In the 1990s, feminist scholars such as Sainsbury (1993) argued that some countries developed systems of social provision that focused either on social insurance or on social assistance programs, with varying outcomes for men and women. This paper investigates aspects of what Sainsbury called the ‘dual welfare state’, using Canada and New Zealand as case studies. Although both have been labelled as ‘liberal’ or ‘residual’ welfare regimes, the paper focuses on differences in program design for sickness, injury and unemployment that contribute to gendered outcomes. The paper finds that the Canadian programs in these three areas are delivered mainly as social insurance while sickness and employment programs in New Zealand are based on social assistance. Canadian programs exclude many women or pay them less than men, as benefits are based on labour market participation and employment earnings. However, Canadian programs also use the individual as the unit of analysis, providing higher levels of benefits and greater autonomy for partnered women working full-time than do similar programs in New Zealand.

This analysis shows that social programs continue to be underpinned by cultural ideas about family and gendered work, about who deserves state assistance, and what role the state should play in promoting health and wellbeing. Social insurance and social assistance not only lead to gendered outcomes but they also generate different consequences for women in varying circumstances, even within similar types of welfare regimes.

The development of welfare states was premised on the belief that the state, employers, employees, families, and voluntary organizations should all contribute to the maintenance of income security, health and safety, and wellbeing. Nevertheless, researchers

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1 Direct all correspondence about this article to Maureen Baker, Department of Sociology, University of Auckland, 10 Symonds Street, 9th Floor, Private Bag 92019, Auckland 1142, New Zealand. e-mail: ma.baker@auckland.ac.nz
have identified considerable cross-national variation in the delivery and funding of social programs based on different ideas about who deserves public support, how best to assist those in need, what the ideal or typical family looks like, and the role of the state in family life. Explanations for program variations relate to the timing of welfare state development and restructuring, the ideologies and concerns of governing parties, and interventions by powerful interest groups (Baker, 2006; Bambra and Smith, 2010; Esping-Andersen, 1990; Hantrais, 2004; O’Connor, Orloff & Shaver, 1999).

This paper examines sickness, injury and unemployment programs in two ‘liberal’ welfare states - Canada and New Zealand - which some researchers see as similar. The paper discusses how these programs differ in their design and focus within and between the two countries, and how these variations influence women’s health and wellbeing, and their potential for autonomy from family. After justifying the country comparison, the paper revisits the Diane Sainsbury’s (1993) concept of the ‘dual welfare state’. She argued that universal services generally promote high levels of health and wellbeing for both men and women, but women more often rely on means-tested social assistance while men benefit from the more generous social insurance programs in the liberal states (Sainsbury, 1993). This article tests her argument for three social health programs in Canada and New Zealand, finding that design does matter. It also extends her argument by demonstrating that both kinds of programs impact differently on women depending on their employment patterns, household arrangements, parental status and socioeconomic circumstances.

**Categorizing Welfare States**

Canada and New Zealand are compared in this paper because they have been viewed by some researchers as similar, yet their social programs reveal important design and delivery variations that lead to gendered outcomes. Initially, these countries shared a history of colonization, and English Canada and New Zealand share a common language and many similarities in legal and policy background. In much of the welfare state literature, both countries have been categorized as ‘liberal’ or ‘residual’ welfare regimes (Esping-Andersen, 1990; O’Connor, Orloff & Shaver, 1999; Baker, 2006). These labels refer to the expectation that socioeconomic wellbeing will be derived mainly from individual and family-based care and earnings, and that households should be able to manage their daily lives with minimal assistance from the state. Esping-Andersen (1990) contrasted the liberal regimes with the ‘corporatist’ regimes based mainly on social insurance and the social democratic regimes based largely on universal services and benefits.
Many researchers have critiqued these categories, noted later in this paper, but others have continued to use them.

In Esping-Andersen’s original classification (1990), the liberal state provides health and social services, but targets relatively ungenerous social assistance to low-income households with few assets, as well as those experiencing personal or family crises. These programs are typically funded through general revenue, provide basic levels of income support, and often involve investigations into recipients’ personal lives to ensure that they actually deserve benefits. The amount paid is usually less than social insurance but social assistance benefits often last longer and eligibility may be easier for those outside the labour force (Bryson, 1995; Scruggs and Allan, 2006).

