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Precarious contours of work–family conflict: The case of nurses in Turkey

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Abstract

This article examines the impact of the neoliberal restructuring of health services on female nurses in Turkey. It provides a qualitative analysis of work–family conflict, establishing that not only work but also family life has become more precarious. The contours of precariousness of both work and family are analysed through interviews with 50 female nurses working full time in different areas of health service provision. The findings suggest that the neoliberal restructuring of health services has led to staffing deficits along with workload intensification, unpredictable work schedules and poor organisational support. This has increased work–family conflict, defined as a form of precariousness because it heightens the difficulties, risks and insecurities entailed in balancing family-related expectations with increasing work demands for female nurses. This precariousness makes spousal support critical if nurses are to be able to address work–family conflict and leads to nurses' compliance with unfavourable working conditions as a way to resolve the mutual interference of family and work. The increased subordination of life to work has resulted from the neoliberal managerialisation of health services, creating precarisation in the lives of female nurses.

JEL Codes: D1, J2, J7, J81

Keywords

Female nurses, healthcare labour process, neoliberal restructuring of health services, nursing, patient–customer relations, precariousness, precarisation, privatisation, shift work, work–family conflict

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Introduction

This article examines how neoliberal restructuring is reflected in the health labour process (HLP) of female nurses working full time in the first, second and third level of health service provision in Turkey. Focusing on work–family conflict (WFC), it identifies dimensions of precariousness in both work and family life, and questions how and through which arrangements female nurses manage intensified demands on their physical and emotional labour inside and outside of the HLP. Therefore, the article aims to contribute to the research on precariousness through a focus on the gendered aspects of the work–family (im)balance experienced by full-time nurses and on how gender roles have adjusted to current tendencies inside and outside of the HLP.

Health transformation in Turkey

The neoliberal restructuring of the HLP in Turkey has been based on the Health Transformation Programme (HTP), applied since 2003. The HTP is promoted to decrease public health expenses and is based on decentralisation, pressing health institutions to become financially and administratively autonomous management units (Elbek and Adaş, 2009; Kasapoğlu, 2016). The programme reinforces the requirement for health institutions to meet their expenses from within their own incomes, without putting a 'burden' on public resources and, in order to do so, places them under increased pressure to manage working conditions according to the demands of the market.

This health system restructuring is supported by two interrelated processes. First, in the current formation of the HLP, patients are transformed into customers, whose requests should be answered immediately, effectively and continuously (Çınar et al., 2013; Çelebi-Çakıroğlu and Harmancı-Seren, 2016; Kaya and Tekin, 2013; Zencir, 2009). Competition among health institutions to attract more customers results from the need to balance their income and expenses. This leads to customer-oriented management principles, empowering patients via more available complaint channels and tightening control over the physical and emotional labour of health workers (Çınar et al., 2013; Kaya and Tekin, 2013). Second, decentralisation has put health institutions under increased cost pressure (Selberg, 2013), with the minimising of labour costs becoming a prominent issue (Buchan, 2000: 320). Through the application of flexibilisation strategies, health institutions tend to set working times, shifts and leave according to the service production rhythm, for the sake of efficiency and cost minimisation. The tendency to offer a wider range and higher quality of service with fewer workers has been another prominent labour cost minimising strategy (Zencir, 2009: 183). The result has been both an extensiveness and intensity of nursing effort (Selberg, 2013: 13). The former process refers to increases in the amount of time spent at work (Cooke, 2006; Skinner et al., 2011), and the latter refers to excessive physical, as well as emotional, input to fulfil tasks within the intensified workload. The result is a reinforcement of WFC that makes life beyond work more uncertain, unpredictable and precarious for the labour force.

Nurses in between work and family

The neoliberal restructuring of the HLP has generated concerns about the conflict between intensified work demands and family-related expectations. The academic literature has focused on work interference with the family (WFC) rather than family interference with

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work (Aycan and Eskin, 2005: 453; Burke and Greenglass, 1999; Grzywacz et al., 2006). However, the conflict between work and family is inherently bidirectional.

