Care Systems

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ABSTRACT

This article deals with the interplay of care as practical tasks and as ways of constructing and reconstructing social relations. We maintain that the division of tasks in care reflects a social organisation, and that the 'who' and 'what' in care are inseparably linked. On this basis we suggest that care be studied as care systems. This perspective is developed through case studies and other data. Theoretical and practical implications are suggested.[1]

Introduction

The regular and daily burdens of care are in modern society divided between virtually no more than two parties: paid personnel and the immediate family. This is not to say that more distant, kin, friends neighbours, volunteers and others have no role to play in the 'production' of care. On the contrary, we shall often find that care is a truly collective action, depending upon direct and indirect contributions from a number of actors, including the cared-for himself.

We shall have an open mind as to what kind of activities and actors are relevant to care. As a starting point, we shall state that what is instrumental to a care event must be judged by the output, rather than by the input. This is an approach suggested by Becker[2] to the study of art, but which he finds relevant to the study of social organisation in general. Within Becker's paradigm we start with the event itself and ask what activities are necessary to bring it about. The social scientist should, in Becker's words, 'look for the network of people, however large and extended, whose collective activity made it possible for the event to occur as it did' (p. 775).

This approach invites us to extend the types of activities and actors normally considered relevant to care. Also, it puts the question of what are the necessary contributions to empirical test. We cannot assume that

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hard work and good intentions will always 'pay off', although probably they will most often do so. Neither can we expect that all good results necessarily were intended as such. The outcome of care is not only a question of right or wrong activities, but as much a question of whether they are done by right or wrong actors.

This paper deals with the interplay of care as practical tasks and as ways of constructing and reconstructing social relations. We maintain that the division of tasks in care reflects a social organisation, and that the 'who' and 'what' in care are inseparably linked. On this basis we shall suggest that care be studied as 'care systems'. We shall develop this perspective through case studies and other data from a Norwegian context, and point to the theoretical and practical implications following this approach.

By *system* we imply that there are several parts involved, constituting the system as a whole, and that there is some stability and structure in the way these parts interact, so that changes in one produce changes in others and vice versa.[3] The 'systemic' feature of care is seen as having to do both with the interdependence of tasks *and* the social relations involved.

By *care* we mean activities that help persons manage their functions of daily living, which they cannot manage by themselves. It is the condition of the person in question, and not the nature of the activities, which defines them as care. The same type of act may be 'service' to a self-sufficient person and 'care' to a person needing help.[4] The person's inadequacies may be due to physical or mental problems or both. Small children are both mentally and physically incapable of taking care of themselves. Frail old people may be either–or both.

Case 1: Care as a collective action

We shall illustrate the complexity and collectivity of a care event by a case[5] showing how an old wife copes with the care of her sick and helpless husband. They are both in their early eighties, and live alone near the centre of a Norwegian town. The town is a more or less typical Norwegian small town, densely populated on a small area by approximately 3000 inhabitants, of whom a fairly high proportion are aged. Service (public and private) is the main industry, followed by small-scale manufacturing and trade. With a low migration (both ways), the town is characterised by social stability and continuity of social relations, with a common feeling that 'we all know each other'. This should give an idea of the setting for Anna and Arthur A.[6]

Anna and Arthur A. had nearly ten good years as retirees before Arthur suffered a severe cerebral haemorrhage. After four weeks in hospital, the doctor would have moved him to the local nursing home, but Anna said no. She could not relax until she had tried to take care of him herself as a good wife should, in her opinion.

She tells me the doctor and 'everybody' thought she was too old and could not make it, but she did. She does not know where her stamina came from. 'I'm not strong, you know, being past eighty now – but maybe I wouldn't have had the strength and will to live had it not been for this task.' She wonders, and sees her fate as a test from above.

The daily work starts with Anna serving Arthur breakfast in bed around eight. Nine o'clock the home nurse comes to wash Arthur and get him up. She dresses him and helps him to a chair by the window. They sing a couple of songs. It's good language training. His only two words in conversation are yes and no. Anna usually joins them when they sing, and says she takes pleasure in it.

Arthur is rather worn out by the time this is done, and sits dozing in the chair for an hour or so. This is the time for Anna to do her shopping. She laughs when she describes herself as a lizard leaping from one shop to the next, trying to get all her errands done. She cannot carry much, and has no car, so this is an almost daily event.

Anna feels she ought to stop and chat with friends and acquaintances she meets in the town. They ask her how Arthur is doing, and what about herself, does she manage? Take care, Anna!

