The need for care is universal, yet there is no universal template for providing it. Care is needed by those who reach advanced age and require assistance as a result of chronic illness or disability. All people need it in the first years of life, during periods of illness or misadventure (Fineman 1995). In our everyday relations, care is expressed as both caring about another, a disposition or concern for the wellbeing of another person, and caring for, the work involved in supporting another (Graham 1983). In practical terms, care may be thought of as the most intense expression of social support, involving not just affective concern for the other but the performance of care work and an expression of personal relationships (Chappell 1992, Rummery and Fine 2012).

The form that care may take varies enormously and is subject to continual development and change. In contemporary welfare capitalism, care is provided formally and informally. Informal care involves unpaid assistance provided by intimate partners, family or close friends, or care that is paid but organized without formal authorization. Formal care is that provided by formally organized and authorized services and generally involves paid labour, although assistance may also be provided others, including volunteers. The links between and mix of sources has become one of the key dilemmas facing the understanding of contemporary society (Fine 2007). Like the expression and satisfaction of other bodily needs, the forms that the responses to the need for care take are shaped by and in turn are central to culture. The recognition of the complexity involved in the interplay between these two types of phenomena is implicit in the use of the term cultures of care.

Understanding care as cultural ideals and as practice

Arlie Hochschild (2003) has distinguished a number of different cultural ideals commonly assigned to the concept of care, identifying key dimensions of difference: warm and cold; traditional and modern; family or social responsibility. What she terms the traditional values of care are emotionally warm, based on conventional conservative ideals in which care provided by women as mothers, wives and daughters is seen as an unpaid familial duty for women in the home. An alternative modern set of cultural ideals is based on formal care. The ideals she terms cold modern are based on providing formal, institutionalized care solutions as a substitute for care in the family or among significant others. This is exemplified in the models of child and aged
care in the Israeli kibbutz and the specialized homes for the aged, the mentally ill and the disabled, that are easily recognizable icons of cold modern care in western welfare capitalism and Stalinist socialism.

In contrast, the warm modern ideal of care seeks to promote shared care between women and men, with formal services made available when necessary to supplement and extend the capacity of family members and other intimates. The approach is warm, for Hochschild, because it acknowledges the emotional importance of care for developing personal relationships. It enables us to share intimacy and trust, enrich our intimate lives and take advantage of the professional skills available outside the home. This approach sees care as embedded in a complex set of social circumstances. Each of these ideals stands in contrast to the fourth, cold postmodern, a depersonalized approach placing emphasis on self-sufficiency and reliance on a variety of technological solutions such as personal monitoring devices. This vision of care, in which access to formal support is linked to user-payments and other individualized risk management and mitigation strategies, leaves individuals to fend for themselves with the help of the market.

What varies in these different approaches, Hochschild (2003: 222) points out, is ‘the value placed on care’. The various values present competing and overlapping cultural ideals through which various senses of personal identity, responsibility and entitlement are invoked. But culture refers not just to ideals, values and expectations, but to practices as exemplified in actions and behaviours (Bauman 1999). The term culture of care is also commonly used to refer to care behaviour in the context of national welfare and labour markets or care regimes (Chamberlayne and King 2000). This approach builds on and extends earlier discussions that identified care as a cultural practice (Wood 1994), documenting cultural differences among those of a variety of different peoples, ethnic groups and nations (Kleinman et al. 1978). Culture is also a term widely invoked in the analysis and representation of professional, occupational and organizational practices of care (Boris and Salazar-Parreñas 2010). While there are important differences between each of these approaches, each builds on the concept of culture, and a number of areas of common concern emerge.

Major theories and approaches

Care as a feminist issue

The study of care and caring was neglected until the 1970s. From that time, feminist writers in Europe, particularly in the UK and Scandinavia, increasingly saw care as a political/policy issue, documenting the problems experienced by women carers at home and proposing policy solutions to deal with them (Finch and Groves 1983, Waerness 1984, Baldwin and Twigg 1991).

Much of the initial research identified, described and measured domestic duties and the gendered social norms that confined women to the home, holding them back from achievement in public (Land 1978). The analysis was extended to child care and community care policy, with concerns expressed that the latter was another way of enforcing the gendered provision of unpaid care in the home (Finch and Groves 1980). Research also identified hidden costs of care, borne primarily by unpaid women carers, including social isolation and psychological distress, as well as earnings and careers foregone (Nissel and Bonnerjea 1982, Glendinning 1983, Ungerson 1990). In subsequent years research increasingly explored the way that care operates in both domestic and public spheres (Twigg et al. 1990). Like its unpaid domestic counterpart, paid care was shown to be predominantly based on female labour, its treatment in the labour market reflecting the unequal wages and lack of recognition accorded women (Land 1991, Ungerson 2000). Providing care is a physically and emotionally demanding activity. Skilled, often strenuous
physical effort (bodywork) is combined with what Hochschild has termed emotional labour (Hochschild 1983, Twigg 2006, Wharton 2009). Later research on the body and care (Isaksen 2002, Twigg 2004) provided new insights into the links between gender and responsibility for the management of bodily functions.