With 1.9 nurses per 1000 inhabitants, Turkey is ranked 5th from last among 41 OECD countries for nursing care availability (Organisation for Economic Cooperation and Development (OECD), 2016). However, compared to other countries (Black et al., 2008; Charlesworth and Heron, 2012; Cooke, 2006; Trinkoff et al., 2010), the nursing shortage in Turkey cannot be explained on the labour supply side through career inactivity – the rate at which nurses leave the occupation in response to unpleasant working conditions and interference with family expectations. On the contrary, the restructured system relies on a labour demand policy of deficit staffing, in order to provide more care with fewer nurses as a strategy of cost minimisation (Zencir, 2009: 182). It is staffing policy that intensifies the workload, extends relative and absolute working hours, leads to rapidly rotating, irregular and unpredictable shifts, restricts recovery times inside (breaks) and outside (leave) of the labour process, and strains nurses' family and social relations (Charlesworth and Heron, 2012; Girard, 2010; Skinner et al., 2011; Zencir, 2009).

Furthermore, customer-oriented management mainly affects nurses in their role as the interface between patients and health institutions. In the current provision of health services, the effectiveness of the service is attached to patient–customer satisfaction and nurses are the main group dealing with the increased expectations of the patients (Selberg, 2013). Nurses are now obliged to offer a smiling face and perform more physical and emotional work in order to avoid any future complaints (Bolton, 2004; Çınar et al., 2013; Cooke, 2006; Kaya and Tekin, 2013). Together with the intensified workload, the excessive physical and emotional exhaustion reflects negatively on nurses' marriages and social relationships (Girard, 2010; Russell et al., 2009: 74; Selberg, 2013: 28).

Female nurses not only provide care as a part of their professional paid work, but they are also the main caregivers in the household by virtue of societal gender roles (Skinner et al., 2011: 215–216). In Turkey, women spend 4 hours per day more than men on household and family care (Turkstat, 2019: 170), and 6 out of 10 women do not participate in the labour force due to their domestic responsibilities (Turkstat, 2019: 123). Concurrently, dual earner families are becoming the norm in order to maintain a satisfactory household income. This norm underlines the growing inadequacy of male wages for dependents and challenges the traditional male-breadwinner household model. The result tends to be perceived as a modification in household gender relations, with women's involuntary part-time employment being described as a strategy for balancing work and family responsibilities (Campbell et al., 2009; Crompton, 2002; Fagnani and Letablier, 2009; Fredman, 2006; Girard, 2010; O'Reilly et al., 2009; Vosko and Clark, 2009). However, restructuring is underlined by the persistence of the full-time work tradition in Turkey (Mütevellioğlu and Işık, 2009: 194). While the national rate of part-time work is already low by international standards, being only 7.1% of total female employment, in the health sector part-time work is only 3.7% of total female employment (Uysal and Kavuncu, 2019). This implies that the persistence of maternalism along with the full-time work tradition creates more difficulty for female nurses in reconciling work and family demands in Turkey.

In line with the literature on shift working (Costa, 2003; Girard, 2010; Pisarski et al., 1998), nursing has already been shown to be associated with difficulties in scheduling family activities, reduced marital happiness and weakened social relationships (Shiffer

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et al., 2018; Vitale et al., 2015). However, staffing deficits along with workload intensification result in less employee control over shift scheduling (Charlesworth and Heron, 2012; Skinner et al., 2011), and excessive physical and emotional exhaustion heighten the experience of work interference with the family domain in the current formation of the HLP. Rapidly rotating night and evening shifts, in particular, add special stress to marriage and disrupt evening family routines (Vitale et al., 2015). In addition, shift working has an asymmetric effect on the stereotypical household division of labour (Barnett et al., 2008). Absence of the mother necessarily increases the father's involvement in the care of the children (Aycan and Eskin, 2005: 454; Barnett et al., 2008; Presser, 2000) as the 'delegated carer' (Lindsay et al., 2009: 672) and spousal support is increasingly important in reducing family interference with work (Aycan and Eskin, 2005; Burke and Greenglass, 1999). However, to underline the persistence of the ideology of the mother as the primary caregiver, Lindsay et al. (2009: 665) suggest the term 'modified maternalism', where 'women tend to be important but secondary wage earners and the men are important but secondary carers'. It is therefore evident that while household gender roles have been challenged as a response to the intensified interference of paid work with family, re-gendering of roles has not been completed (Lindsay et al., 2009: 662; Pocock, 2003).

