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Creating A Caring Society

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Why is it important to achieve a society that values caring and caring relationships? The answer might appear obvious: It seems inherent in the definition of a good society that those who cannot care for themselves are cared for; that those who can care for themselves can trust that, should they become dependent, they will be cared for; and that people will be supported in their efforts to care for those they care about. But even more is at stake. Currently we are caught in a nasty circle. To the extent that caring is devalued, invisible, underpaid, and penalized, it is relegated to those who lack economic, political, and social power and status. And to the extent that those who engage in caring are drawn disproportionately from among disadvantaged groups (women, people of color, and immigrants), their activity—that of caring—is further degraded. In short, the devaluing of caring contributes to the marginalization, exploitation, and dependency of care givers. Conversely, valuing and recognizing caring would raise the status and rewards of those who engage in it and also increase the incentives for other groups to engage in caring. Thus, a society that values care and caring relationships would be not only nicer and kinder, but also more egalitarian and just.

In addressing the question of how to create a society in which caring is valued, I first give a brief account of the contemporary “crisis” in care which stems from its being defined as a privatized, feminized, and therefore devalued domain. In the next section I review recent feminist attempts to rethink the concept of care in ways that open it up to critical analysis. I then define some desirable goals for a society that values care. In the final section I outline four major directions for change in social citizenship rights, family responsibility, organization of paid care, and employment policies and practices.

The Contemporary Problem of Care

A spate of popular books and articles in the last decade has sounded an alarm about a new “crisis in care,” a crisis occasioned by the exodus of women from the home into the work force. The need for care of children, the elderly, and the chronically ill and disabled has not diminished, and may have grown because of increased longevity and medical advances that keep people with serious injuries or illnesses alive. Yet

traditional caretakers—stay-at-home wives and mothers—are now less available to provide care on a full-time basis.

Dual-worker families—and more concretely, employed women—are said to be increasingly overburdened and strained by the need to meet both earning and care responsibilities. At the same time, most families don’t have the economic means to purchase care, and state services are grossly inadequate. As Mona Harrington (1999: 17) says in a recent popular treatment, “we have patchwork systems, but we have come nowhere near replacing the hours or quality of care that the at home women of previous generations provided for the country.” The question of how care is to get done without substantial numbers of nonemployed women to do it has become the subject of research and policy initiatives. For example, the Alfred P. Sloan Foundation has funded several university research centers on work and family life, including one at my campus devoted to “Cultures of Care.”

The “crisis in care” is just one impetus for recent critical examinations of the concept and organization of care in modern political democracies. Feminist theorists and researchers for some time have been examining care in its gendered dimensions. Their work makes it clear that the current crisis is a product of a privatized and gendered caring regime in which families, rather than the larger society, are responsible for caring and in which women (and other subordinate groups) are assigned primary responsibility for care giving.

The relegation of care to the private sphere and to women has had two further corollaries: the devaluation of caring work and caring relationships, and the exclusion of both from the arena of equality and rights. As feminist critics of liberal political philosophy have explained, the very concept of citizenship (i.e., full membership in the community, including reciprocal rights and responsibilities) has been premised on two conceptual dichotomies. First has been a split between the public and private, with the private realm of concrete relations of care defined not only as separate from, but also in opposition to citizenship. The private realm encompasses emotion, particularity, subjectivity, and the meeting of bodily needs, while the pub-

lic arena of citizenship is ruled by thought, universality, objectivity, and the ability to act on abstract principles. Those relegated to the private sphere and associated with its values—women, servants, and children—were long excluded from full citizenship. Second has been a dichotomy between independence and dependence, with the ideal citizen defined as an autonomous individual who can make choices freely in the market and in the political realm. Within the liberal polity, citizenship supposedly created a realm of equality in which independent individuals had identical rights and responsibilities, regardless of differences in economic standing and other attributes. Those deemed dependent, whether categorically (as in the case of women, slaves, and children) or by reason of condition (as in the case of mental or physical disability) lacked standing and therefore were defined as outside the realm of equality (Okin 1979; Pateman 1988).¹ The fiction of liberal philosophy that independent and autonomous actors exist also obscures the actual interdependence among people and the need for care that even “independent” people have.

