elderly or disabled?

  Who? Ages?

- Do you help anyone you don't live with to look after themselves?

  Who? Ages? Where?

2) TYPICAL DAY

Ask if they were able to complete the diary.

- Which do you consider to be a typical diary day? If there is a typical day?

- Look at diaries and clarify any points that aren't clear.

- What times during the day does your husband/partner work/are your children at school?

- What do any other people in the household (ie. older children or elderly parent) do during the day and at what times?

- How does the time/distance commitments of husband/partner and other adults/older children fit around your day? What are the interactions with woman's day?

RECENT CHANGES

- Has the shape of activity of people in the household changed in any substantial way say in the last two years?

  If YES,
  With this activity diary and your previous answers in mind. how has the activity pattern of the household changed?

  Prompts
  - children starting/changing school
  - new jobs for self/partner
  - additional caring tasks ie. elderly dependants
  - alternatively, caring tasks removed
  - illness

3) HOW CARING TASKS ARE HANDLED

Given what you have told me about household activity patterns and bearing in mind the diary, can we talk a bit more about the ways you cope with household and caring tasks?

FOR THOSE WITH CHILDREN

- Who usually looks after the children?

  When you are not at work? When you are at work?

- What happens when one of the children is sick?

- What happens if the person who usually helps you (partner, childminder etc.) is unwell or unable to have the children? Can you think of a real case and describe it to me?

- What happens if you are unable to look after the children? Again, can you think of a real case and tell me about it?

FOR THOSE WITH OTHER PEOPLE TO CARE FOR (WHO LIVE WITH OR DO NOT LIVE WITH)

You said that you also look after .... Can I go through the same sorts of questions again to see how you cope?

- Who usually looks after the dependant?

  When you are not at work? When you are at work?

- What is the matter with them and what kind of help do they need?

- How much time do you spend on this and how do you get there if they live elsewhere?

- Does anyone share looking after the dependant ie. family members, home help, district nurse, meals on wheels, day centre etc? Ever had respite care?

- Explore income carefully here ie. who pays for sheltered housing etc.

- Has the situation changed recently ie. before/after April 1993 (Community Care).

- What happens when the dependant is sick?

- What happens if the person who usually helps you (partner, childminder etc.) is unwell or unable to look after the dependant? Can you think of a real case and describe it to me?

- What happens if you are unable to look after the dependant? Again, can you think of a real case and tell me about it?

4) WOMAN'S OWN HEALTH NEEDS AND HEALTH CARE USE

Can we talk a little about your own general health and how you deal with issues of health for yourself and the family?

HEALTH

In the questionnaire you said that you ...

- don't have a long-standing illness but you had visited the GP several times
- have a long-standing illness that limits your activities but you had not visited a GP
- short-term illness etc.

Can we talk about this in a bit more detail in complete confidence. If you don't mind, can we talk about your general health.

- Do you consider yourself to be a healthy person in general/or apart from the long-term illness?

- Long-standing illness details.

  How long have you had the illness?
  Type of treatment?
  Hospital stays?
  How far it affects normal activities?
  How far it affects other people in the family?

- If don't have a long-standing illness, ask if have ever had and illness that has troubled you for a long time?

- Any/any other major illness and/or operations in the recent past?

- What sorts of health problems, if any, have you had over the last year or so?

HOSPITAL STAYS

- You mentioned a hospital stay in the questionnaire. Could we talk a bit more about this and any hospital stays since then?

  If didn't mention hospital stay in questionnaire, ask if been to hospital since then?

  Which hospital?
  Reason for attendance?
  How long were you in for?
  Views of hospital?

VISITS TO LOCAL GP

You said that you had been to the doctor ... times about your own health in the sixth months before the questionnaire.

- Have you been to see a GP about your own health since the questionnaire? If so, roughly how many times?

- Could you give me a general idea of the sorts of problems you went to see the doctor about?

- Would you be prepared to tell me the general circumstances?

PREVENTATIVE AND OTHER HEALTH CARE USE

You said that you had/had not had a smear test and had used ... /had not used other preventative health services.

- Have you used any preventative or other health services at all since the questionnaire?

- Can you give me a general idea of what you went for?

HEALTH PROMOTION IN THE WORKPLACE

- Are there any health awareness programmes at work? Can you tell me a few details?

- Have you ever used occupational health, nurse at work? Can you give me a general idea what for?

OTHER FAMILY MEMBERS (WHO LIVE WITH OR NOT)

- Does anyone in the family have anything that has troubled them for a long time?

  What kind of illness?
  How often are they ill?

You said on the questionnaire that you ...

- Have you taken them to hospital or the doctors since then? (Can you tell me a few details?)