The term 'precarious contours of work–family conflict' applies as well to the work-care regime in a particular country as a whole. Regulation of birth-related leave and provision of childcare affect the work–family nexus, with precarious consequences (Clement et al., 2009; Gottfried, 2009). The work-care regime in Turkey has been characterised by contradictory assumptions that support women's labour force participation (Republic of Turkey Ministry of Development, 2013: 164) yet insist on attaching childcare to the mother. The critical point is that working mothers are expected to organise childcare preferably within the household or in the private sector without putting additional costs on the workplace and/or welfare state. Indeed, instead of an institutionalisation of childcare, a tendency to extend the duration of maternity leave and promote market-driven solutions for childcare seems to characterise the work-care regime in Turkey. Despite the importance of organisational support in lowering WFC (Aycan and Eskin, 2005: 455; Vitale et al., 2015: 71), the provision of daily nurseries is very limited in workplaces and nearly lacking in the 0 to 3 age range. Even if some health institutions provide nurseries, institutional childcare is rarely available outside of standard working hours and weekdays (Black et al., 2008: 154). Thanks to strong family ties in Turkey, this lack of alternatives often makes involvement of the extended family in childcare one of the major sources of social support to ease WFC (Aycan and Eskin, 2005: 454). However, in the case of night and evening shifts, spousal support appears as an inevitable dimension in reducing family interference with work demands in Turkey (Aycan and Eskin, 2005: 455).

Within this scope, and consistent with recent research (Anderson, 2010; Boese et al., 2013), precariousness is not confined to the labour process but is also linked to broader societal power relations, among which are gender relations. As a response to the implications of the neoliberal restructuring of the HLP, the family maintains its centrality as a source of both support and conflict, and it is apparent that 'changes in gender consciousness at home are the final frontier in the quest for greater gender equality in work–family linkages' (Loscocco, 1997: 223).

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Precariousness beyond work

For the last 40 years, increasingly adverse impacts of neoliberal restructuring on working and living conditions have been conceptualised as precariousness, referring to less individual or collective control by workers over working conditions and more generalised insecurity in employment, income, working time, career and social protection.

Precariousness should not be taken as a mere description of the labour process. The concept of precariousness underlines the fact that more and more areas of life are subordinated to the needs of the economy (Alberti et al., 2018: 449; Federici, 2014). In the flexible formation of the labour process, work, in order to be productive, has become incorporated into non-working time; the exploitation of the workforce happens beyond the boundaries of work and is distributed across the whole time and space of life (Neilson and Rossiter, 2005: 52; Precarias a la Deriva, 2005; Tsianos and Papadopolous, 2006).

One aspect of precariousness beyond work is reproductive insecurity, referring to the increasing centrality of work in family-related decisions and the constrained capacity of workers to make reproductive choices, such as the decision to have a child and form a family (Chan and Tweedie, 2015). Precariousness beyond work also includes being unable to plan one's time, being a worker on-call whose life and time is determined by external forces (Foti, 2004). Mothers may opt for insecure forms of 'flexible' work in order to provide greater security of care (Carney and Junor, 2014). The deterioration of public social services, conceptualised as double precarisation (Candeias, 2004), is another aspect of precariousness beyond work. Indeed, the neoliberal shift in the formation of the welfare state has been centred on the transfer of risk to individuals by promoting personal responsibility and market-driven solutions for social problems (Crompton, 2002: 544; Candeias, 2004; Gottfried, 2009; Kalleberg, 2011: 87).

