Identifying Gendered Outcomes of Gender-Neutral Policies

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Most social policies are written in gender-neutral language, but their effects are frequently different for men and women. This article analyzes two policies—the Community Mental Health Centers Act of 1963, which was the basis for deinstitutionalization, and the Social Security Amendments of 1983, which established diagnosis-related groups—both of which depend on unstated assumptions that women are informal caretakers. To help uncover gendered assumptions that may have negative effects on women, the article concludes with some questions that can be used to supplement existing policy analysis models.

A thorough policy analysis provides information on the intent of a policy, as well as on the results of its implementation. It is essential because the language used in writing a policy or legislation is often intentionally broad and ambiguous, and thus the outcomes of implementing the policy may be different from what was intended (Figueira-McDonough, 1993). In the past few decades, a number of policy-analysis models have been developed to guide policy analysts in asking appropriate questions and gathering the necessary information for an informed evaluation and usable suggestions for improvement (see Gilbert & Specht, 1974; Huttman, 1981; Karger & Stoesz, 1994). None, however, specifically directs the analyst in examining a policy and its outcomes for their immediate and long-term

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effects on the lives of women, or in considering the issue on which the policy is based from women's experience of either the problem or its proposed solutions (Dominelli & McLeod, 1989). Yet such an inquiry is essential because all policies inevitably have an impact on women, which must be identified and addressed (Miller, 1994).

The system within which social policies are created is dominated by men, who benefit from maintaining the gendered division of labor (Lorber, 1994). Women not only provide free labor in the home, caring for relatives and people in the community, but, to a large extent, serve as a source of cheap labor in the paid workforce (Abramovitz, 1988). These arrangements are suitable for the dominant group, so there is little incentive for policy makers and politicians to change the system (Miller, 1990) or even to examine the biases underlying this arrangement. Maintaining the status quo, supporting capitalism and patriarchy, and keeping women in a financially precarious position are not the stated goals of most social policies. However, they are visible if one inspects the policies and their outcomes from the perspective of women (Spakes & Nichols-Casebolt, 1994).

In most models, the first step in conducting a policy analysis is to examine the problem or situation that led to the policy. Other steps involve a review of previous attempts to solve the problem and an examination of the components of the proposed policy. These components include the bases for social allocations, types of social provisions that will be allocated, strategies for delivering the provisions, and methods of financing them (Gilbert & Specht, 1974). This type of analysis answers questions regarding who will get what goods or services, how these goods and services will be provided, and who will supply the funds.

Another approach to policy analysis—and the one followed in this article—was proposed by Huttman (1981). The first step in this approach is to examine the unmet needs to be addressed by the policy, as well as its goals and intended outcomes. The second step is to assess the indirect effects of the policy and

problems that may result from them. The third step is to identify the implementation strategies, the bases of the policy, and the values embedded in it (in terms of research and social work values). The last step is to determine the power bases supporting the policy and the resources available for implementation, as well as the costs of implementation and the benefits that may result.

This article examines two policies—the Community Mental Health Centers (CMHC) Act of 1963 and diagnosis-related groups (DRGs), established by the Social Security Act Amendments of 1983—to illustrate how hidden assumptions about issues, such as provision of care in the community, directly affect the lives of women. It also presents a series of questions that can be added to any policy analysis model to identify unstated assumptions and implications and their potential effects on women.

THE TWO POLICIES

CMHC Act of 1963

By the mid 1950s, institutionalization of people who were chronically mentally ill had become the treatment of choice. The original intent of institutionalization was to place these people in settings in which they could learn self-regulation and thus be cured and returned to the community (Johnson, 1990). The actual outcome of this policy, however, was the warehousing of thousands of people, rather than their "cure." Many investigations and authors, such as Goffman (1961), denounced state mental hospitals for their inhumane treatment of patients. At about the same time, the expense of custodial care for so many "incurable" people came under scrutiny. Supported by information from a study by the World Health Organization and a report by the Joint Commission on Mental Illness and Health and other sources, a movement began to transfer a majority of mentally ill people from institutions to the community (see Johnson, 1990). The culmination of these efforts was the CMHC

Act of 1963, under which funds would be allocated for the construction of centers to provide medical care, case management, and other needed components of a comprehensive mental health service system to mentally ill people who would live in the community (see Johnson, 1990). The intent was to provide care to the thousands of formerly institutionalized people in the least restrictive and most natural setting possible, which, according to the experts who proposed this policy, was the family.

Nowhere in the legislation or in the hearings that accompanied it was it stated explicitly that when these patients returned home, their care would be provided by women. Given the assumptions about the role of women at that time, there was no question which family member would care for the mentally ill relative in the community.