The ‘corporatist’ regimes (in much of Europe) are largely based on contributory social insurance schemes that typically benefit full-time workers earning moderate to high wages (Esping-Andersen, 1990). These schemes were intended to promote social security for those with stable jobs. They are usually financed through payroll deductions from employees and employers, which are sometimes matched with government contributions, and paid to eligible employees as a percentage of previous earnings. Those who are not regularly employed are often excluded from these schemes and are expected to rely on other forms of social provision, as well as on their family and charitable organizations.

Social democratic regimes (in the Nordic countries) tend to provide universal benefits and services that are available to all citizens and are most effective in preventing poverty, inequality and poor health (Esping-Andersen, 1990). They are also designed to encourage labour market participation but recognize financial hardships at certain stages in the life cycle (such as childbirth and retirement). These programs are often funded through a combination of general revenue from various forms of taxation, including contributions from employers but not always from employees. These three welfare regimes were initially presented as ideal types but the liberal regimes have since been associated with Canada and New Zealand, as well as the Australia, the United Kingdom and the United States.

Numerous researchers have disputed the accuracy of this classification and argued, for example, that social provision in southern Europe differs substantially from that in Germany or France, and that the same country is often more generous in some program areas than in others (Baker, 2006). More relevant to this paper are the arguments that New Zealand and Australia are not really liberal regimes at all (Mitchell, 1995; Castles & Pierson, 1995; Castles & Shirley, 1996). Trade unions in both countries historically allied with governments to regulate wages, production, immigration, imports and exports rather than to encourage
extensive social assistance or social insurance programs. Both countries have been labelled ‘wage-earner’s welfare states’ because high (male) wages were ensured through centralized bargaining, arbitration and limited immigration. Full (male) employment and high rates of home ownership protected economic wellbeing more effectively than income support programs. In recent decades, however, especially New Zealand has come to look more like North America in its social provision and neo-liberal restructuring (Lunt, O’Brien & Stephens, 2008).

Viewing Canada as a liberal welfare state may also be problematic. While provincial ‘welfare’ programs are funded and delivered as targeted social assistance, several federal programs are financed through contributory social insurance schemes (including prolonged sickness, workplace injury, unemployment and retirement). A few programs are universal (or have been in the past). In contrast, New Zealand delivers most social provision through social assistance, except for injury compensation which is a partial social insurance program and the old age pension which is universal (Lunt et al., 2008). In addition, hospitalization and emergency health care are universal but doctor’s visits entail user fees. Despite these complications, the paper views the welfare regimes in Canada and New Zealand as similar and classifies them as ‘liberal’ because their social provision systems share many of the defining characteristics noted above.

**Feminist Critiques of the Welfare State**

In recent years, considerable research has investigated the impact of welfare state restructuring on women, families and children (Baker, 2008; Baker and Tippin, 2004; Balmer et al. 2005; Bryson et al. 2007; Cohen and Pulkingham, 2009; Hantrais, 2004; Jenson, 2004; Orloff and Palier, 2009; Raphael and Bryant, 2004). Earlier feminist scholars argued that (male) theorists misrepresented welfare state development because they relied too much on employment-related programs used mainly by men, over-emphasized relations between trade unions and governments, and neglected social provision by charitable organizations, women and families (Pedersen, 1993; Sainsbury, 1994). They also argued that social programs incorporated specific models of family and gender relations that did not always reflect the ways that people actually live (Lewis, 1992; Leira 2002; McKeen, 2004). While many states have assumed that families contain a male earner and female carer, others now expect that two-parent families should be dual earners (but less often dual carers).

Comparing social programs cross-nationally remains complex, with many variations in politics and culture, and because program design and models of family differ within as well as between jurisdictions. For example, at least two family models are inherent within
the liberal states. The dual-earner model is implicit in divorce reform especially in North America but the male breadwinner/female caregiver model has been widespread in income support programs (Baker, 2006). The dual-earner model assumes that both men and women are potential wage earners responsible for supporting themselves and each other during cohabitation/marriage. The male breadwinner assumes that the male partner is the main household earner while the female is primarily responsible for child care and housework, even if she is employed.

The dual-earner or mother-earner model is more apparent in Canada than New Zealand, reflecting stronger employment expectations for beneficiaries and different ideas about ‘good mothering’ (Baker, 2009). This model is also consistent with neo-liberal ideas that paid work is morally superior to ‘dependency’ and taxpayers should not have to support ‘workless households’. However, it downplays the gendered division of labour at home and work, including the lower earning capacity of mothers. Clearly, low-income mothers with dependent children face different benefit levels and work expectations depending on where they live within liberal welfare states (Kingfisher, 2001; Daly & Rake, 2003; Baker, 2006).