Pursuing this line of analysis, the feminist debate reconceptualises the interplay between work and life as an indicator of a specifically gendered precariousness. Rooted in the domestic labour debate and socialist feminist approaches, feminist studies have already bypassed

> the old androcentric focus on the marketplace and recognised the existence of other times and work; these exist in the shadows of economic activity, cannot be calculated in monetary terms and yet are absolutely essential for the continuance of life. (Carrasco and Mayordomo, 2005: 233)

However, in contrast to early feminist claims considering work and family as discrete spheres, the feminist precariousness debate underlines that 'the economic and the social (i.e. employment and the family) should be seen as intertwined rather than approached as separate phenomena' (Crompton, 2002: 537). Thereby, it is no longer plausible to speak only about the precariousness of work, but rather the precarisation of life (Casas-Cortés, 2014: 220; Precarias a la Deriva, 2005). The feminist precariousness debate thus refocuses on WFC as a gendered form of exploitation, yet in a way composed of both the inside and outside of the labour process.

This analysis leads to a revival of care in the feminist precariousness debate as well. Indeed, 'the way care is connected through the labour market, social security and household is at the core of the intersection perspective on precarious lives' (Clement et al., 2009: 241). Gottfried (2009) suggests that the concept of reproductive bargain should

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add the organisation of social reproduction to an understanding of the precariousness. Such an account sees 'how reproduction and care are organised (their locus in the household, state, market), who bears the cost of the reproduction, who performs reproductive labour and under what conditions (right, risks, responsibilities)' (Gottfried, 2009: 77) as determining the reproductive bargain and affecting gendered aspects of precariousness in the conflict between work and family.

Within this framework, the article seeks to shed new insight into the dimensions of precariousness in understanding the adaptation of gender roles to the current tendencies inside and outside the HLP in the case of full-time female nurses. It thereby aims to contribute to the body of research linking precariousness with non-working outcomes.

Method and scope of fieldwork

The method adopted in this article was qualitative research. Qualitative research provided an inter-subjective environment for gaining insight into experiences, allowing HLP to be seen from nurses' perspective. The data were collected within 4 months (from November 2016 to February 2017) through 50 in-depth interviews based on a semi-structured interview schedule, which included questions about nurses' working history, current and past working conditions and WFC experiences. Income, working time, control over the pace of work, career progression, social protection security and reproductive insecurity were the set of indicators for precariousness used for the interviews.

In-depth interviews were conducted with nurses working in the first level (3 family health centres, 11 in-depth interviews), second level (1 public hospital, 15 in-depth interviews; 1 private hospital, 13 in-depth interviews) and third level (1 university hospital, 11 in-depth interviews) of health service provision. As nurses were reluctant to assign extra time outside of their shifts, interviews were conducted in health centre and hospital wards during their shifts. This caused interruptions to the interviews due to their ongoing duties. Nevertheless, it also created an opportunity to gain firsthand observation of labour process, interactions among nurses and patients.

The selected health institutions were based in Ankara, the capital of Turkey, and accessed with a headed letter to nursing directorates, asking for cooperation and permission for interviews. Capacity (inpatient bed availability) and history (being an historically old, institutionalised and well-known hospital providing health services before and after the HTP) were the criteria used in the selection of hospitals, in order to understand the impact of the HTP on the restructuring of the HLP and to analyse changes in nurses' working and living conditions. Family health centres were selected from Çankaya, one of the biggest and most crowded districts in Ankara.

Female nurses were selected as a group to examine the adjustment of gender roles to the current tendencies inside and outside of the HLP. To enable nurses to compare their past and present working and living conditions, nurses having at least 10 years tenure were selected. This led to a concentration of interviews with head nurses in wards (19 out of 28 interviews), which in turn enabled us to gain detailed knowledge on the management of the HLP in general. The average tenure of the interviewed nurses was 20–30 years. Marital and motherhood status were interview selection criteria, to provide an understanding of access to birth-related rights (such as maternity leave, breastfeeding

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leave, organisation of night shifts before and after delivery), organisation of childcare and strategies for reconciling work and family. Of the 50 nurses, 42 were married, 43 had children and nearly half of these children (21 children) were of pre-school age.