Policy analysis. An analysis of the CMHC Act suggests that the impetus for deinstitutionalization was the enormous expense of continuing to house thousands of people in custodial settings that had no record of improving the lives of their patients (Johnson, 1990). An additional impetus was the exposure of the appalling conditions in some institutions (Goffman, 1961). Thus the problem was either the rapidly increasing costs of institutionalization or the poor treatment of patients in state mental hospitals.

The goals of the policy were to reduce the beds—and hence the number of patients—in state mental hospitals and to develop systems of community centers that would provide comprehensive treatment for chronically mentally ill people. The outcome would be the provision of services to this population in a less restrictive and, what is more important, much less expensive setting.

The side effects that were not identified in the policy involved the families to whom the formerly institutionalized patients were expected to return, given that family caregiving was an unstated consequence of the deinstitutionalization movement (Benson, 1994). As early as 1976, a report by the National Institute of Mental Health noted that

> returning patients to their families is . . . a logical step in the deinstitutionalization movement. And yet as progressive as that movement is, it may be causing serious crises in the lives of those families who are now responsible for the care and rehabilitation of relatives released from mental hospitals. (p. 14)

The answers to Huttman's next questions, regarding the delivery of services and the sufficiency of organizational arrangements and funding, would have provided clear warnings if these questions had been addressed before the CMHC Act was implemented. Funding was not sufficient; many community mental health facilities were never constructed; and, in those centers that were constructed, staffing was never adequate to meet the needs of the severely mentally ill people who were being dumped into the communities. The research that was used to support the policy reflected the experience of the least needy of the hospitalized patients—the first group released because they had the fewest needs. This group's relatively easy transition into the community led to the belief that the release of all patients was an appropriate solution to the expense of institutionalization (Johnson, 1990).

The values on which the policy was based were both humanistic—providing care for people who were chronically mentally ill in the least restrictive setting—and economic—saving money by closing large state-funded institutions. The power bases that supported the policy were the psychiatrists and the insurance companies that would be paid for treating mentally ill patients in the community.

As the results of a policy analysis based on Huttman's (1981) model indicate, it is obvious that serious problems were inherent in the policy and its implementation. The long-term effects on women, however, would not necessarily have emerged even from this thorough analysis.

DRGs. Another policy that ignored the potential effects on women was the establishment of DRGs as part of the Social Security Act Amendments of 1983. The problem was the rapidly rising costs of Medicare and the predicted increase in the num-

ber of elderly persons who would be eligible for these services. The goal of the policy was to reduce these expenses, and the mechanism was the development of DRGs. Under the DRGs, a flat fee is paid to physicians and hospitals for each of 467 categories of disorders, rather than for each service. As with the CMHCs, the appropriate community-support system was not developed. The result has been a reduction in the number of days Medicare patients can stay in hospitals—that is, patients are sent home earlier and sicker. A concomitant result has been the need for much more home care services for patients (Glazer, 1990), but not necessarily an increase in the availability of such services.

According to the Medicare program, the lack of available services in the community is not a deterrent to patients' early dismissal from hospitals. In a hearing on DRGs, representatives of the program testified that Medicare will not pay hospitals for providing services that patients need simply because those services are not available in the community. They justified this policy by stating that such an action would reward communities for not providing needed services (Jencks, 1987). At no point in the reports on the policy is there an indication of who will provide assistance to patients after they are discharged from hospitals. The assumption is that family members will be willing and able to meet the patients' needs.

One result of the DRGs has been the emergence of another new arena of unpaid work for women. Highly technical medical services, formerly provided by trained hospital personnel, are now delivered by family members—notably women (Glazer, 1990). Although this new arrangement reduces the costs of the formal health care delivery system, it has critical effects on the lives of women who now provide this care.

CARETAKING

These two major pieces of legislation were passed and are implemented on the basis of the unarticulated expectation that

people who are not in institutions or hospitals have families who can provide the care and supervision these persons need. The accompanying unstated implication is that, in this case, "family members" mean women. The costs of caregiving for women, however, are high. Over a lifetime, the fulfillment of these roles can lead to poverty (Hooyman, 1992; Kingson & O'Grady-LeShane, 1993), especially for women in low-wage jobs.