The concept of ‘de-commodification’, which contributed to Esping-Andersen’s argument about the generosity of regimes, has also been criticized because it was never relevant for most women (Orloff, 1993; Lister, 1997; Baker, 2006). Historically, women have had a lower attachment to paid work and especially mothers have performed unpaid care work while their male partners earned most of the household money. Therefore, categorizing welfare states by how effectively they allow employees to retain an income after unemployment or retirement does not apply to many women. Consequently, some researchers have compared welfare regimes on ‘de-familialization’ or how well they enable women to live without depending unduly on the financial support of their male partners or parents (Cohen and Pulkingham, 2009; Sainsbury, 1994).

McKeen (2004) saw gender and family as central to Canadian social policies, discussing reasons why the efforts of feminists were not more successful in counteracting the ‘familialist and liberal-individualist constructions’ underpinning the welfare state. An important question in the feminist literature is how various welfare regimes help women into paid work and protect or disregard their interests when they become lone mothers or widows (Orloff, 1993; Lister, 1997; Christoper, 2002; Millar, 2010). Do social programs enable or prevent women from forming autonomous households when they want to or need to be independent from the state and their families? Most feminist scholars conclude that women living in social democratic regimes can maintain their health and wellbeing and can best form autonomous households
without depending unduly on marriage or relatives. However, focusing on the ability to form autonomous households has encouraged these scholars to privilege employed mothers over homemakers (Shaver, 2002).

**The Dual Welfare State & Gender Equity**

Earlier feminist researchers noted that many countries created ‘dual welfare states’, with some programs organized as social assistance and others as social insurance (Sainsbury, 1993; Bryson, 1995). They argued that men are more likely to use social insurance, which is usually based on employee/employer contributions that are related to previous earnings, while eligibility is based on employment history and individual earnings rather than household income. In contrast, women tend to rely more on social assistance, which is designed for those unattached to the labour market, is non-contributory, targeted to those ‘in need’, and eligibility is based on household income. As social insurance is more generous and less intrusive, and based on individual earnings, men benefit more from dual welfare states.

McKeen (2004: viii) continued this argument by saying that real gender equality is impossible within Canadian social policy because the “dual-breadwinner economic system [is] harnessed to a single-breadwinner social policy system”. Furthermore, governments continue to ignore ‘social reproduction’ and the unpaid care work done by women, which means that women disproportionately pay the price in high rates of poverty and stress. The second-wave women’s movement advanced an alternative vision of social policy in the mid 1970s, which recognized the social context of people’s lives and focused on the ‘social individual’ as the unit of benefits rather than the household. However, left-liberal social policy and anti-poverty organizations helped to restructure policy in ways that were readily incorporated into the emergent neo-liberal social policy regime, with its emphasis on targeting and its reassertion of a male-centred ‘familialist approach’ (McKeen, 2004). Gender and women’s issues slipped from view and social policies now focus on reducing child poverty and protecting vulnerable children (Jenson, 2004). Yet children are poor and disadvantaged because their parents are unemployed or marginally employed, because employed parents earn low wages, and state income support is often set below the poverty line (McKeen, 2004; Baker, 2006).

To understand how social programs continue to impact on women, including specific categories of women, it is necessary to provide a brief overview of the relationship between social programs and health, and gendered work patterns in Canada and New Zealand. Then, details of the three social programs in those countries will be discussed.
Health, Employment & Welfare State Restructuring

Numerous studies have shown that the allocation and expenditure of public resources on health and social services, as well as the ability to find paid work, contribute to health and well-being (Bambra and Eikemo, 2009; Chung and Muntaner, 2006; OECD, 2009: 117). Women’s wellbeing is particularly influenced by spending priorities because women reproduce and lactate, they normally care for children and frail family members, are often the guardians of family health, particularly mothers move in and out of paid work, and mothers rely more than fathers on targeted income support (Baker, 2006; Raphael and Bryant, 2004; Cohen and Pulkingham, 2009). Poor health interferes with employment and wealth accumulation, and poverty and stress contribute to poor health and shorter life spans.

Since the 1960s, life expectancy has increased in both Canada and New Zealand, women live longer than men, and the gender gap has widened slightly. Life expectancy has increased with higher living standards, better nutrition, less smoking and drinking, and better access to health services (OECD 2009: 102). In 2006, health outcomes were similar in both countries but public health care expenditure per capita was slightly higher in New Zealand where a higher percentage of the population also reported that they were in ‘good health’ (OECD, 2009: 117). Social spending on family-related programs was also higher in New Zealand at 2.3 percent of gross domestic product compared to 1.2 percent in Canada (OECD, 2007). New Zealand poverty rates are lower for families with children, especially for one-parent families, but levels of household debt are higher (Giroaurd et al., 2006; OECD, 2007).

