'Social care', the 'care ethic' and 'carework': New definitions – new directions?

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Abstract

In Dame Denise Platt's report on the status of adult social care in England (2007), she states that the notion of social care is poorly understood. This paper examines the related concepts of 'social care', 'care ethic' and 'carework' in the hope of progressing the debate about the meaning of social care more generally. There seems to be no doubt that the field requires a degree of agreement about what constitutes social care for a number of reasons, these include being able to support resource arguments, encouraging a positive view of people receiving social care services, and promoting an inclusive notion of social care that incorporates self management and altruism in caring for others. It is suggested that the narrow idea of social care meaning only services delivered by an industry of providers has some disadvantages. Broader perspectives are explored such as the notion of carework (derived from the care ethic) which transcends traditional conceptual and professional boundaries. The relative merits of different conceptions of care are discussed and their implications for policy and practice are considered.

Keywords: Social care, care ethic, carework

Introduction

This paper examines the concepts of 'social care', the 'care ethic' and 'carework' in order to add something to the current debate about social care in the UK. Dame Denise Platt (2007) argues that the term social care is not well understood by the public in the UK and elsewhere, and that there is no agreed definition. She also suggests that the term was developed to describe the set of workers in residential and domiciliary settings who were not 'social workers'. (She goes on to say that the terms 'social worker' and 'personal social services' are terms that are more widely understood.) It is not clear what the precise evidence is for her assertions, and one might counter them to some extent by pointing to the

increasing way in which the Department of Health (DoH) and the NHS have adopted and perhaps 'colonised' the concept of 'social care' over recent years by: creating and strengthening the social care section of the Department with its associated web presence; separately funding and 'badging' research into social care; establishing a 'social care institute of excellence'; creating a social care sector skills council; and making it appear natural to add '*and social care*' whenever the term 'health' is used. This of course conveys the message that the two are in some way if not synonymous then at least to be thought of as 'integrated'. Whether or not they are 'integratable' as the rhetoric suggests, is another matter, but for our purpose here, we simply note the unfortunate consequence that social care

is at best equated with health care, and at worst treated as a semi-detached 'afterthought'. In fact, social care has a far greater number and variety of providers than the NHS, and the social care sector as a whole employs more people than the NHS.

Platt's final working definition is a service based conception, one which reflects the vast industry of providers in the field. Social care, she writes, is:

> The **group of services** that provide personal care and support to people in social situations – such as family; the community; a communal setting; to help them achieve independence and to promote their positive contribution as citizens (2007, p.4) (bold added).

The UK White Paper *Our Health, Our Care, Our Say* also adopts the 'industry' definition of social care, which it describes as:

> the **wide range of services** designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships (DoH 2006, para. 1.29) (bold added).

Skills for Care define social care even more narrowly as practical support:

> Social care work is about helping people with their lives. People who have physical or psychological problems often require **practical help** coping with the everyday business of living. Social care workers provide this **practical support** (Platt, 2007, p4) (bold added).

There is, however, as Phillips (2007, p.3) has suggested, a real sense in which 'care' and 'social care' are wider than

this service based conception, and there may be a tension between narrower service based conceptions and wider ones. She argues that the definition of care in the 21st century needs to be recast:

> from the perception of care as a set of tasks, burdensome to the caregiver, to a broader perspective that views care within the wider environment in which it takes place, from duty and obligation to rights to give and receive care.

When considering the term 'care' in the broader sense, Williams (2003, p.1) has suggested that it involves:

> those processes of social reproduction, which involve meeting the needs for care and/or support of children, some groups of older people, and some groups of disabled people, people with learning disability and mental health problems. This can be in a paid, unpaid, formal or informal capacity.

Kröger (2001, p.4) has defined 'social care' as:

> assistance that is provided in order to help children or adult people with the activities of their daily lives and it can be provided either as paid or as unpaid work, by professionals or non-professionals and it can take place as well in the public as in the private sphere.

And like Williams, he makes the point that social care is distinctive in that:

> it transcends the conceptual dichotomies between the public and the private, the professional and the non-professional, the paid and the unpaid (Kröger 2001, p.4).