The interviews lasted 40–90 minutes. All interviews were digitally recorded, and the recordings were transcribed verbatim. The approach adopted was descriptive content analysis, widely used in studies examining health care and nursing-related phenomena (Polit and Beck, 2014). In qualitative description, the aim is not to build or test theory, but rather to provide an in-depth account of 'who, what, and where of events of experiences and to gain insights from informants regarding a poorly understood phenomenon' (Kim et al., 2017: 2). The transcripts were coded word by word to identify recurrent and salient themes in nurses' experiences.

Findings

Invasion of life by work

One of the current characteristics of the HLP is extension and unpredictability in working hours, including shifts and leave, due to the primacy of the service provision rhythm. The extension and unpredictability of working hours prevented nurses from scheduling their lives beyond work, indicating an invasion of life by work.

Irrespective of the level of health institutions, nurses claimed that they had not had a chance to use the regulated duration of their annual leave during their career because it is expected that nurses will organise both the duration and the dates of their annual leave according to workload. Nurses emphasised how this expectation had grown over time, due to the downward pressure on the numbers of nurses despite the intensified workload in health service provision over time:

> Due to inadequacy in the numbers of nurses, using annual leave may become a problem. We are using annual leave by turn; two nurses cannot use their annual leave at the same time. Moreover, you are able to use only 10–12 days of your 30 days annual leave. (N33)

However, staffing deficits made task completion harder within shifts and led to intensified pressure on both absolute and relative working hours. Irrespective of the level of health institutions, working outside the determined weekly and daily working hours appeared to have become typical, especially in wards. In addition to extended working hours, nurses faced shift irregularity and increases in the numbers of night shifts. Moreover, as another outcome of the staffing deficit, shifts rotated rapidly and the absence of one nurse for some reason (such as health problems, maternity leave, annual leave) put the physical and emotional burden of the workload on the shoulders of nurses remaining at the ward. This intensified the remaining nurses' working-time insecurity and increased the pressure of work on their life beyond work:

> In this ward, there are 6 nurses for 30 beds. Due to working in critical numbers, when someone goes on leave, others become obliged to shoulder the shifts and tasks of this nurse. Our workload has always been very intense; however, in the past our numbers were adequate. In the 90s, we had 8–9 nurses for 30 beds. Therefore, using annual leave and shift-rotation were more

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> convenient in the past. The workload is the same, but we do more jobs with fewer personnel. The workload has become more intense. (N5)

Rapid shift rotation, upward pressure on working hours and increases in the numbers of night shifts made HLP physically and emotionally more demanding for nurses and led to WFC. Indeed, extension and intensification of the workload made nurses feel they were devoting adequate physical and emotional labour to their family, marriage and social relationships:

> As compared to children in a ward, I do not devote the same amount of attention and patience to my own children and husband at home. I sometimes regret this situation and ask myself 'don't my husband and children deserve the same attention and patience?' (N34)

The degree of working-time predictability or employee control over shift scheduling is one of the important indicators of work-life balance, enabling workers to meet family-related responsibilities and expectations. Moving beyond considerations of the precariousness of working-time insecurity and control solely within the labour process, the findings underline a perspective comprising an extended control of work over the entire life, intensified uncertainty in scheduling life beyond work and difficulty in managing family-related expectations and social relations.

Compliance in the hope of work–family balance

Being a member of the hospital's nursing directorate and being a head nurse of the ward are two main career steps in the nursing occupation. Assignments in different administrative units, such as the education unit, infection control committee or desk jobs in institutions belonging to the Ministry of Health, are also considered as career steps among nurses. While climbing career steps increases responsibility, nurses emphasised that the impact of these positions on wages is not commensurate. What these positions offer, then, is the possibility of working in the daytime without night shifts.