Much European and other international research on care since the millennium has followed and further developed this approach, exploring the links between globalization, immigration and the division of care labour between countries (Lewis 2002, Theobald 2003, Bettio and Plantenga 2004, Glucksmann and Lyon 2006, Williams 2010), and the impact of care work and family care provision in immigrant families (Wall and Jose 2004). A recurring theme is the link between female gender and the low value placed on both formal and informal care work (Armstrong and Armstrong 2005, Stark 2005). The low status of care work is exacerbated by the impact of cross-national inequalities and the deployment of women care workers in low-paid positions across much of the developed world (Benoit and Hallgrimsdottir 2011).

**Ethics of care**

A parallel approach, generally referred to as the ‘ethics of care’, comes from the USA, where it had its origins in psychological research on the moral development of children. In this, the importance of care is emphasized as a concern for others, a disposition towards supporting interpersonal relations. These ethical values and practices are traditionally associated with women (Gilligan 1982, Noddings 1984). Joan Tronto, among others, uses this to advocate for an ethic of care as a positive value. She argues that care work has been the work of ‘slaves, servants and women in Western history’ (Tronto 1993: 113), understood in this culture not as work but as an ‘emotional activity’. The ethics of care, Tronto argues (1993: 103), need to be moved across the ‘moral boundaries’ of western culture from the margins, where they have been confined to the home, to a place ‘near the centre of human life’, acknowledged as human and constitutional rights.

**Gender, rights and the receipt of care**

A number of more recent European advocates have joined the two debates and argued that, as care has become an increasingly public activity, it should be codified so that the rights of all citizens to give and receive care can be recognized (Knijn and Kremer 1997, Sevenhuijsen 1998, Kittay 2011).

In each approach, caring has been seen as an activity undertaken by a caregiver, with those who receive care at times receiving little attention or being portrayed as inactive, dependent or a burden (Fine and Glendinning 2005). Seeking recognition, disability rights authors (Keith 1992, Morris 1993, Shakespeare 2000) have criticized this position, with the result that the recipient’s perspective has increasingly come to be acknowledged as central to a culture of care (Lloyd 2000). This is particularly evident in the formulation of the ethics of care as a fundamental political right, placing the emphasis on the right to both give and receive care in a manner in which the rights of each party to a decent life and to self-determination are acknowledged (Morris 2001, Williams 2001).

**Medical anthropology**

A parallel exploration of the links between culture and medical care emerged from the field of medical anthropology as it went from studying illness and its management in traditional societies.
to explore illness and medical care in western societies. Arthur Kleinman, Leon Eisenberg and colleagues were among the first to demonstrate the relevance of anthropological cultural concepts of illness, illness behaviour and expectations of appropriate care, arguing that it is 'culturally constructed':

How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate that care are all affected by cultural beliefs.

(Kleinman et al. 1978: 152)

Understanding cultures of both formal and informal care in different societies and historical periods remains a key concern in the field of medical anthropology (Kohn and McKechnie 1999, Sobo 2000, Sokolovsky 2009).

**Shaping and transmitting cultures of care**

*Professional cultures of care and their appropriation by management*

Renee Fox and colleagues analyze the compassionate response of American nurses to the AIDS epidemic in the 1980s as evidence of a 'culture of caring' (Fox et al. 1990, Watson 1979, Benner and Wrubel 1989). Nurses become nurses through self- and professional selection processes, followed by the process of socialization that accompanies their education. The culture of nursing care they aspire to is acquired through education and work practices. For nursing theorists such as Leininger (2002) and Flowers (2005), culture is understood as a form of learnt behaviour, an inter-generationally transmitted system of symbols, behaviours and understandings that is acquired as part of general socialization. Secondary socialization, through nursing education, reinforces, develops and professionalizes this.

A contrasting application of the term *cultures of care* is found in a body of research and theory that derives from the adoption and application of the concept culture by experts from organizational, management, and business studies fields from the mid-1980s (Kilmann et al. 1986, Roth 2005). A recent Norwegian study, for example, draws on the approach to examine health care personnel’s work culture in a palliative care setting, reporting a conflict between the cultures of ‘hi-tech’ and ‘high touch’ care orientations among personnel (André et al. 2012, see also Ascoli et al. 2012, Hunt et al. 2012).