The SOCCARE project interviewed 400 European families in detail about their opportunities and difficulties in making flexible and responsive care arrangements and to combine these with participation in paid employment (Kröger, 2003). Recommendations were made for policies on formal care, policies on informal care, labour market policies and other social policies (including housing policies, immigration policies, social security policies and social work). In the final and most general recommendation of the SOCCARE Project Kröger (2003, p.100) concludes that:

> it is highly necessary that policies do away with strict dichotomies. Citizens of Europe are not either workers or carers. They are both at the same time. As well, children, disabled people and older people are not in need of either informal or formal care. Both are essential and practically always, there is a need to integrate both at the level of everyday family life. To face the challenges of the future, an integrated policy perspective on work and care is required in Europe.

What wider definitions such as these provide is a unifying framework, within which one can explore and evaluate the inter-relationships between the different forms of care. It is unfortunate that a great deal of healthcare research in England is dominated by the National Health Service's illness agenda, which draws attention away from other legitimate and relevant research topics that lie outside the remit of the NHS per se. For instance, within the social work profession the 'strengths' and ecosystems perspectives are used to facilitate understanding and mobilization of psycho-social resources such as those found within the individual, family, extra familial,

societal and cultural domains (Healy, 2005). The interaction of these factors may be critical in preventive and ameliorative efforts in relation to the causes, courses and outcomes of diseases of all kinds (Querido, 1959). Moreover, when social care and social work research is narrowly defined, it runs the risk of missing these essential linkages and, perhaps of failing to look in the right places for the causes and solutions. In essence these research agendas look for a narrowly defined service solution (based on the industry of care providers approach), rather than a mainstream or alternative solution based on a broader perspective (the social reproduction approach). Drakeford (2007) has argued that it is one of the core tasks and principles of social work to make these alternative linkages possible in circumstances where they currently are not.

Narrow understandings of social care are unhelpful for several reasons. The narrow conception presents us with problems when we attempt to understand the inter-relationships between formal care, self-care and informal care. The way these inter-relate and interact (or not) are critical not only in the genesis of certain difficulties for people, but essential to the solutions, outcomes, long term support, or recovery. As indicated above, the narrow conception also limits the extent to which social care in the broader sense can be compared between different welfare systems in different countries. Nevertheless, the most unfortunate consequence of the 'industry of providers' definition, is that it portrays the individual as a passive recipient who is in 'need' of social care services. A wider, social reproduction conception of social care places responsibility for care on all citizens and emphasises the centrality of active participation in caring relationships, whether these are

formal ones or not and also attends to the wider context in which need arises.

As both Williams and Kröger indicate, in this broader conception care is a social process. Healthcare can be said to be the process involved in achieving or regaining a healthy or healthier state. 'Health' on the other hand is not a process it is a personal state to be achieved or restored to. Social care is a process involving interpersonal provisions the ultimate objective of which varies from individual to individual, but which is likely to be aimed at the promotion of individual or collective well-being. While self-care is very familiar as a key component of independence in western thought, the provision of care is normally achieved through relationships with one or more others. In this sense, caring is about the realisation of interdependence. It involves the provision of concepts such as practical and emotional support, reliable alliance, social capital and social inclusion.

The provision of social care is intended to improve general well-being, (which might include better health status, but includes other aspects of life as well, giving it a far broader function). One of the main metrics of well-being is quality of life, and this encompasses the quality of things other than individual well being, such as the quality of the local environment, and the performance of state and private agencies. It therefore makes sense to talk of the quality of life or well-being of individuals, groups, communities, populations and nation states. While there are also individual actions that lead to enhanced well being and quality of life, the provision of care is made both formally by the 'industry of providers', and informally by all members of an interdependent society. This is the care ethic.

The care ethic

The chief originator of the 'care ethic' concept, Fiona Williams (2003), has outlined its essential components:

- A recognition that care of both the self and care of others are meaningful activities in their own right; they involve us all, men and women, old and young, able bodied and disabled. We are all, after all, neither just givers nor receivers but at some level, the givers and receivers of care to and from others. Care is an activity that binds us all.