Historically, then, in the United States caring work within the family has not been recognized as a public societal contribution comparable to paid employment. As Judith Shklar (1991) has pointed out, earning has always been seen as a responsibility of citizenship because it is the basis for independence. In this view, earners fulfill citizenship responsibilities and therefore deserve certain entitlements, such as old age pensions, unemployment insurance, and health and safety protection. In contrast, unpaid family caregivers perform strictly private responsibilities and do not fulfill broader citizenship responsibilities. Hence, they are not accorded entitlements comparable to those of wage earners.

Moreover, the dominant family model assumes that support for dependents and caregivers comes from the male breadwinner. Historically, the United States has provided little support for care giving, compared to other Western nations where paid parental leave, fam-

ily allowances, child care services, housing subsidies, and health care coverage have been common (Fraser and Gordon 1993). During the World War I era, Progressive reformers pushed though maternalist programs, such as the Mothers' Pension program, to allow widowed women to keep their children rather than sending them to orphanages. But pensions were so low that single mothers were forced to work as well as care for their children. The Mothers' Pension was quickly phased out. New Deal-era social welfare policies institutionalized a two-tier system based on a male breadwinner-female caregiver model. The upper tier consisted of safety net entitlements for male breadwinners, which provided relatively generous, non-means-tested benefits such as unemployment insurance, social security retirement, and disability payments. Dependents of male breadwinners, including female caregivers, received indirect benefits through their relationship to a male earner, via provisions such as social security survivor benefits. The lower tier for women without connections to male breadwinners provided relatively ungenerous, means-tested “welfare” as in the original Aid to Dependent Children (ADC) and in the later Aid to Families with Dependent Children (AFDC). These benefits were considered a response to the neediness of children, not as an entitlement for mothers' caring labor (Nelson 1990; Gordon 1994; Abramovitz 1996). These programs were not only gendered, they were also raced. Black single mothers in the South and Mexican single mothers in the Southwest were routinely denied relief on the grounds that they were “employable.” Thus, these women were not seen as “dependent” caregivers in the same way that white women were (Mink 1994).

Yet despite the prevailing ideology of the family as the realm of care, the growing need for care has generated a demand for paid care giving as an alternative or supplement to unpaid family care. Some of the demand has been met by institutions and services administered by the state and nonprofit organizations. The greatest growth, however, has been in institutions and services organized by for-profit corporate entities formed to take advantage of payments available through (industry-backed) government medical insurance. Overall, then, there has been a shift of some portion of caring to publicly organized settings, whether administered by state, nonprofit, or for-profit entities.

¹ Kittay (1995) has extended the critique to argue that dependence and relations of dependence are simply not accommodated in liberal theories of justice, which are premised on a model of autonomous individuals who can make choices in their own best interests.

In these settings, the actual work of caring is done by “strangers”—paid workers, sometimes supplemented by unpaid volunteer workers. When caring is done as paid work, it not only remains gendered, it also becomes conspicuously racialized. In institutional settings such as hospitals, nursing homes, and group homes, nursing aides and other workers who actually do the day-to-day work of caring are overwhelmingly women of color, many of them recent immigrants. Home care workers also are drawn disproportionately from the ranks of women of color (Glenn 1992).

When care work is done by people who are accorded little status and respect in the society by reason of race, class, or immigrant status, it further reinforces the view of caring as low-skilled “dirty” work. This dual devaluation—of care work and care workers—rationalizes the low wages and lack of benefits that characterize care work. From her analysis of national wage data, Paula England (1992: 182) concluded that “being in a job requiring nurturing carries a net wage penalty of between \$.24/hour and \$1.70/hour.” Taking into account such factors as workers’ education, service jobs involving care giving paid less than comparable jobs not involving care giving. Thus child care workers earned less than manicurists; nursing aides and orderlies earned less than janitors; and psychiatric aides earned less than elevator operators. One ironic result is that those who care for others usually have to give up caring for their own dependents, yet cannot afford to pay anyone to care for them. Caring work is considered low-skilled and largely physical in nature, despite the importance of emotional and psychological aspects of caring.