- Have you talked to anyone else ie. family, neighbours about the health of family members? Can you tell me a few details?

- Anything else that worries you about the health of anyone in the family?

ATTITUDES TO HEALTH

- Do you ever ignore symptoms you have or do you go to the doctor straight away? (Can you give me an example?)

- How about for your children and other dependants or you partner?

- Have you ever put off seeing the doctor because you felt the reason for your visit was not important enough? (Can you give me an example?)

PRESSURES ON HEALTH

- Do you ever feel that you are under enough strain that your health is likely suffer? Why?

- Do you have any pressures from your job?
  Does your job affect any other areas of your life?
  Do you enjoy your job?

- Can you switch off at the end of the day?

- If looking after the home, are there any stresses?
  Can you switch off at the end of the day?

- Do you have any health problems, or have you had any problems in the past, related to your job or caring tasks?

- If you get the time to relax and switch off, what do you do?

  Prompts
  - have a cigarette
  - have a drink
  - go to the pub
  - take exercise etc.

5) TIME-SPACE IN RELATION TO HEALTH CARE

(ie. Who did what? When? How was responsibility shared between family/household members? Inter-generational exchanges? Problems encountered?)

What I am most interested to know more about is how all the things we have been talking about up to now fit together ie. work, home activities, caring responsibilities and, most importantly, your health and health and health needs.

So I'd like to know a bit more about how you cope, how you fit everything in, how you get to and from the places you have to be in the time available. How your health care use fits the time line we've drawn up.

Again bearing in mind the diary and your typical everyday activities, can we focus on health needs for you and your family?

HOSPITAL AND AFTERCARE

- When you went to hospital, you had to get to ... hospital and were in for ... days.

  How did you manage?
  How did you get there?
  Who looked after the children/dependant?

- When you came home, things must have been organised to give you a chance to get fully better?

  Who looked after the children/dependant?
  Did you have any community health care support ie. district nurse, occupational therapy?
  How did this fit your needs?

- How easy was it to take time off work?

- If haven't been to hospital, ask what would happen if they did have to go?

  Would anyone be able to look after the children/dependant?
  Would you ask them?

- Is there anyone you can rely on under these kind of circumstances no matter what happens?

GP VISITS

- Which GP surgery do you go to?

  What kind of appointment system and opening times do they have?

  How easy or difficult do you find it to get to your GP?

- What sorts of feelings do you have if you have to ring to make an appointment for yourself or call the doctor out for yourself?

- If you have to visit the surgery, what sorts of arrangements do you have to make, looking at the diary?

  What time of day?
  How does it fit around family and work commitments?
  If arrangements are a problem, how do you cope?

- Do you ever not tell anyone in case they worry?

- How easy do you find the doctor to talk to and can you always say everything you want to?

- Do you ever ask about your own health when you've taken the children to the doctor etc?

- What about work, do you have any problems, in dealing with your health problems, in respect of your employer?

  Is it easy to take time off work and/or home commitments if you're ill or have to go to the doctor?

  How about if the children/dependant are ill or need jabs etc or if you husband/partner is sick?

PREVENTATIVE HEALTH CARE

- When you went for smear test, breast screen etc. ...

  Where did you go? Which Well Woman Clinic did you attend?
  What kind of appointment system and opening times did they have?
  Was it a male or female doctor?

- What sorts of feelings did you have went you went for ... and for ...?

- When you went for ... what sorts of arrangements did you have to make, looking at the diary?

  What time of day?
  How did it fit around family and work commitments?
  What would make an appointment inconvenient?
  If arrangements are a problem, how do you manage?

- How were you referred or suggested the service?

- Do you ever not tell anyone about this kind of thing in case they worry?

- What about work, did you have any problems, about this in respect of your employer?

  Is it easy to take time off work and/or home commitments for preventative health care?

- Are you aware that your GP has ... clinics?

  Would you consider using them and what sorts of arrangements would you have to make?

- Are you aware that the Community Trust has Well Woman Clinics, Family Planning Clinics, Abacus shop in town?

  Would you use them? Why/Why not?
  What arrangements would you have to make?

CHEMISTS

- If the doctor gives you a prescription do you find it easy to get to a chemist? How do you get there? How about if you got a prescription after 7.30pm? Would it depend who the prescription was for?

- Have you ever asked a chemist for advice about yours or someone else's health and not gone to/before going to the doctor?

GENERAL

- Is there anyone else you would ask for advice about health?

- What do you think of health services in the local area? Is there anything you would like to see changed? Anything at all?

- Just out of interest what are your reasons for working part/full-time/not working/giving up work?

- What kind of help do you get from family and friends? Where do people who help live/do they have a car etc?