In both Canada and New Zealand, elements of the healthcare system are delivered as universal or near-universal services, or are heavily subsidized by government. In Canada, hospital and medical care have been administered and delivered as provincial insurance, and largely provided as universal services that are jointly funded by federal and provincial governments (Clarke, 2008). In New Zealand, accident and emergency care and public hospital care are provided as universal services but doctor’s visits require user fees and private hospitals have recently flourished. Low-income families and especially mother-led households less often visit family physicians but rely instead on hospital care after health situations worsen (Baker, 2002; Worth and McMillan, 2004).

In recent decades, health and social programs in the liberal states have been subjected to neo-liberal restructuring involving increased user fees for health services, tighter eligibility for income support, and a stronger focus on paid work for family well-being (Baker, 2006; Bambra and Smith, 2010). Labour markets have also been transformed, offering
paid workers less statutory and union protection, and more part-time and temporary work (Fairbrother & Rainnie, 2006; Baker, 2009). Women’s employment has increased considerably and their earnings have been largely responsible for the maintenance or increase of household incomes (Girouard et al., 2006; OECD, 2007). Gender segregation in the workforce has been declining for several decades as women gain education and fewer mothers interrupt paid work for extended periods (OECD, 2008b: 81). However, men continue to occupy the more lucrative and senior managerial and professional positions, and a gender gap persists in hourly earnings, for full-time employees and for all workers. This gap is influenced by occupational segregation, variations in male-female working hours and levels of seniority, and gender discrimination (Daly & Rake, 2003).

Gendered employment patterns differ between Canada and New Zealand. More women are employed in Canada, especially on a full-time basis, but the gender earnings gap (male earnings over female earnings) is also larger. In 2006, men earned 21 percent more than women in Canada but only 10 percent more in New Zealand (OECD, 2008b: 358). However, net national income per capita in 2006 was higher in Canada at $31,811 US dollars compared to $20,596 US in New Zealand (OECD, 2009:63).

Table I: Employment Statistics for Canada, New Zealand & OECD

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>New Zealand</th>
<th>OECD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Employment/ Population Ratio, 2007</td>
<td>70.1</td>
<td>77.2</td>
<td>69.0</td>
</tr>
<tr>
<td>Incidence of Part-time Work, 2007</td>
<td>26.1</td>
<td>11.0</td>
<td>34.7</td>
</tr>
<tr>
<td>Unemployment Rate, 2007</td>
<td>5.7</td>
<td>6.4</td>
<td>3.9</td>
</tr>
<tr>
<td>Maternal Employment Rate, Child under 2, 2005</td>
<td>58.7</td>
<td>45.1</td>
<td>51.9</td>
</tr>
<tr>
<td>% of Lone Parents Employed, 2007</td>
<td>67.6</td>
<td>53.2</td>
<td>--</td>
</tr>
<tr>
<td>Poverty Rate for 1-parent household</td>
<td>Employed parent</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Non-employed parent</td>
<td>89</td>
<td>48</td>
</tr>
<tr>
<td>Gender Wage Gap (male/female difference as %) 2006</td>
<td>21</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Incidence of Low Paid Work (%) 2006</td>
<td>22.2</td>
<td>14.5</td>
<td>17.9</td>
</tr>
</tbody>
</table>

Table I shows the similar proportion of women earning money in the two countries but the lower employment after motherhood and more part-time work among women in New Zealand. It also shows the higher gender wage gap in Canada, the higher percentage of low paid jobs (paid at less than 2/3 of median wages), and the higher unemployment rate (although unemployment is lower for women than men in Canada but not in New Zealand). In addition, more sole parents are employed in Canada but their poverty rates are higher whether or not they are working for pay, but especially when they are outside paid work and relying on state income support (Baker, 2009).

In both countries, mothers are less likely than fathers to become self-supporting, partly because women accept more responsibility for daily childcare. Women tend to experience a ‘motherhood penalty’ when they attempt to combine earning and caring, as pregnant women or mothers are perceived as less qualified, competent and committed to the job (Correll, Benard & Paik, 2007; Baker, 2010). The earnings gap between mothers and women without children is often larger than the gender earnings gap (Crittenden, 2001; Zhang, 2009). In both Canada and New Zealand, women are still more likely than men to work in low-paid jobs and to work part-time, especially after becoming parents (OECD, 2008b). This means that women’s contributions to household incomes and social insurance programs are typically lower than men’s, and that more women rely on (less generous) social assistance.