Care in institutional settings is compromised by a combination of factors: pressures to cut costs, government regulations, medicalization, and bureaucratization (Foner 1994). Deborah Stone (1999) notes that cost-containment pressures affect both private for-profit care and public nonprofit and taxpayer-supported facilities. Efforts to reduce or control costs have resulted in inadequate training and chronic understaffing. Government regulations, reflected in institutional procedures, also require caregivers to spend time on extensive paper work. As workers are stretched thin, they experience stress and frustration, leading to burnout and high turnover. Bureaucratic structures and regulations, which are designed to both keep down

costs and protect care receivers, nonetheless often restrict the caring activities of caregivers. For example, because of Medicare regulations, health care institutions try to limit staff to performing strictly medical and medical-related tasks such as changing dressings, and not getting involved in social and emotional caregiving.² All of these pressures directly affect the care relationship. Caregivers complain about the lack of time and autonomy to respond to individual needs. Care receivers may be subject to controls that maintain “order” under conditions of understaffing (e.g., through use of sedation or physical restraints). Care receivers may not receive the kind of individualized and time-consuming care that would allow them maximum dignity and autonomy.

Rethinking Care

To develop alternatives to the present situation, we need to rethink the concept of care. Because care is so closely associated with womanhood, feminist philosophers and social theorists have subjected care to close analysis. My reading of several theorists of care, including Joan Tronto (1993), Diemut Bubeck (1995), Emily Abel and Margaret Nelson (1990), and Sara Ruddick (1998), suggests the usefulness of defining care as a practice that encompasses an ethic (caring about) and an activity (caring for). “Caring about” engages both thought and feeling, including awareness and attentiveness, concern about and feelings of responsibility for meeting another’s needs. “Caring for” refers to the varied activities of providing for the needs or well-being of another person.³ These activities

² Thus, visiting nurses or health care coordinators may be allowed to make a single home visit to give discharged patients instructions on medical self-care, but not to take longer to provide social and emotional support to help them adjust to their new limitations.

³ For the purposes of this essay, I am deliberately limiting the meaning of care to that of caring for people, even though for other purposes, one might conceptualize care as encompassing caring for objects, animals, and the environment. For example, political theorist Joan Tronto (1993: 103) defines caring as “a species activity that includes everything that we do to maintain, continue, and repair our ‘world’ so that we can live as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.” At

include physical care (e.g., bathing, feeding), emotional care (e.g., reassuring, sympathetic listening), and direct services (e.g., driving a person to the doctor, running errands). The definition is not free of ambiguity, but it does establish some boundaries. For example, defining caring in terms of direct meeting of needs differentiates caring from other activities that may foster survival. Thus, economic provision would not be included, even though it may help support care giving. Men are often said to be “taking care of their family” when they earn and bring money into the household. Despite the use of the term *care* in this phrase, breadwinning would not be considered “caring.” In fact, economic support has historically been seen as men’s contribution in lieu of actual care giving; simultaneously, care giving has been viewed as women’s responsibility, an exchange for being supported by the primary breadwinner.

Within this definition of care as a practice, three features are important. First, this definition recognizes that everyone needs care, not just those we consider incapable of caring for themselves. Often only children, the elderly, the disabled, or the chronically ill are seen as requiring care, while the need for care and receiving of care by so-called independent adults is suppressed or denied. As Sara Ruddick (1998: 11) notes, “most recipients of care are only partially ‘dependent’ and often becoming less so; most of their ‘needs,’ even those clearly physical, cannot be separated from more elusive emotional requirements for respect, affection, and cheer.” At the same time, even those we see as fully independent—that is, able to care for themselves in terms of “activities of daily living”—may for reasons of time or energy or temporary condition need care to maintain their physical, psychological, and emotional well-being. They may turn to a family member, friends, a servant, or a service provider for hot meals, physical touch, or a sympathetic ear. The difference is

that “independent adults” may preserve their sense of independence if they have sufficient resources, economic or social, to “command” care from others, rather than being beholden to relatives or charity.

A second aspect of defining care as practice is that care is seen as creating a relationship; as Ruddick (1998: 14) puts it, “[caring] work is constituted in and through the relationship of those who give and receive care.” The relationship is one of interdependence. Generally we think of the caregiver as having the power in the relationship; but the care receiver, even if subordinate or dependent, also has agency/power in the relationship. Focusing on relationships brings into relief the influence of the recipients of care on caring work. Tronto (1993) notes that for the work of care to be successful, its recipients have to respond appropriately—e.g., a screaming child betokens failure. In some situations where the care receiver employs the caregiver or has social authority (e.g., due to the norm of respect toward elders), the care receiver may have more power than the caregiver.