Caretaking in families and communities has traditionally been regarded as women's work (Baines, Evans, & Neysmith, 1992; Findeis, Larson, Gallo, & Shekleton, 1994; Glazer, 1990; Hooyman, 1992; Kingson & O'Grady-LeShane, 1993; Miller, 1994). Since the early years of the Industrial Revolution, men have been expected to go into the workplace and to earn sufficient wages to support their families. In contrast, women have been expected to remain at home providing care and emotional support for the breadwinners (the men), the children, elderly relatives, and the community in general (Gallagher, 1994). During the 1950s and 1960s, women were not expected to work for pay outside the home unless they were poor, widowed, or nonwhite (Abramovitz, 1988). In the past 2 decades, more and more women at all economic levels have entered the paid workforce (Dwyer & Coward, 1992; Myers, 1989). They have not, however, been relieved of the expectation that they will continue to provide care to their families and communities (Barusch, 1994; Glazer, 1990; Linsk, Keigher, Simn-Rusinowitz, & England, 1992; Stone, Cafferata, & Sangl, 1987).

The costs to women of providing caretaking services have only recently been identified. When babies are born or older relatives need assistance, it is usually women who take at least temporary leaves of absence from their jobs to take care of them. Women who are engaged in caretaking receive the approval of their families, communities, and policy makers. They do not, however, receive financial remuneration. Although the Family and Medical Leave Act of 1993 (FMLA) ensures caretakers that they can return to their jobs after they have taken time off for

family care and that such benefits as health insurance will continue, it does not require employers to pay wages during the leaves, which are limited to 3 months. If the caretaking responsibilities are not completed within the covered time and caretakers must actually resign from their jobs, they must reimburse their employers for insurance premiums paid in their behalf.

These short-term losses are minuscule compared to the long-term losses. If a woman has to give up her paid job to provide care, she generally receives no salary or benefits and has no opportunity to contribute toward her retirement by accumulating a sufficient pension and social security quarters or by saving income (Kingson & O'Grady-LeShane, 1993). Therefore, she often faces a much lower income and benefits on retirement, especially if she was in a low-wage job (Barusch, 1994; Hooyman, 1992).

Given the dependence of the health care delivery system and the mental health system on family-provided care, it would be reasonable to expect that some form of payment would be available. However, the United States has a history of not paying for care that is regarded as a family obligation (Hollingsworth & Hollingsworth, 1994; Orodenker, 1991). Policy makers seem to fear that too many families would request payment for services that are now provided for free, or at least at no cost to the government (Linsk et al., 1992). Because family-provided care makes few financial demands on the government, its cost for families, especially women, is not taken into account. Nevertheless, informal family care is fundamental to health and mental health care. For this family care to continue, social policies must consider the gendered effects of caregiving (Dwyer & Coward, 1992).

Current Policies

The reliance on unpaid family or community care by women is not an artifact of the past. Social policies continue to be built on such unspoken assumptions. In the 1995 congressional session, the aim of the proposed Personal Responsibility Act was to

reduce welfare payments to unmarried teenage mothers by requiring them to live at home, but the bill did not specify who would support these young women. Rather, the expectation inherent in the bill was that the mothers of these young women can and will automatically contribute whatever is needed.

Many social policies continue to undermine women's efforts to gain power and control in their lives. It is important to unearth the underlying philosophy and unspecified outcomes of each policy. Until assumptions and outcomes are identified and named, they cannot be addressed or corrected.

SUPPLEMENTAL QUESTIONS

Policy-analysis models guide analysts to a better understanding of various facets of current and proposed policies. As this article has demonstrated, however, gender-neutral language can obscure the long- and short-term effects of policies on women. Therefore, this section presents questions that can supplement and strengthen the existing analytic models.

A word of caution is in order regarding the search for the effects of policies on women. No classification of women, such as single parent, woman with a disability, or elderly woman, is monolithic. Women live in diverse settings, have a variety of strengths and needs, and respond differently to problems. At every phase of policy analysis, then, it is important to give at least some consideration and attention to the differential impact of women's varied life circumstances and to the diverse ways in which a policy and its implementation may affect their lives.

Given that caveat, the analysis of a policy can be strengthened by asking the following additional questions:

- How is the underlying or current situation or problem different for women and for men?
- What attempts have been made to remedy these situations in the past? What were some of the outcomes of these attempts? In what ways were these outcomes different for women and for men?

- What is the current proposal to solve the problem? How will it affect women?
  1. What assumptions are built into the policy, especially those that involve women (such as that women are available, able, and willing to provide some care or service)?
  2. What are the probable long-term effects of this policy on women? For example, if women leave their jobs to provide care or services, will their social security and pension benefits be reduced at retirement?
  3. What are the short-term effects of this policy on women? Will taking leaves from their jobs reduce women's ability to return to work—especially in terms of skills and the timeliness of their knowledge of their fields? How will the lack of current income affect women, their families, and the relatives who receive care?
- How will the outcome of this policy or program be evaluated? How can data be gathered that are relevant to the needs and experiences of women?
- What changes should be made in the policy or program so it is more responsive to the needs of women?