- In receiving and giving care we can, in the right conditions of mutual respect and material support, learn the civic virtues of responsibility, trust, tolerance for human limitations and frailties, acceptance of diversity. Care is part of citizenship.

- An ethic of care demands that interdependence be seen as the basis of human interaction; in these terms, autonomy and independence are about the capacity for self-determination rather than the expectation of individual self-sufficiency.

- It attributes moral worth to key positive dimensions of caring relationships such as dignity and the quality of human interaction, whether based upon blood, kinship, sexual intimacy, friendship, collegiality, contract or service. And it recognises and respects diversity and plurality in the social process of care.

- It argues against inequalities in care giving and care receiving; it recognises that these inequalities

may be constituted through different relations, including gender, disability, age, ethnicity, 'race', nationality, class and occupational status, sexuality, religion, marital status. Care requires time, financial and practical support and the recognition of choices. These extend beyond income maintenance benefits and social services to access to public space, transport, anti-discriminatory and anti poverty policies.

Tronto (1993) contributed an essentially similar proposition:

> *Care is not a parochial concern of women, a type of secondary moral question, or the work of the least well off in society. Care is a central concern of human life. It is time we began to change our political and social institutions to reflect this truth* (Tronto, 1993, p.180).

Carework

The concept of carework is derived from the care ethic, and as suggested by Williams, Kröger and others (e.g. Daly & Lewis 2000), transcends traditional conceptual and professional boundaries. A Carework Matrix, Table 1 below, shows how carework, both paid and unpaid occurs at many societal levels. It covers acts of compassion and altruism on the one hand, and paid acts of carework, not simply by care professionals, but also by other agents and agencies such as the fire service and the police.

Table 1: A possible Carework Matrix

Carework Matrix	Paid formal workers (all sectors)	Unpaid
Qualified Professional staff	Social workers, care managers, brokers, charity managers, pedagogy	Voluntary/charitable work
Unqualified staff and volunteers	Many residential workers	Voluntary/charitable work
Family members	Carer welfare payments	Carer status Young carer status
Friends/significant others	Personal assistants	Social capital and support
General public	Agencies such as firefighters, ambulance crews etc	Acts of altruism, heroism and interdependence

Key components in carework

While recognising the existence and importance of 'self-care' there is an important sense in which most social care can only be delivered as part of a relationship, whether this is a proximal relationship such as that of a spouse or a distal one such as an encounter with a paramedic. Relationships, as Weiss (1974) observed, enable provisions to be made from one person to another. Not all relationships and not all interpersonal encounters involve carework; however even salutations and greetings between relative strangers can convey a limited amount of 'care' for the other, and are intended to demonstrate a minimum

level of respect and mutual interest, which can be said to constitute a low level of carework. One key feature of carework, even at this relatively low level, is the requirement to make an effort on behalf of others. In some circumstances, the level of care requires responsibility over others. For instance, Beckett (2006) points out that social workers engaged with children in the care system are required to provide a level of responsibility and care, parallel to that expected of a parent.

Studies of the care workforce show that there is high intrinsic job satisfaction in caring. People do care work because they enjoy 'people work'. This is a common cross-national finding and across all types of care work (Moss & Cameron, 2002). In our national pilot study of Support Time and Recovery Workers, in which we and service user researchers studied three of the lead pilot sites in England, both the workers who were interviewed and the service users said that a good relationship was at the heart of the caring relationship (Huxley *et al.*, forthcoming).