This overview provides a background for the discussion of sickness, injury and unemployment programs in the two countries.

**Sickness Programs**

Sickness and injury programs are often based on social insurance, especially in the member countries of the Organisation of Economic Cooperation and Development (OECD) (Scuggs & Allan, 2006). These programs could be a part of unemployment insurance or in separate programs for sickness, injury or disability. If they form part of unemployment insurance programs, full-time workers with moderate incomes (who are more often men than women) receive the highest benefits.

Canada is an example of a country where both sickness and injury are covered by federal social insurance, but these are in separate programs. However, legislation relating to short-term sick leave falls under provincial/territorial jurisdiction. In Ontario, for example, employers with fifty or more employees are required to give their employees up to ten days of unpaid but job-protected leave for ‘personal emergencies’, which can be used for personal or family illness. In addition, unpaid leave is also provided for family medical emergencies (8 weeks), pregnancy (17 weeks) and for new parents (37 weeks).
(Ontario Ministry of Labour, 2009). Although many employees negotiate for paid sick leave through collective agreements, the Ontario government does not require employers to provide it.

If employees exhaust their provincial sick leave and require prolonged absence from work for reasons of illness, they may be covered by Employment Insurance. This federal program, established in 1941 as Unemployment Insurance (Baker, 2006), now covers income replacement for unemployment, sickness, compassionate caring and pregnancy for workers regularly attached to the labour force. Eligible employees who have worked at least 600 hours in the previous year could be entitled to 15 weeks of sickness benefits. Employees and employers fund this program through contributions, based on a percentage of earnings and payroll. Benefits are paid to individuals based on their work record and contributions, regardless of their household income, and payments cover up to 55 per cent of previous earnings (to a ‘ceiling’ of $457 per week) (Service Canada, 2010). As the average weekly wage in Canada was about $884 CAD per week in January 2010 (Statistics Canada, 2010), the maximum sickness benefit represents a little over half of median wages. However, women receive lower wages than men and work shorter hours, and therefore receive lower payments than men. The Employment Insurance Program also reimburses a portion of maternity and parental leave, with 15 weeks of maternity benefits taken only by women and 35 weeks of parental benefits taken mainly by women (Ontario Ministry of Labour, 2009).

New Zealand employers are required to provide employees with five days of paid sickness leave per year (after working for them for six months), although more could be negotiated through individual or collective bargaining (Employers Assistance Ltd, 2009). However, women are less likely than men to meet the eligibility requirements. Employees can also use their annual or vacation leave for sick leave. After that is exhausted, the state may provide income support if the employee cannot work for reasons of sickness, injury, pregnancy or disability. Parental benefits, which were first introduced in 2002 for employees working for six months for the same employer (Baker, 2008), are provided under a separate program for employees, and now provide income support for all eligible employees for fourteen weeks at a fixed rate of $429.74 NZD per week before taxes (New Zealand Inland Revenue, 2010). However, most women find that this period of leave is too short, and either take additional unpaid leave or quit their jobs (NZ Department of Labour, 2007).

The New Zealand Sickness Benefit is a social assistance program financed through general revenue and eligibility is based on low household income. The cut-off depends on the age and living arrangements of the sick individual and ranges from $13,600 NZD a year...
for a young person living at home to $24,400 for a sole parent living with children (Work and Income New Zealand, 2010). The benefit level also varies by age, marital status and living arrangements. The gross weekly rate varies from $145.04 for a young single person living with their parents, $217.59 for a single person over 25 years old, $316.22 for a sole parent and $363.62 for a couple ($181.31 each) if both are unemployed (Work and Income New Zealand, 2010).

In New Zealand, the average weekly wage was about $538 in 2009 (Statistics New Zealand, 2009), much lower than the Canadian average wage, and the value of the NZ dollar is usually about 75 cents Canadian. This means that the maximum sickness benefit represents about 40% of the average wage in New Zealand, as Table II indicates, but partnered women are ineligible unless their partner is unemployed or earning a very low wage. This table shows that the Canadian replacement rate for sickness benefits is higher, but some New Zealanders are permitted to draw this benefit for an indefinite period (Lunt, 2008). However, increasing pressure is placed on beneficiaries in both countries to move more rapidly into paid work.