Third, the definition of care as practice recognizes that caring can be organized in a myriad of ways. The paradigmatic care relationship is the mother-child dyad, which often serves as the template for thinking about caring. In this model, caring (mothering) is viewed as natural and instinctive—women’s natural vocation. However, this idealized model is deceptive in that it ignores the actual diversity in the ways mothering/caring is actually carried out within and across cultures. Caring can take place in the household or in publicly organized institutions, and can be carried out individually or collectively and as paid or unpaid labor. Much caring takes place in the family, usually as the unpaid work of women, but it is also done as paid work (e.g., by babysitters, home health aides, and the like). It also takes place in the community as unpaid volunteer work, as in the case of church or charitable organizations that run day care or senior activity centers. It also takes place in institutions organized by the state, corporations, or individuals as commodified services using paid caregivers.

Care can also be “fragmented,” divided among several caregivers and between “private” and “public” settings. Thus, a parent may take ultimate responsibility for ensuring that a child has care after school but delegate the actual work of care giving to a babysitter, a relative, a

the same time, I am adopting a somewhat broader definition than one that restricts caring only to meeting the needs of those who cannot care for themselves—e.g., Diemut Bubeck’s (1995: 129) definition of “caring for” as “the meeting of the needs of one person by another person where face-to-face interaction between carer and cared for is a crucial element of the overall activity and where the need is of such a nature that it cannot possibly be met by the person in need herself.”

paid home care worker, and/or an after-school program. Barrie Thorne (1999) found in her study of childhoods in an urban multicultural community that parents often have to patch together several of these arrangements.

What Should Our Goals Be?

To achieve a society in which caring is valued in all spheres of social life, all of the elements—the work of care giving and the people involved (care receivers and caregivers)—would have to be recognized and valued. Hence, a society in which caring is valued would be one in which:

- Caring is recognized as “real work” and as a social contribution on a par with other activities that are valued, such as working, military service, or community service, regardless of whether caring takes place in the family or elsewhere or as paid or unpaid labor.
- Those who need care (including children, the elderly, disabled, and chronically ill) are recognized as full members of the society and accorded corresponding rights, social standing, and the voice of citizens. This would mean that care receivers are empowered to have influence over the type of care, the setting, and the caregivers, and that they have access to sufficient material resources to obtain adequate care.
- Those who do caring work are accorded social recognition and entitlements for their efforts similar to those who contribute through paid employment or military service. These entitlements include working conditions and supports that enable them to do their work well and an appropriate level of economic return, whether in wages or social entitlements.

For each of these ideals to be achieved, additional specific conditions would have to be fulfilled; these conditions are also desirable for reasons of equity and social justice.

- Caring is legitimated as a collective (public) responsibility rather purely a family or private responsibility.
- Access to care is relatively equally distributed and not dependent on economic or social status. Ultimately, the ideal would be a society in which there is an adequate amount and quality of care for

all who need it—i.e., care that is individualized, culturally appropriate, and responsive to the preferences of those who are cared for.

- The responsibility and actual work of caring is shared equitably so that the burden of care does not fall disproportionately, as it now does, on disadvantaged groups—women, racialized minorities, and immigrants.

Some Directions for Change

Rethinking social citizenship: One important step is to redefine social citizenship to make care central to the rights and entitlements of citizens. This would involve a radical reversal of the present situation, in which care is defined as a private responsibility and therefore outside the realm of citizenship. Making care central to citizenship would entail three elements: establishing a right to care as a core right of citizens; establishing care giving as a public social responsibility; and according caregivers recognition for carrying out a public social responsibility. These three elements are interrelated. If citizens have a right to care, then there is a corresponding responsibility on the part of the community to ensure that those who need care get it. Further, if care giving is a public social responsibility, then those who do care giving fulfill an obligation of citizenship and thus are entitled to societal benefits comparable to those accorded for those fulfilling the obligation to earn—for example, social security, seniority, and retirement benefits.

Additionally, a constraint that is specific to caring (in contrast to earning) and that needs to be addressed is what Kittay (1995) has called the “secondary dependence” of the caregiver. By taking on the care of a dependent and foregoing earning, unpaid caregivers become dependent on a third party—a breadwinner or the state—for resources to sustain both those they care for (primary dependents) and themselves (secondary dependents). Historically, U.S. welfare policy has been premised on the assumption that support for care giving belonged to the male breadwinner, and that the state should assume responsibility for support of caring only in the absence of a male breadwinner. Sometimes, as in the case of black single mothers, the lack of a male breadwinner was not seen as adequate grounds for the state to step in. Instead, black single mothers were deemed to be “employable mothers” who should support themselves and

their dependents. In a step backward from recognizing caregivers' need for support, the U.S. Congress passed the Personal Responsibility Act in 1996, which abolished AFDC, devolved welfare back to individual states, and restricted the amount of lifetime benefits; most states have mandated stringent "workfare" to get single mothers off welfare.