This implies that climbing career steps was seen, not simply a means to higher income and prestige for female nurses, but a way of escaping the intensified interference of work with family demands. Especially for nurses who were married and mothers, securing daytime work had become a main career motivation:

> Nurses' married life is different than other people. After 10 years with night shifts, I started to work daytime as a head nurse and felt like I was not married before. Now, I began to see my husband and children every evening. We could not get used to this situation at the beginning because for 10 years, we had been able to see each other on my off days and my husband and children generally stayed alone at home. (N37)

Crucially, however, this career motivation appeared to encourage nurses to quietly comply with unfavourable working conditions. Nurses claimed that, compared with objective criteria such as education and working experience, having a good relationship with administration was generally more important in career progression. Thus, arguably, the subjective criterion of a compliant relationship with the administration has been

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operating as a control mechanism within the HLP in terms of encouraging nurses to suppress their criticisms of working conditions in order to be the one selected for daytime positions exempt from night shifts:

> There is a baby waiting for you in at home at night. If you want to be exempted from the night shift, you have to build good relationships with hospital administration to be the one selected for higher positions. Being the one selected is not based on education; it is attached to establishing good relationships and personal networks. (N14)

Therefore, the findings extend the scope of labour process theory concepts of control by underlining the intervention of gender roles into nurses' attitudes within the HLP. It is apparent that household caring responsibilities, by virtue of the persistent ideology of maternalism, lead to nurses' compliance with precarious working conditions in the hope of exemption from night shifts or being the one selected for daytime positions. Despite their criticisms of working conditions, the pressure to ease the tension between work and family demands precludes the possibility of nurses voicing their criticisms. The possibility of securing daytime work becomes a control mechanism, making nurses a part of the reproduction of precariousness in their working and living conditions.

Aspects of reproductive insecurity

The intensified WFC generates a tension more specifically for nurses who have children. Due to the persistence of maternalism, nurses regret or feel sorry about not being able to devote enough time and labour to their children, more specifically during their preschool years. Although it is possible to avoid domestic responsibilities, nurses find it difficult to reconcile motherhood responsibilities with intensified workload, unpredictable working hours and rapidly rotating night shifts.

Irrespective of the level of the health institution, nurses are able to use their maternity leave in accordance with the regulations. It is apparent that nurses interpret recent regulations extending the duration of birth-related leave (maternity and breastfeeding leave) and providing the opportunity of daytime work without night shifts for a period of time after birth as indications of administrations' more supportive attitude before and after birth:

> In the past, maternity leave was two weeks before and four weeks after birth. I returned to work when my child was 42 days old. Night shifts began immediately after maternity leave. To give birth was like a punishment in the past. Now, maternity leave is extended and more available. (N9)

In comparison to maternity leave, nurses are not able to use breastfeeding leave in accordance with the regulations. Head nurses show a tendency to organise breastfeeding leave in accordance with the rhythm of the workload in the ward. Moreover, different from the regulation, breastfeeding hours are generally collected together instead of being provided on daily basis.

Extension of birth-related leave can be considered a reflection of the work-care regime promoting childbirth among working women by extending the duration of maternity and breastfeeding leave. However, the critical point is that reproductive ages

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correspond to the period that nurses are working actively and productively in wards and night shifts. While an extended duration of birth-related leave is an enabler in easing work-care tension, it puts the pressure of the intensified workload on the shoulders of nurses remaining in the ward. As an outcome of the conflict between workload intensification and staffing deficits, it is apparent that an absence of even one nurse due to maternity leave intensifies the remaining nurses' working-time insecurity and in turn the interference of work in the security of the family domain:

> Now, nurses are able to work in the daytime and use breastfeeding leave until their children turn two years old. In this situation, night shifts are compulsorily allocated among the remaining nurses in the ward. This means that one nurse's absence becomes a punishment for the remaining nurses. I have 3–4 nurses in the ward carrying the potential of a pregnancy. I, as a head nurse, am worrying that one of them will come and say 'I am pregnant', due to inadequateness in our numbers and heavy workload. (N30)

After birth-related leave, nurses use a variety of childcare arrangements. The hospitals in this study provide nursery opportunities. While the public hospital and the university hospital had their own nurseries, the private hospital had an agreement with a private nursery offering a lower price to hospital personnel. Although the availability of nurseries seems to indicate organisational support of childcare, these were not free and the nurses' possibility of benefitting from these nurseries was restricted by limited capacity and expensiveness. Moreover, these nurseries were available only in the daytime:

> I sent my child to nursery, but it was not the hospital's nursery due to its limited capacity. This was an unacceptable excuse; its capacity should match with the number of the personnel. It is also very expensive; 700–800 TL per month. I am an employee of the hospital; an adequate and affordable nursery should be provided to eliminate my burden as a mother. I really had financial difficulties; I was spending more than half of my wage on nannies and nurseries. The stress of financial difficulties, the stress of a job and the stress of a night shift . . . we, as nurses, are trying to provide service under the pressure of these emotions. (N35)

Limited capacity and expensiveness make childcare the nurses' personal problem, compulsorily solved within the household or through private nurseries if affordable options are available. It is seen that childcare is a problem generally absorbed within the household (26 nurses) in its paid (9 nurses) but mainly unpaid (17 nurses) forms. Due to the expensiveness of nannies compared to nurses' wages, families often depend on care provided by close relatives, generally grandparents. This implies non-institutionalisation of childcare and underlines social protection insecurity in terms of poor access to formal childcare sponsored by the state or employers. It underlines income insecurity as well. Rather than irregularity and uncertainty in wages, the findings suggest that nurses experience income insecurity as an income insufficiency – low and/or insufficient wages that restrict the nurses' possibility of purchasing associated childcare services on the market.

In this regard, unpaid female extended family members provide additional support, despite nurses' claims about administrations' more supportive attitude in birth-related leave, as compared to the past. Thanks to strong family ties in Turkey, the problems of capacity and affordability in its institutional provision make the involvement of extended

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family one of the major social supports that ease family interference with work. Poor organisational support for childcare, considered by nurses as another aspect of cost sensitivity in health institutions, heightens WFC and is reflected in the long age-gap between nurses' children. It is possible to see more than a 6-year gap (eight nurses) between births:

> My first child is 15 and the second one is 3 years old. I was obliged to have this gap between them. I raised my first children while I was working night shifts. It was really difficult. We decided to have the second child after I was exempt from night shifts. (N37)

This implies nurses' restricted control over their decisions about their life beyond work, even if it is the very personal decision of giving birth. Therefore, the findings extend the scope of the concept of reproductive insecurity by considering it in relation to persistent maternalism and by indicating the influence of organisational support to very personal life decisions of nurses.

Fathers as delegated carers

The findings suggest that childcare is not only organised by means of paid or unpaid labour of another woman, but fathers also play an active role due to the existence of night shifts in nursing:

> My husband supported me. We raised two children together. Especially during night shifts, my husband looked after the children. I sometimes wonder which one of us was the mother. (N35)

The findings underline the increased importance of spousal support in easing family interference with work associated with rapidly rotating night shifts due to staffing deficits. In addition to poor organisational support for daily childcare, it is apparent that the lack of nurseries on nights and weekends makes fathers a part of childcare as delegated carers. Fathers' consent to take over childcare despite the dominance of the mother as the main caregiver ideology is evidence of a modification of stereotypical household gender roles as a response to the intensified conflict between work and family. This moderation of household gender roles also underlines the growing inadequacy of male wages in enabling support of dependents and signifies the erosion of the traditional male-breadwinner household model. In exchange for maintaining a sufficient household income, it is apparent that fathers consent to resolve family interference with the work domain by being involved in the childcare and in turn by being a part of the means to satisfying intensified work demands on nurses.

Discussion

The interplay between work and family has undergone radical changes in the current formation of the labour process. The global move towards a 24/7-service economy leads to more variable shift arrangements and makes extension of working hours almost a norm. Nursing still preserves its specificity in the WFC debate, as it is a highly feminised occupation requiring a high degree of physical and emotional dedication and is associated strongly with gendered caring labour off the clock. Moreover, similar to other

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countries, neoliberal restructuring since 2003 has reflected on the HLP in the shape of unpredictable working hours, rapidly rotating shifts and physically and emotionally intensified workload, reinforced by staffing deficits as a strategy of cost minimisation in Turkey. In addition, poor organisational support for childcare despite the persistence of maternalism makes nurses an important occupational category for examining precarious contours of WFC.