### Table II: Comparing Sickness Benefits

<table>
<thead>
<tr>
<th>Country</th>
<th>Funding of Program</th>
<th>Eligibility</th>
<th>Replacement Rate</th>
<th>Duration Limit (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Social insurance</td>
<td>Worked 600 hours in past year</td>
<td>55% (maximum Can$457/wk)</td>
<td>15</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Social assistance</td>
<td>. No work requirement . Annual household income less than $16,000</td>
<td>40% (maximum NZ$217.59 for single adult)</td>
<td>None</td>
</tr>
</tbody>
</table>

Source: Various government websites

In recent decades, lost days from work have increased in many OECD countries with the stress from longer working hours and higher debt levels, but mainly from more mothers in the workforce. Employed mothers take more sick leave than other employees because they care for sick children at home more often than fathers (Scuggs & Allan, 2006). Lost days from work are also seasonal and more employment-related leave is taken in winter when sickness is more prevalent and working conditions could be more dangerous, especially in Canada. However, low-income workers (who are disproportionately mothers) cannot afford
to take unpaid or underpaid employment leave when they are sick or injured.

**Injury Programs**

Social insurance programs for accidents and injuries have been favoured by many employers because they are generally no-fault programs that avoid battles over liability. Governments also favour these programs because they help reduce destitution and poverty (and therefore social unrest), and can be used as a forum to raise awareness about workplace safety (Scuggs & Allan, 2006). In Canada, employment-related injury is covered by Workers Compensation, which is a social insurance program funded by contributions from employers and employees, and paid to employees as a percentage of previous wages. Some industries, especially those with large numbers of male manual labourers, pay higher contributions than others because the premiums are related to accident rates. Workers Compensation is a national program but the federal government and the provinces/territories administer their own programs, leading to considerable variation by jurisdiction. Payments vary from 79 percent of previous wages to 125 percent depending on the province and the circumstances of the injury safety (Scuggs & Allan, 2006). Gender differences are also apparent in the amounts received, as payments are based on previous earnings and women’s earnings are lower than men’s.

In New Zealand, the Accident Compensation Corporation (ACC) started in 1974 as a national and comprehensive no-fault social insurance for injury, and is one of the few social insurance programs in the country (New Zealand Department of Labour, 2010). Regardless of who caused the injury or where the incident occurs, treatment is paid for citizens, residents and visitors. Residents may also be reimbursed for home assistance during recovery and income support if they cannot work because of an injury, and income support for employees varies with previous wages up to a maximum of 80 percent.

ACC has been popular because employers cannot be sued for liability, residents and visitors are guaranteed medical treatment, and employees may be entitled to wage replacement if they cannot work due to injury. However, seventy-two percent of work-related claims were for males, and many of these men were in trade jobs (Statistics New Zealand, 2008). Furthermore, the program has recently been controversial with the National (conservative) government, which cut some services in 2010, including reducing the duration of counselling for families of suicide victims and for rape victims, and contribution rates were raised to ensure that the program is self-funded (Wilson, 2010). Table III compares injury programs in Canada and New Zealand, showing the relative generosity for women of New Zealand’s program.
More women benefit in New Zealand because injuries are covered regardless of where they occur.

**Table III: Injury Programs in Canada & New Zealand**

<table>
<thead>
<tr>
<th>Country</th>
<th>Injury Program</th>
<th>Eligibility</th>
<th>Coverage</th>
<th>Rate of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Workers Compensation (work-related)</td>
<td>Must be employee to benefit</td>
<td>Accidents/injuries in the workplace</td>
<td>Varies from 79% to 125% of previous earnings</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Accident Compensation Corporation</td>
<td>New Zealand resident (or visitor for treatment)</td>
<td>Accidents or injuries anywhere</td>
<td>Covers the cost of treatment &amp; income support for employees (up to 80% of previous earnings)</td>
</tr>
</tbody>
</table>

Source: Various government websites from Canada & New Zealand

In addition to injury insurance, the health care systems in the two countries also vary considerably. In New Zealand, patients must pay a fee for service of about $45 to $55 when they visit their family doctor (but not for diagnostic services or emergency hospital care), but recipients of state income support (who are more likely to be women) pay less if they have a community card (www.justlanded.com). In contrast, Canada’s health care system does not require similar fees for physician services although there are many provincial variations. Although New Zealand’s ACC covers a wider range of injuries than Canada’s Worker’s Compensation, including in the home and community, New Zealand’s health care system does not provide the same level of primary health care.