In contrast to the U.S. welfare system, European welfare states have all provided some forms of family allowance for citizens with children. Most countries have supported caregivers with child allowances, and some even give small pensions to those who engage in unpaid care work. In conservative welfare regimes, such as France and Germany, the rationale for maternal allowances typically has been framed in terms of child welfare and promoting natalism, to ensure the size and well-being of the future population, rather than in terms of the value of caring and social citizenship rights and responsibilities in caring. Nonetheless, the allowances have been designed as universal entitlements not tied to income or means testing, unlike U.S. welfare programs. In more progressive social democratic welfare regimes support for care giving is extensive, including allowances, subsidies, and direct services, such as child care and home aides (Pederson 1993; Sainsbury 1996).

Transforming citizenship in the United States to make care central to rights and entitlements would require us to challenge the linked ideologies of individual independence and family responsibility that I have described above. The United States for the most part has not even recognized mothering/parenting as a contribution to the national welfare, nor has it assumed a larger societal responsibility for supporting caregivers. As with previous historic changes in the boundaries and meanings of citizenship, it would require concerted struggle. Political citizenship, in the form of suffrage, was gradually extended to include previously excluded groups: nonpropertied white men in the early nineteenth century, black men after the Civil War, and, finally, women in 1920. The democratization of the vote was achieved only after concerted struggles by each of the groups in the course of over 100 years. Social citizenship rights of the welfare state, including social security, unemployment relief, minimum wage, and job creation were responses to the political mobilization of millions of Americans displaced by the Great Depression.⁴ In the second half of the

twentieth century, the second civil rights movement and second-wave feminism impelled legal, political, and social changes that dramatically expanded employment, education, and legal rights for racial minorities and women.

An important recent example of expanding citizenship is the success of the disability rights movement in establishing federal laws and policies that require schools and universities, employers, and public programs to provide facilities and activities that enable differently-abled citizens to work, study, travel, and otherwise participate in the social and cultural life of the society. The latter movement comes closest to addressing the issues central to caring and social citizenship. It addresses the rights of citizens who have physical and mental conditions that limit their physical and economic independence to receive services and accommodations that allow them to achieve social and political independence.⁵ There is thus a precedent for claiming the right to care as essential for meaningful citizenship.

Rethinking the family as the primary site of care: The previous discussion about state policies on social citizenship and care has assumed that most care takes place within the family and is carried out as part of unpaid labor of family members. However, if we take seriously the notion that caring is a public social responsibility, we also need to examine critically the conception of the family as the institution of first resort for caring. Indeed, one can argue that keeping the family as the "natural" unit for caring relationships helps anchor the gender division of caring labor. Seeing family and women's caring as "natural" disguises the material relationships of dependence that undergird the arrangement. But as those who care for others know, love is not enough: Care requires material resources. We need therefore to consider "defamilializing" care in order to relieve women of disproportionate responsibility for care giving and also to free both care receivers and caregivers from economic dependence on a male breadwinner.

⁴ Similarly, veterans' benefits, the G.I. Bill, hospitalization, and other social welfare benefits came about partly because of veterans' political organizing efforts.

⁵ There has been a recent movement to franchise citizens with mental illness.

Utopian societies in the past, ranging from communes to the Kibbutz movement, have attempted to transform care, especially infant and child care, into a public or communal responsibility by collectivizing child care. Theoretically, communal arrangements in which child care is treated as a form of "public" labor equal to other forms of labor free those who engage in caring from dependence on a breadwinner and also free children from dependence on (and therefore subordination to) biological parents. In practice, collectivized care has not eliminated the gendered division of caring labor, since it was still women who were the principal caregivers in publicly organized child care. Moreover, collectivized care generally has arisen in homogeneous religious and socialist communities where members shared fundamental cultural and political values. Completely collectivized care would be unlikely and perhaps undesirable in large-scale multicultural societies in which people maintain divergent cultural and political values. Family remains the main institutional nexus for anchoring distinctive cultural and social identities.