'It's a bother really, I never get my shopping done', says Anna, sounding as if she would not miss it for the world. 'The whole town' knows her, and she knows them, or at least the older part of them. They all know how she struggles and praise her: 'She's just fantastic, that's what I call a good wife!' That was what another old woman told me when we casually came to talk about Anna.

Anna just manages to do the dishes before the home nurse arrives for the second time around two o'clock, but now only for a quarter of an hour. A quick wash and to bed with Arthur.

He used to lie in bed from two until nine the next morning, but he has grown stronger, and by mutual strength he and Anna manage to raise him to a sitting position, with the assistance of a handle their son has fastened to the wall for Arthur to lift himself up by. 'This makes a nice change for him', says Anna, who felt sorry for him when he had to lie down most of the day, not being able to watch television and all.

The two of them have a cup of coffee in the afternoon. She reads for him every day, the local newspaper or some pages from a book, until he is tired. She has learned to tell by now; when he is tired, he easily

gets angry, or he may start to cry. Anna knows it as a part of the illness; she has been told so by a friend who had experienced the same. So she is coping better now, but had Arthur not been so nice as a patient, she could not have stood it. However, she must hide the fact that she is tired. It upsets Arthur, and this is almost the worst part of it – she always must appear fresh and relaxed despite her being tired to the bone and mentally exhausted after nights half in sleep, listening for strange sounds from Arthur's room.

Anna washes him and prepares him for the night herself. She no longer has the third visit by the home nurse now that the local authorities have cut down on public expenditure. She could have used more help, but would never dream of asking for more under the present circumstances. 'They would think I'm crazy and ungrateful if I asked for more help now!'

But she cannot manage with less either. Once a week a home help comes for three hours to do the house for her. She has a neighbour who calls in at least a couple of days a week, and on winter mornings she hears the newly fallen snow being brushed away from the stairs. Not that it happens often, this particular town has a fairly mild coastal climate; but it comforts her to think about it and to know she can count on help if and when the snow falls. And she (the neighbour) won't ever have anything in return! Says she does it to keep fit!' Anna sighs smilingly and adds that she hopes the neighbour is richly rewarded in her next life.

The children – there are three of them – have their own families and live in other parts of the country. Besides, Anna would not have asked them for help, she says. She won't be a burden to them, or to anyone for that matter. But still, their nearest-living son comes to visit them at least once a month as well as at vacation time. 'And I haven't asked him, it's his own idea', says Anna proudly. The son takes care of repairs that need to be done in the rather old and large house. Anna presents him with a list each time he comes.

Anna states repeatedly how 'everybody is so helpful'. She tells about friends coming to visit her now and then, bringing flowers, a cake, some jam they have made, but only for short visits. Anna feels she hasn't the time to entertain them, hence they mostly chat a couple of minutes in the kitchen, not even taking their coats off. Anna tells me that the friends are concerned with how she manages, but she lets it show through that she is reluctant to ask them for help, or even let them help her. 'My sister would have been here every day, had she been alive. That's the kind of person she was.' And I get the strong impression that Anna misses such a person now.

Anna herself has arranged treatment for Arthur by a physiotherapist, and she was the one who demanded a home help. She has also arranged with the doctor that she can call him whenever she wishes. It is almost like a deal they have, which allows her not to feel unreasonably persistent when she calls him.

She has been assured by the hospital that they will take Arthur in as a patient the very moment she cannot cope any longer, which is a great relief to her, as there are long waiting lists for admission to both the hospital and the nursing home. She feels certain there will be help if something should happen, and hopes Arthur will 'go' first. 'He just couldn't take it if he was put into the nursing home', according to Anna.

Last summer Anna was offered a two-week stay for Arthur in the nursing home. It was the doctor's idea, and was meant to give Anna an opportunity to relax, take a vacation, and maybe visit the children. She accepted – she felt she could not say no when they had gone to all that trouble for her sake – but ended up spending the two weeks from noon to evening by Arthur's bed in the nursing home. She just could not leave him. 'You know, Arthur can't be anywhere but at home', Anna explains, 'I know, and I'm the only one that really knows him. A nursing home, all the strangers – it would "kill" him. And what about me then? That would have been even worse than this toil!'

Contributing activities

We do not present Anna and Arthur as a typical case, nor as a model, but rather because their story focuses on typical aspects of care. It illustrates well the complexity of a care event, and how practical tasks and social relations interplay. We shall use the case to identify the types of activities involved in the care event.