Common sources of stress in service contexts often involve the failure to deliver high quality care within the organisation. For example, in our national surveys (of mental health social workers in England, Evans *et al.,* 2006 and generic social workers in Wales, ADSS 2005) worker stress, and the intention to leave social work were both related to the way the individual worker felt treated by the organisation. Feelings of a lack of respect and value by service managers were a key factor in staff burnout. Protective factors, valued by the individuals, came from their relationships with supervisors and their peers. The formal duty of care, even where discharged adequately, may be insufficient to protect an individual employee from adverse effects of the work environment and their work, and in these circumstances it is the reciprocal care relationship with fellow workers that acts as the protective factor. It is debateable whether the relationship between the worker and the user of services is also a reciprocal one, or indeed whether it has the same protective impact as peer support. This point warrants more attention than we are able to offer in the context of this paper. Briefly though, there are fundamental power differentials inherent within 'formal' care relationships. These are inherent in the social work role, as Beckett (2006) points out, social workers are required to perform a range of different roles and responsibilities on a spectrum from advocacy through care management, to social control functions. This entails negotiating competing needs and rights of service users, carers, the wider community, and the resourcing authorities. It is likely that roles performed at the advocacy end of the spectrum provide greater reciprocal support and are more protective to the worker, than roles at the control end of the spectrum. This is a proposition that can be tested by future research.

Conclusion

It seems that social care when narrowly conceived in the 'industry of care providers' sense, is situational, contextual, contingent and may or may not be reciprocal. When broadly defined social care (at its best) is the realisation of an underlying ethic of care, through multiple, frequently reciprocal relationships. This raises the questions, are these two perspectives mutually supportive or mutually exclusive? And does this matter? One could argue that formal services are only required because of the lack of successful informal care services, and on many occasions there is certainly some truth in this (see Phillips 2007, pp.6 5-68 and

Kröger 2003, p.98). If, as appears to be the case, the Third Sector (i.e. voluntary and community organisations, charities, social enterprises, cooperatives and mutuals both large and small, value driven and likely to re-invest surpluses in social objectives) is to be given even greater prominence in England by the Brown government, then it is the underlying ethic of care that will be tapped. The emphasis on partnership and integration of approaches would suggest that mutual support between the care ethic and care services should be the order of the day, but again, as with so many other developments at government department level, the Third Sector is being managed and delivered through a separate entity within the Cabinet Office. So, can regional and local social care arrangements avoid treating the Third Sector as a separate entity? This may be difficult. Take for example the social care workforce; our intelligence about this now depends upon obtaining 80% of the information from providers outside the public sector; but for some of these providers workforce information constitutes commercially sensitive data. In addition, personal care workers, direct payments and individual budgets (and similar developments in the future) bring a further unregulated number of people into the care workforce. How can a genuinely integrated approach to workforce development and planning be achieved under these circumstances? We are not saying it is impossible, but it requires us to adopt a wider conception of social care, rather than the industry of providers conception alone.

We need to ask whether the concept of carework, arising from the care ethic has any further benefits than either the narrow or broad definitions of social care offered here. Some of the arguments against the term 'carework' are that: not all care givers necessarily

think of caring as 'work' while others do and may even perceive their role as enforced amidst a lack of formal care. Conversely, some caring is far from deliberate and is more intuitive, tacit, unreflective, and barely considered 'giving' such as that shared by intimates; many of the workers covered in the suggested carework matrix would not think of themselves as care workers; and of course many care relationships are not facilitating or positive, working for or with the other person, but limiting or abusive, and working against them in some way.

On the other hand the narrow service-based conception of social care excludes those aspects of caring that are not the province of formal services. Some might argue that this does not matter, as there is enough to consider in relation to the provision of formal services both in terms of development, monitoring, regulating, evaluating and researching, to keep everyone busy, and this is certainly hard to gainsay. If we are considering whether we have made progress in provision in this limited conception of social care, then it is more difficult to be convinced. Current research, funded by the Care Services Improvement Partnership (CSIP) in England, looking at the 10 highest impact changes that have been or could be made to social care services will reach a consensus on the most important from the different stakeholder perspectives, but the evidence upon which these conclusions will be based is extremely variable and very slim. Jodi Picoult in a recent novel reminds us of the Chinese proverb, that 'if we continue on the route we are headed we will arrive at where we are going' – implying that a change of direction from the narrow 'industry of providers' definition to the social reproduction concept of social care (rather than 'carework') might serve us better in the future.

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