Thus, for both practical and ideological reasons it seems likely that families (broadly defined) will continue to value caring, and that family members will feel responsible for caring for children and, to a lesser extent, elderly and disabled members and will choose to do so. This does not mean that the family should be defined in the traditional way as the conjugal heterosexual household or that it should be the first resort for care in all cases. The states' and employers' care policies currently recognize dependency and caring relationships in rather traditional terms of parents and children (whether biological or adoptive) and spouses (defined through legal marriage). However, there are many other types of family relations that generate relationships of care, including cohabiting couples, gay and lesbian couples, extended kin such as grandparents and siblings, and sometimes "fictive kin" who participate in mutual support. As Carol Stack and Linda Burton (1994) point out in relation to their study of African-American families, men, women, and children may be "kin-scripted" to care for the children of siblings, grandparents, grandchildren, aunts, and uncles when there is no one else able to do so. To the extent that caring in the "family" is valued, the notion of "family" must be extended to encom-

pass diverse kin relations, including "voluntary" or "fictive" relationships.

Regarding the knotty question of the primacy of family vs. the larger community in care giving: In a survey conducted in England by Janet Finch (1996), respondents affirmed the importance of kin ties; they indicated that "rallying around in times of crisis" was what defined a functional family. The actual degree of responsibility that respondents felt in particular situations and toward particular relatives varied, however, depending on prior relationship and current circumstances. (I would also add that in a diverse society, there is considerable cultural difference in degree of obligation and in who is included in the net of obligation.) In general, Finch's respondents emphasized that relatives should not expect or take for granted assistance from other family members. Another British researcher, Jenny Morris, found that, in turn, people requiring care often prefer not to rely on family. Many of the disabled adult women Morris interviewed said they preferred paid helpers or helpers provided by social service to help from family members, because it allowed them more independence (cited in Cancian and Oliker 2000: 99).

Finch (1996: 207) argues that the moral reasoning of people in her survey suggests the principle that people should have the right *not* to have to rely on their families for help: "To point in another way, the family should not be seen as the option of first resort for giving assistance to its adult members, either financial or practical."

Finch is careful to say that her point is not to deprecate generosity, care, and support within families, but only to see these as "optional, voluntary, freely given" (1996: 207).

Taken together, the findings from Finch's and Morris's studies support the case that the community, as represented by the state, has primary responsibility for care of its citizens, and that citizens in turn have the right to nonfamily care. Public policy would thus be that all persons are entitled to publicly organized care or to allowances or vouchers to pay for care, regardless of whether or not family members are available to provide it.

Rethinking Paid Care

As noted in the introduction, the sheer demand for care, the inability of families to provide all care, and economic incentives to commodify care have brought about significant shift of caring to paid caregivers. This is especially the

case for those needing physically demanding, round-the-clock care, such as children or adults with severe mental and physical disabilities, and elderly with dementia or Alzheimer's. Much of the latter care takes place in institutional settings, nursing homes, hospitals, and residential facilities, where the intensive face-to-face caring is done by nursing aides and other nonprofessional workers under the supervision and authority of administrators and medical and nursing professionals.

Thus, any scheme to create a society in which caring is valued in all spheres must address the growing commodification and defamilization of care. We need to think about the changes that occur when caring is made into a public rather than private function, when "strangers" rather than family members provide care, when care giving is paid rather than unpaid, and most importantly when caring is regulated and controlled by bureaucratic rules and hierarchy.

Transferring caring from private household into publicly organized settings inserts "third parties" into the caring relationship. Both caregivers and care receivers are hemmed in by rules and regulations about time spent and kinds of care that are covered (e.g., shopping). Foner (1994) and others have argued that the "iron cage" of bureaucracy that constrains people in organizations creates fundamental dilemmas for care workers who are caught between conflicting ideals. Whereas bureaucracies operate according to principles of standardization, impersonal rules, and efficiency, care relationships encourage individual treatment, personal ties, and patience.