- Is there anything you would like to do or think you could do for/to improve your health?

INCOME (Show income band card)

- Are you or your partner or others eligible for any benefits? Do you claim them?

- How is income shared/what is it spent on?

- Who pays for prescriptions etc.?

LEVEL OF DEPENDENCE OF PEOPLE CARED FOR (Show card)

- What motivates you to look after this person? (If adult dependant).

APPENDIX 5A

PROMPT CARD TO INITIATE DISCUSSION OF INCOME

1) Which is the closest to the total income after tax that comes into your household each week?

2) Which is the closest to your own personal income after tax each week?

(INCLUDE WAGES, BENEFITS & OTHER INCOME)

a) LESS THAN £100 PER WEEK

b) BETWEEN £100 AND £200 PER WEEK

c) BETWEEN £200 AND £300 PER WEEK

d) BETWEEN £300 AND £400 PER WEEK

e) OVER £400 PER WEEK

APPENDIX 5B

PROMPT CARD TO INITIATE DISCUSSION OF LIMITING LONG-TERM ILLNESS

Do you/Does the person you help have difficulty with any of the following activities?

a) Preparing a cooked meal

b) Dressing or undressing

c) Washing self

d) Using the toilet

e) Taking showers or baths

f) Cutting up food for meals

g) Taking medicines

h) Getting in/out of bed

i) Getting in/out of chair/wheelchair

j) Climbing stairs or steps

k) Washing own hair

l) Cutting own toenails

m) Housework

n) Doing the washing

o) Doing the shopping

p) Travelling on public transport

q) Getting about home by self

APPENDIX 6

ACTIVITY DIARY FOR SELF COMPLETION PRIOR TO INTERVIEW

Date

Dear XXXX

Thank you very much for agreeing to talk to me about your health and use of health services.

As I mentioned on the phone, I am sending you some diary sheets. It would be very helpful if you could fill these out for up to a week before I come to see you (By 'activity', I mean anything from doing the washing-up to going to the doctor's).

Thank you again for all your help and I look forward to meeting you on [date] at [time].

Yours sincerely,

Ruth Young

ACTIVITY DIARY

NAME _____ **DATE** _____

TIME AT START OF EACH ACTIVITY	ACTIVITY **EG. GOT UP, GOT BREAKFAST, TOOK YOUNGEST SON TO SCHOOL, VISITED PARENTS AND SO ON**	WHO ELSE WAS WITH YOU? **EG. HUSBAND, ELDEST SON, MOTHER ETC.**	WHERE WAS THIS? **TICK IF AT HOME AND DESCRIBE IF SOMEWHERE ELSE**	HOW DID YOU GET THERE? **EG. CAR DRIVER, CAR PASSENGER, WALK, BUS ETC.**

CONTINUE ON ANOTHER SHEET IF NECESSARY

APPENDIX 7

HYPOTHETICAL HEALTH SITUATIONS ADDRESSED AT INTERVIEW

Vignette 1

Your child's school rings you (at home/at work) at 11 o'clock in the morning to tell you that your son/daughter has had an accident in the playground/sports lesson. One of the teachers has taken him/her to hospital.

What would you do?

Would you do anything different if this happened at 3 o'clock in the afternoon?

What about if the child had an accident like that at home in the evening, say at 8 or 9pm?

Vignette 2

One of your parents' neighbours rings you at 11 o'clock in the morning to tell you your mother (or father) has been taken ill and had to be taken to hospital.

What would you do?

Would you do anything different if this happened at 3 o'clock in the afternoon?

What about if it happened at 8 or 9pm in the evening?

What would you do if this happened at 2 o'clock in the morning?

Would it make any difference if this happened on a weekday or at the weekend?

What would you do if, instead of it being a neighbour ringing about your parents, it was someone where your husband/partner works ringing to tell you he had been taken ill and taken to hospital?

Vignette 3

You are woken up at 2 o'clock in the morning by the sound of your baby crying. He/she is running a high temperature and screams when you touch his/her stomach. Nothing you do seems to calm him/her down.

What would you do?

Would you do anything different if it was one or the older children with very severe stomach pains and high temperature?

Would you do anything different if it was your husband/partner?

Would you do anything different if it was elderly dependant who lives with you?

What would you do if it was you yourself with the symptoms in the middle of the night?

Vignette 4

Your doctor gives you a prescription for your baby or young child and it's after 7.30 in the evening.

What would you do?

How about if the prescription was for an older child?

If it was for your husband/partner?

If it was for an elderly dependant who lives with you?

If it was given to an elderly dependant who does not live with you?

If it was for yourself?

Would it make any difference if it was a weekday or at the weekend?

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