*The transmission and negotiation of cultures of caregiving*

A key question for researchers concerns how care cultures develop and how they are transmitted and applied. On the basis of ethnographic research on aged care in middle USA, Albert (1990) argues that there is evidence of a shared ‘culture of caregiving’ in the norms of returning care for a parent in need, which constitutes an expression of reciprocity, delayed over a life course. He claims that care is a cultural value that is part of a shared national system of culture that shapes beliefs and action. Margaret Perkinson (1994: 264) instead focusses on more immediate micro-processes of interaction, where ‘socialization to the caregiver role . . . may be viewed as an “evolving form of membership in a community of practice” . . . a community composed of peer caregivers’. These ideas are developed in other anthropological studies of residential care (Henderson and Vesperi 1995).
Gender and responsibility for care

While statistics demonstrate that women predominate among care givers, they also show that responsibility is not exclusive. Since the publication of empirical evidence from the British 1980 General Household Survey (GHS) showed that around one-third of co-resident carers of older people were men (Arber and Gilbert 1989, Arber and Ginn 1990), further research has confirmed a similar pattern in which males, particularly the husbands and partners of older women, are more likely to take on responsibility for personal care than a purely gendered model might predict (Hirst 2001, Fine and Glendinning 2005).

In the ‘hierarchical compensation model’, Marjorie Cantor sought to explain why older people generally choose help from females who are close family members in preference to support available from formal services (Cantor and Little 1985, Cantor 1989). Assistance from spouses (including de factos) was the first preference, but if this was not available, help provided by daughters was a close second, followed by that from sons and other family members, in that order of preference, over help from state supported or charitable organizations. The approach suggests that help would likely be sought from formal services only when these informal caregivers were inadequate or needed supplementation. Research in the UK (Qureshi and Walker 1989) and Australia (Fine and Thomson 1997) provides some support for this approach. Research by Finch and Mason (1993) suggests that preferences for care by female family members demonstrate the existence of a ‘public normative consensus’, but that this has become more flexible and is nowadays open to negotiation. Hazel Qureshi, however, points to the way that people’s preferences and expectations of the availability of various alternative sources of support are shaped by their lifelong experience, their social class and cultural background (Qureshi 1990).

Chamberlayne and King’s (2000) work, Cultures of Care: Biographies of Carers in Britain and the Two Germanies, applies and develops these understandings through an exploration of care giving in three different welfare states. Patterns of informal caring, they argue, are not just direct products of official welfare systems but are cultural phenomena.

‘Culture’, in our usage of the term, interweaves an analysis of action (both intended and actual), meanings (ideologically received and more personally derived), and patterns of social resources and relations. It centres on the life worlds of carers, meaning a contextualised account of their experiences, drives and motivations.

(Chamberlayne and King 2000: 5)

Their approach used biographical research methods to examine the way that carers approached the task of supporting a seriously disabled family member in the UK, West Germany and East Germany. They compared the public ideologies that confronted family carers and documented how carers in each country subsequently negotiated the restrictions they faced and managed the formal and informal resources available to them. Their intention was to assess how cultural and social patterns of the different welfare regimes produced typical patterns of adaptation to the challenge of providing care to children and disabled adults who need ongoing support. A core element of the approach is to see culture not simply as a traditional pattern but as a creative and living production, a praxis. By focusing on culture as revealed through everyday life—what people actually do, how they talk about it and respond to constraints and make use of available resources—they were able to explore relationships between actions (agency), structure and consciousness.

Other researchers concerned with social policy addressing intimacy and caregiving outside traditional ‘hetero-normative’ families have sought to address questions of care as a creative
cultural process. Roseneil and Budgeon (2004) and Williams (2004), for example, use the concept of culture as an emergent and creative shared response to explore contemporary relations, intimacy and care among adults outside of traditional nuclear families. Similarly the approach is used to discuss the emergence of new values in the workplace, as well as a way to revisit and interrogate history (Cox and Luddy 2010, Reznick 2011). Kremer (2007), however, argues that while welfare states shape behaviour, cultures of care cannot simply be reduced to financial incentives and labour market opportunities—traditional cultural values and ‘care ideals’ are deeply linked to a sense of personal identity.

Conclusion

The concept of cultures of care provides a powerful conceptual approach to understanding the dynamic associated with changing care provisions for an ageing world. One of the values of identifying cultural approaches to behaviour is that the approach offers an understanding that may lead to change. Yet the richness of academic discussion on the topic stands in contrast to its limited use in policy. Two areas stand out as having significant potential for development in this regard. First, there is considerable scope for paying greater attention to the recipients of care—the demands, changing preferences, behaviours and responses of those who currently need or in the future will need care, have been identified as significant, but remain under-reported and under-discussed in the literature. Second, there is a need for deeper examination of the male resistance to taking greater responsibilities for care.

References


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