Bureaucratic rules and control were instituted because of publicity about widespread abuse and neglect of patients. Having done an ethnographic study of a nursing home in New York, Foner (1994) agrees that bureaucratic rules and oversight are necessary to protect elderly patients, and that nursing aides, who do the actual physical care, feeding, cleaning, bathing, and so on, cannot be allowed to act autonomously. However, the rules and the way they are administered emphasize "efficiency" in getting physical care tasks done, meeting time deadlines, and maintaining records. Yet, as Tim Diamond (1988: 48) found in his ethnography of a nursing home, emotional care is essential to the nursing aide's job: "holding someone trying to gasp for breath" or talking to residents to

"help them hold on to memories of their past." Diamond observed that these kinds of emotional support were not listed in the aides' job descriptions, nor were the aides rewarded for these activities. In the nursing home she studied, Foner found that Ana, a nursing aide who regularly took time to talk to patients, and comfort or reassure them while bathing them or changing them, was constantly reprimanded for being inefficient, while Ms. James, an aide who never spoke to patients and handled them roughly to get them through their routines, was praised by supervisors as a model aide.

Deborah Stone (2000) found that home care workers also faced a conflict between bureaucratic rules and principles and their own ethic of care. Thus, they often stretched or evaded rules and supervisors to provide personal care, or spent off-work time or money to provide extra services.

The various ethnographic studies reveal that many care workers do provide quality emotional care, but they do so "around the fringes" so that their skills and effort are unrecognized or they do so in direct defiance of the rules. These studies point to the existence of "oppositional cultures" in which workers cooperate to provide the kind of care that the bureaucratic structure does not recognize or disallows. One case study of a psychiatric hospital (Lundgren et al. 1990) found the quality of care was excellent because psychiatric technicians who did the daily care carved out areas of autonomy in which they could act in accordance with an ethos of care. Because the psychiatric technicians had opportunities to interact freely when residents were in classes, they developed camaraderie. Workers supported one another to go beyond the policies they considered unreasonable or against the interests of the residents. They developed customs, such as "time out" to leave the unit when they were about to lose control. These kinds of practices that workers themselves develop could be incorporated into organizational practices. Encouraging a team approach in which workers model and support each other for sensitive caring would be one such salutary practice. Procedures could also be reformed to build in more opportunity and recognition for aides who show kindness and go out of their way for patients. Organizations could offer more regular training in sensitivity and emotional aspects of care, include emotional caring work in job descriptions and worker evaluations, and pro-

vide a reward system for caregivers who go beyond the call of duty to help patients.

At the professional level, the bureaucratic and chart-keeping imperatives of caring institutions could be harnessed to build in accountability for the social and emotional well-being of care receivers. Foner (1994) notes that one reform that has been adopted in many institutions is the psychosocial model of care, which pays attention to the emotional and social as well as the physical aspects of caring. The psychosocial model involves a case management approach that includes both health and social service needs of care receivers. Cancian and Oliker (2000) describe a "Clinical Practice Model" of nursing that Bonnie Wesorick has developed and introduced in several hospitals. This model challenges the medical model by emphasizing "holistic caring." It does so by such methods as keeping a record on each patient that includes personal histories, religious orientation, family situation, and individual concerns. Importantly, it calls for writing a plan of care that documents the patient's needs, concerns, and problems and an individualized approach to reach desired outcomes.

Encouraging caregivers to focus on social and emotional aspects of care may be salutary in some respects. Yet there is an inherent pitfall to empowering caregivers: It may exacerbate the already unequal relationship between caregivers and care receivers. Caregivers may feel that they understand the needs of care receivers and that they are acting in their best interests. However, care receivers might have different values and priorities. To the extent that care receivers depend emotionally and physically on their caregivers, they may feel they have no choice but to defer to the caregiver's judgment.

Thus, an additional concern should be to ensure that care receivers are given voice and influence over their care. In the case of mentally competent adults requiring home care assistance, for example, it would be preferable for them to be given grants or vouchers to hire their own caregivers rather than being assigned a helper by a social service agency. Several of the 50 disabled women interviewed by Jenny Morris in England said they especially valued helpers they hired and paid for themselves rather than those sent by government social services, because they had greater control. One woman said that only when she started employing her own helper did she feel she could pay attention

to her own appearance. She had her paid helper assist her with clothing and makeup, which she felt justified in doing because "They need to be patient and I'm paying for that patience so I feel OK about expecting it" (quoted in Cancian and Oliker 2000: 99). One group already has direct access to government funds for paid care. The Department of Veterans' Affairs has a program for Universal Aid and Attendance Allowance that gives direct unrestricted cash payments to 220,000 veterans to pay for homeworkers or attendants (Cancian and Oliker 2000: 155). The right of veterans to state supported paid care is acknowledged because of their "service to the country." What is needed is a more universal approach that extends entitlements to nonfamilial paid care to all citizens.