CONCLUSION

Recent trends in legislation and policy making have been to reduce the involvement of governmental and other institutions in many areas and to transfer responsibility for the provision of services to families, which generally means to women. Given the conservative direction of governmental bodies, a reversal of this trend appears unlikely. Thus social workers in all areas of practice need to examine policies and legislation carefully for unarticulated assumptions that can have long-term, negative effects on women. The use of the questions presented here can be a first step in identifying and publicizing unstated expectations and in recommending alternative approaches to solving problems.

REFERENCES

Abramovitz, M. (1988). *Regulating the lives of women*. Boston: South End Press.

Baines, C. T., Evans, P. M., & Neysmith, S. M. (1992). Confronting women's caring: Challenges for practice and policy. *Affilia, 7*, 21-44.
Barusch, A. S. (1994). *Older women in poverty: Private lives and public policies*. New York: Springer.
Benson, P. R. (1994). Deinstitutionalization and family caretaking of the seriously mentally ill: The policy context. *International Journal of Law and Psychiatry, 17*, 119-138.
Dominelli, L., & McLeod, E. (1989). *Feminist social work*. London: Macmillan.
Dwyer, J. W., & Coward, R. T. (1992). Gender, family, and long-term care of the elderly. In J. W. Dwyer & R. T. Coward (Eds.), *Gender, families, and elder care* (pp. 3-17). Newbury Park, CA: Sage.
Figueira-McDonough, J. (1993). Policy practice: The neglected side of social work intervention. *Social Work, 38*, 179-188.
Findeis, A., Larson, J. L., Gallo, A., & Shekleton, M. (1994). Caring for individuals using home ventilators: An appraisal by family caregivers. *Rehabilitation Nursing, 19*, 6-11.
Gallagher, S. K. (1994). *Older people giving care*. Westport, CT: Auburn House.
Gilbert, N., & Specht, H. (1974). *Dimensions of social welfare policy*. Englewood Cliffs, NJ: Prentice Hall.
Glazer, N. Y. (1990). The home as workshop: Women as amateur nurses and medical care providers. *Gender and Society, 4*, 479-499.
Goffman, E. (1961). *Asylums*. Garden City, NY: Doubleday Anchor Books.
Hollingsworth, J. R., & Hollingsworth, E. J. (1994). Comprehensiveness and coordination of care for the severely disabled. In J. R. Hollingsworth & E. J. Hollingsworth (Eds.), *Care of the chronically and severely ill: Comparative social policies* (pp. 199-223). New York: Aldine.
Hooyman, N. R. (1992). Social policy and gender inequities in caregiving. In J. W. Dwyer & R. T. Cowart (Eds.), *Gender, families, and elder care* (pp. 181-201). Newbury Park, CA: Sage.
Huttman, E. D. (1981). *Introduction to social policy*. New York: McGraw-Hill.
Jencks, S. F. (1987). *DRG refinement: Outliers, severity of illness, intensity of care*. Baltimore: Department of Health and Human Service, Health Care Financing Administration.
Johnson, A. B. (1990). *Out of bedlam: The truth about deinstitutionalization*. New York: Basic Books.
Karger, H. J., & Stoesz, D. (1994). *American social welfare policy*. New York: Longman.
Kingson, E. R., & O'Grady-LeShane, R. (1993). The effects of caregiving on women's social security benefits. *The Gerontologist, 33*, 230-239.
Linsk, N. L., Keigher, S. M., Simn-Rusinowitz, L., & England, S. E. (1992). *Wages for caring: Compensating family care of the elderly*. New York: Praeger.
Lorber, J. (1994). *Paradoxes of gender*. New Haven, CT: Yale University Press.
Miller, D. C. (1990). *Women and social welfare: A feminist analysis*. New York: Praeger.
Miller, D. C. (1994). What is needed for true equality: An overview of policy issues for women. In L. V. Davis (Ed.), *Building on women's strengths: A social work agenda for the twenty-first century* (pp. 27-56). New York: Haworth Press.
Myers, J. E. (1989). *Adult children and aging parents*. Dubuque, IA: Kendall/Hunt.

National Institute of Mental Health. (1976). *Deinstitutionalization: An analytical and sociological perspective*. Washington, DC: U.S. Government Printing Office.

Orodenker, S. (1991). *Family caregiving in a changing society*. New York: Garland.

Spakes, P., & Nichols-Casebolt, A. (1994). Perspectives of women on family and social policy. *Affilia, 9*, 360-381.

Stone, R., Cafferata, G. L., & Sangl, J. (1987). Caregivers of the frail elderly: A national profile. *The Gerontologist, 27*, 616-626.

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