**Unemployment Programs**

Unemployment programs vary considerably between the two countries. Eligibility for Canada’s federal Employment Insurance (EI) is based partly on the local unemployment rate and the eligible employee must have worked from 420 to 700 hours per year, depending on place of residence (Service Canada 2010). Prior to 1996, eligibility required 26 weeks of continuous work for the same employer in the past year for at least 15 hours per week, which was said to discriminate against part-time workers who are mainly female (MacDonald, 2009). However, in the conversion from weeks to hours, eligibility was further restricted.
The 35-hour work week was used as the normal work week, and penalties were built into the system to increase work incentives and to discourage quitting jobs and re-entering the workforce, as many mothers do. Furthermore, the duration of benefits was also reduced to 45 weeks (down from 51 in the 1970s) in 1996 (MacDonald, 2009). More recently, the federal government has introduced variable duration of benefits from 19 to 50 weeks depending on the local unemployment rate. In addition, EI benefits for maternity, parental, sickness and compassionate leave will be available for self-employed workers as of January 2011 (Service Canada, 2010), which will help many women.

Employees and employers fund EI through contributions that form a percentage of their earnings and payroll. Benefits are paid to individuals based on their work record and contributions, regardless of their household income, and payments cover up to 55 per cent of previous earnings (to a ‘ceiling’ of $457 per week). As the average weekly wage in Canada is about $884 per week (Statistics Canada, 2010), this maximum represents over half of average wages. However, only 81% of women workers in Canada who paid contributions to EI and lost their job or quit with just cause were able to draw benefits. Others were disqualified because they were recently employed, self-employed or worked insufficient hours to qualify (HRSDC, 2009a). Employees who exhaust EI benefits are forced to rely on provincial social assistance programs, which vary in generosity, are based on household income and pay considerably less than EI.

Table IV: Comparing Unemployment Benefits in Canada & New Zealand

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of Program</th>
<th>Eligibility</th>
<th>Coverage</th>
<th>Replacement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Social insurance (Employment Insurance)</td>
<td>. unemployed &amp; available for work&lt;br&gt;. already worked from 420 to 700 weeks, depending on place of residence</td>
<td>. paid to eligible contributors&lt;br&gt;(only 81% of employed women deemed eligible) for maximum of 26 weeks</td>
<td>. paid as % of previous earnings up to 55% to a maximum of $457 Canadian per week</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Social Assistance (Employment Benefits)</td>
<td>. unemployed &amp; available for work&lt;br&gt;. household income less than $16,000</td>
<td>Payment depends on age &amp; living arrangements&lt;br&gt;. paid indefinitely (although work incentives)</td>
<td>. maximum is $217.59 per week for single adult and $362.62 for an unemployed couple ($181.31 each)</td>
</tr>
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Source: Various government websites
In New Zealand, unemployment benefits are paid as ‘welfare’ or social assistance and entitlement is based on household income that varies by age and living arrangements (Work and Income New Zealand, 2010). To be eligible, an individual over the age of 25 must have a household income of less than $18,356 per year or $24,440 for a sole parent. This means that women with employed partners are unlikely to qualify for benefits. When women do qualify, the maximum payment is less than half the average wage, except for a sole parent living with their children. If women live as a couple and their partner is also unemployed, they could each receive $181.31 per week. If an adult woman lives alone, the maximum unemployment benefit would be $217.59 per week, which is less than half of the average weekly wage. Table IV compares eligibility and benefits in Canada and New Zealand, showing that benefit levels are far lower in New Zealand but there is no limit on the duration of benefits.

Many sole mothers in New Zealand are eligible for the Domestic Purposes Benefit (DPB), a targeted benefit which pays $527.00 per week to sole parents with dependent children at home and incomes less than $27,390 (Work & Income New Zealand, 2010). This means that few sole parents would be receiving the (lower) Unemployment Benefit unless their children were all in school and there were no other reasons to remain outside the labour force. It also suggests that parenting at home is still an acceptable activity especially for mothers with preschoolers but also those with school-age children if there are other issues inhibiting paid work (such as poor mental or physical health of the mother or child, few suitable jobs in the area, or transportation or childcare problems). None of the Canadian provincial welfare programs routinely permit women to care for their children at home for as long as New Zealand’s DPB (Baker, 2008).

DISCUSSION & CONCLUSION

Comparing social programs cross-nationally is complicated because comparable data are difficult to find and variations are apparent in the design, eligibility and level of social benefits and services. In addition, employment rates vary as do wages, living costs and the relative value of local currency. Nevertheless, cross-national comparisons can provide useful illustrations of the generosity of health and social services for men and women in different socioeconomic circumstances. These comparisons can also reveal other cultural differences such as implicit assumptions about ideal families, maternal employment and ‘good’ mothering.