In short, both paid caregivers and receivers of paid care need to be empowered. Sometimes, when the interests of caregivers and care receivers intersect, it makes sense for them to organize together. For example, when social service agency budgets are cut and home care and other services are reduced, caregivers may be forced to serve more clients less well and clients don't get the care they need. During the 1980s and '90s, coalitions of home health care workers, care receivers, and community leaders have formed to improve wages and benefits for care workers. Since services are paid from Medicaid or other public funds, care receivers will support wage increases for care workers, especially if it means that their caregivers will continue rather than leaving for higher-paying jobs in other fields (Cobble 1996; SEIU 1999).

Rethinking Employment Practices

Changes in employment practices are also needed to make it possible for people to integrate work and care and so that care giving is not penalized. A small proportion of citizens currently benefit from private-sector initiatives by corporations that recognize the caring responsibilities of their employees. Some of these corporate employers provide child care and unpaid leaves to care for children or elderly relatives. Model programs include those by CitiBank, Stride Rite, and Campbell's Soups, which provide child care on or near their premises. Bristol Myers-Squibb has a family leave policy for employees that covers care for elderly relatives (Cancian and Oliker 2000: 75, 155).

The passage of the 1993 Family and Medical Leave Act marked a first step in developing a national policy that supports combining work

and care. The act recognizes care responsibilities for those engaged in paid work and accepts public responsibility so that dependents can receive adequate care. As in many European countries, the stated goal of the legislation was the development of children and promotion of the family unit rather than recognition of care giving as a social responsibility. The preamble to the Act recognizes job security and parenting as important for citizens' well-being and acknowledges the role of the state in supporting both. However, coverage is extremely limited. By mandating only unpaid leave, the government accommodates care rather than fully supporting it, since few parents can afford to use the unpaid leave. Moreover, by exempting employers with fewer than 50 employees, the law leaves an estimated half of the workforce uncovered—56 percent of women and 48 percent of men, according to Spalter-Roth and Hartmann (1990). Ultimately, when employer interests are at stake, employer needs are allowed to trump care needs. Finally, the Act recognizes dependency only within traditional conjugal family relationships—spouse, children, and parents (Kittay 1995). It thereby “refamilizes” care by excluding other types of voluntary relations of dependency and care.

Besides parental and care-giving leave and child care, employment policy must consider the sheer number of hours needed for care. A national survey of a representative sample of 1509 English-speaking households found an average of 17.9 hours of care giving per week per household, while several other specialized surveys found a much higher number of unpaid caregiver hours in households with persons having specific medical conditions or disabilities (Arno et al. 1999). At the same time, work hours of employed Americans have become the longest of those in all industrialized nations, according to a 1997 United Nations survey. The survey found that U.S. workers averaged 40 percent more hours than Norwegians and 25 percent more than the French (calculated from figures in the *San Francisco Chronicle*, September 6, 1999).

In combination with lack of state support for nonemployed caregivers, long work hours increase the strain on U.S. workers who have care responsibilities. Comparisons of worker productivity suggest that the longer hours of U.S. workers have not produced comparable increases in productivity. Thus reduction of work hours

can be justified on economic as well as social welfare grounds. The 40-hour week was the goal of labor movements starting after the Civil War, but it was only when organized labor acquired sufficient political power in the 1930s that it became the standard. It involved the recognition of workers' rights for a life apart from the job. It is now time to recognize the reality of workers' multiple responsibilities for earning and caring by reducing work hours through a combination of reducing the standard for “full-time work” and increasing vacation and leave time.

Closing Thoughts

I have focused on specific ideological and structural constructions of caring. But ideas about and structures of caring are tied to other ideologies and structures that they support and are supported by. Achieving the kinds of changes needed to create a society that values caring will require transforming the ways we think about ourselves, our relationships with others, the family, civil society, the state, and the political economy. Ultimately, the transformation of caring must be linked to major changes in political-economic structures and relationships. Perhaps most fundamentally, the liberal concept of “society” as made up of discrete, independent, and freely choosing individuals will have to be discarded in favor of notions of interdependence among not wholly autonomous members of a society.

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