Despite their potential, feminist accounts of precariousness remain confined to gender stratification, linking precariousness with the feminisation of part-time work as a response to intensified WFC (Campbell et al., 2009; Cranford et al., 2003; Crompton, 2002; Fagnani and Letablier, 2009; Fredman, 2006; Menéndez et al., 2007: 778; O'Reilly et al., 2009; Vosko and Clark, 2009). Nevertheless, reducing precariousness solely to part-time working conditions neglects other implications for household gender roles and work-care regimes through work interference with family. In addition, despite the growing emphasis on moving beyond the standard/nonstandard dichotomy in understanding precariousness (Burgess and Campbell, 1998; Campbell et al., 2009: 60; Ferreira, 2016: 145; Tompa et al., 2007: 210), the concentration on part-time work results in an inability to explain WFC experiences of women working full-time in terms of precariousness.

As full-time work remains the main employment category in total female employment and in nursing, particularly in Turkey, the concept of precarity, defined in terms of part-time or non-standard work, is not applicable as an explanation of WFC. Using comparisons with other countries, nor does the notion of career inactivity explain gendered aspects of WFC for female nurses in Turkey. Rather than part-time work and career inactivity, as a contribution to the feminist debates on WFC, this article applies the concept of precariousness to an explanation of WFC in terms of nurses' compliance with unfavourable working conditions in the hope of decent shifts. It shows that criticisms of such working conditions are suppressed in the hope of selection for a daytime position; and that fathers consent to modified household gender roles in exchange for a measure of household income security – by being delegated carers.

Sticking to part-time work in feminist precariousness debates also leads to inadequacy in merging gendered aspects of WFC with the dimensions of precariousness. By placing precariousness at the intersection among household gender roles, the labour process and the work-care regime, this article contributes to the feminist precariousness debate by giving new insight into dimensions of the precariousness in the literature, as follows.

Income insufficiency, a level of income insufficient to maintain the well-being of workers and their dependents is an aspect of income insecurity in the literature (Fagnani and Letablier, 2009; Julià et al., 2017; O'Connor, 2009; Tompa et al., 2007: 217; Tucker, 2002). As seen in the case of nursing, income insufficiency also signifies becoming more distant from the paid forms of childcare within a work-care regime reinforcing market-driven solutions for social reproduction.

Uncertain working hours (Campbell et al., 2009; Tucker, 2002), low schedule predictability and working hour intensity (Julià et al., 2017) are important indicators of working-time insecurity in the literature. As seen in the case of nursing, consideration of working time also requires questioning of workers' control over scheduling their non-working times, possibilities of meeting family-related expectations and access to paid and unpaid leave.

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In addition to reduced employee control over the pace of work (Fagnani and Letablier, 2009; Rodgers, 1989; Tompa et al., 2007: 216), as seen in the case of nursing, subordination of life to work demands implies workers' loss of control over their life beyond work as well. Moreover, in the exercise of this control, this article identifies the impacts of gender roles on workers' attitudes within the labour process. As seen in the case of nursing, nurses' pursuit of daytime shifts generates uncritical attitudes about precarious working conditions, in turn making them a part of and accomplice in employer control over both their working and their family lives.

Rather than explaining workers' constrained capacity to make reproductive choices in terms of job insecurity alone, as do Chan and Tweedie (2015), this case of nursing reveals two possible indicators of reproductive insecurity. The first is household gender roles – in terms of the level of spousal support. The second is work-care regimes in an individual country – in terms of the level of organisational support for accessing birth-related leave and institutional childcare.

In addition to fewer career progression opportunities (Tompa et al., 2007: 218), as seen in the case of nursing, career insecurity also relates to the attachment of career progression to subjective criteria, such as having good relationships with the administration. This article also identifies the decisive impact of gender roles on expectations from a career. As seen in the case of nursing, more than income and prestige, the possibility of gaining daytime work can be a motivation for pursuing career progression to ease work interference with family satisfaction.

Conclusion

Adequate staffing, predictable working hours, decent shift scheduling and institutional childcare appear in the findings as needed interventions within the HLP in order to allow family-related expectations to be reconciled with increasing work demands. Although the importance of spousal support in easing family interference with work is clear in the findings, to provide a more comprehensive account of modified household gender roles, couple interviews questioning spouses' employment patterns, earning capacity and consent for childcare should be included in future studies.

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