In recent decades, labour market conditions have deteriorated with the erosion of union protection, the flight of capital and global
labour markets (Baker, 2006; Fairbrother & Rainnie, 2006). Many men and women are working longer hours for similar (or even lower) levels of remuneration, and especially women and visible minorities are concerned about job security and ‘time poverty’. Women’s employment has increased in recent years, raising household income, and the gender wage gap has narrowed as women gain credentials and develop lifetime careers. However, fewer women than men work fulltime and men typically work longer hours with higher wages. This means that women’s contributions to social insurance programs, and consequently their benefit levels, remain less than men’s. However, sole mothers in both countries are better off financially when they are employed than when they rely only on welfare or social assistance.

Despite the presumed similarities between Canada and New Zealand, Canada has created more social insurance programs and also places greater emphasis on the dual-earner family or mother-worker, even when children are young. Ironically, the Canadian labour force also contains more low-paid work, a larger wage gap between men and women, and higher poverty rates for one-parent households. In contrast, most New Zealand social programs are delivered as social assistance targeted to low-income households and fewer mothers work full-time, especially when they have preschool children. Unlike Canada’s Workers Compensation, New Zealand’s ACC is an inclusive social insurance program, covering injuries in the home, community or workplace although recent cuts indicate that the current National-led (conservative) government believes that this program has been too generous. New Zealanders continue to pay a fee for service to visit a physician, but not for emergency hospitalization or diagnostic services recommended by physicians. The duration of income support is longer than in Canada for all categories of beneficiaries, but living standards and per capita income remain lower in New Zealand.

As more women work for pay in both countries, more contribute to social insurance schemes. Programs that pay benefits on an individual basis and as a percentage of previous earnings help women see themselves as employees who are entitled to benefits in their own right rather than simply as wives, mothers or carers. However, these programs are often time-limited and reflect male models of work.

Internationally, employers, conservative governments and supranational organizations such as the OECD promote paid employment for a larger percentage of the population and also want to reduce ‘lost days from work’ because they tend to threaten economic productivity. Sick days and workplace injuries can be reduced by safety programmes, longer statutory holidays and stress reduction programs, while effective health and rehabilitation services can hasten the return to work and create a safer work environment. However, paid leave for
sickness and injury are crucial for employees, especially older workers and mothers trying to combine earning and caring. Stress levels are especially high for employed mothers who have no one else in the household to care for them when they are sick or to share the care of a sick child (Baker & Tippin, 2004; Worth and McMillan, 2004).

In the current work environment, the expectations that more adults will engage in paid work is particularly complicated and risky for low-income mothers. Moving from ‘welfare’ to paid work may result in a net financial loss for their families. The extent of the complications (both perceived and real) are not always recognized by policy makers because they require some acknowledgement of the lack of training to allow workers to move to better positions, the insecurity of many jobs, and the psychic damage caused by dead-end and low-paid work (Baker, 2006). Incorporating an acknowledgement of the complications of people’s lives into social programs remains complex and challenging.

Policy makers need to recognize that many women and mothers accept more responsibility for daily care and household tasks than men and fathers, but mothers also rely more heavily on paid sick leave and childcare services in order to retain their jobs. Furthermore, low-income households tend to experience poorer health than higher-income households (Baker, 2002). Nevertheless, some Canadian jurisdictions do not require paid sick leave, even to full-time workers, and New Zealand pays no sick leave for recent employees. Employed mothers with preschool children often take unpaid leave or holiday leave to care for sick children, with the result that their stress levels remain elevated, their health is jeopardized and their job mobility is truncated.

This paper has revisited the ‘dual welfare state’ concept, showing that although Canada and New Zealand can be seen as similar welfare regimes, Canada relies more heavily on social insurance, the dual-earner family, and the mother-worker. In both countries, program design can easily jeopardize the health and wellbeing of those outside the workforce and those with low incomes, including racialized minorities and sole mothers. Although New Zealand provides all forms of income support for a longer duration than Canada does, especially support for sole mothers, benefits in New Zealand are more often tied to low household income, penalizing unemployed or sick employees who have employed partners. This comparison shows that the adequacy of social provision for sickness, injury and unemployment in these countries is tied to gendered and class-based patterns of paid work, models of family, and cultural ideas about the role of the state in family life.
REFERENCES