First of all there is *care provision*, i.e. the direct and instrumental care tasks solved by others than the cared-for himself, and which in this case is done principally by Anna, and next by the home nurse. The person contributing practically and directly in the care event, but who is most often regarded only as a recipient, is Arthur himself. A patient/client also has a job to do, and to the extent that he is not totally unable, we shall find there is an element of *self-care* in almost every care event.

The home help, the son, and the neighbour are not directly involved in providing care for Arthur, but are rather helping Anna to help him. Hence, we may speak of *care-supporting activities*. They may be as essential to care provision as women's (unpaid) domestic functions are for men's participation in (paid) productive work.[7]

Anna says she cannot manage without the housework being done by the home help. She even feels it decisive that she has been promised help from the hospital. To her, not only is the actual help necessary, so also is the potential help, the help she may count on *if* she should need it. Promises and reassurances have an impact on the care event through Anna's feeling of support. Whether these promises are real or not has no significance for the effect. Right or wrong, her feeling that she is not alone with the responsibility is real enough, and may give her strength, calm her anxiety and release her energy for coping with the care tasks. The care-supporing activities may thus be instrumental or expressive (socio-emotional) – or both.

Because the care event rests upon several acts and actors, they constitute an organisation which also needs to be taken care of. The distribution of tasks is a task in itself, and there may be cases where there is more work involved in organising others to do the tasks than in doing them oneself. Hence, we have *care management* as a fourth type of contributing activity. Anna is not only taking care of Arthur, she also arranges her own and others' efforts, she mediates and serves as a link between the informal and formal sub-systems; in short, she manages the care event.

In summary, we have observed care provision, self-care, care-supporting activities and care management, all of which may be necessary components in the care event. Care provision is usually essential and dominant in a care event, but not necessarily so. It may in fact even be dysfunctional, as when too much help creates helplessness and weakens the capacity for self-care.

Socio-emotional support directly to the person in need of care may prove sufficient in itself, in cases where mental problems are the primary cause of care needs. This may serve as an example of how apparent trivialities may have untrivial consequences. The care problem may be solved by small efforts – a regular visit or a telephone call. Physical details may also be essential, like practical equipment in the dwelling such as the handle for Arthur to lift himself up.

How expressive support may be instrumental to care can be illustrated by the high correlation found between social integration and perceived mental and physical health in the Norwegian Standard of Living Study.[8] In another study, one has found that old people often seek institutional care in residential homes because of fear of what may happen when they live alone, rather than because they need actual help.[9] Let these be illustrations of how the various activities may interact in the making of a care event. The basis for the interplay must be sought in the social relations between the parties.

Care as social interaction

The need for care cannot in itself explain the nature of care activities. We understand the care event better by focusing on the relation between the parties than on each party themselves. When Anna feels obliged to take care of Arthur, it is not because Arthur is *sick*, but because *Arthur* is sick. She takes care of him first of all because he is her husband, and by taking care of him she confirms their relationship as a husband–wife relationship – the way she sees this relation.

Friedson[10] points to this dialectic when he sees the division of labour (in our context: care) 'as a process of social interaction in the course of which the participants are continuously engaged in attempting to define, establish, maintain and renew the tasks they perform and the relationships with others which their tasks presuppose' (p. 24). Take the family as an example. The family is in a sense taking care of itself by taking care of its members. This is implied also when Bengtson and Kuypers[11] introduce 'continuity versus dislocation of the family as a functional unit' as one of three conflicting processes in the negotiation of family roles. Faced with a family transition, say Bengtson and Kuypers, 'the family's very survival is at issue' (p. 4). The dialectic of care tasks and their social basis is also implied when Shanas[12] finds that family help and care for the aged seems to persist despite the strengthening of public agency services. It seems the family in a way may need their sick old members just as their sick old members need their family.

Malcolm Johnson[13] has pointed to this symbolic (social relations-producing) function of the public services. He concludes from a study of meals-on-wheels in an English city that the service itself was of little practical value, but served the service organisation itself rather than the clients. How organisations are helping themselves by helping others is perhaps most evident in charity. The critics of voluntary engagement in care maintain that it is the symbolic feeling of helping more than the actual help which is these organisations' primary function. When the son regularly comes to do repairs and odd jobs for Anna, it is probably just as important for her and for the care event that it is her son that comes. His coming as a son contributes to the maintenance of the very family ties and obligations which support – or rather force – Anna to take care of Arthur at home.

A case of almost purely symbolic interchange which, however, still may prove instrumental to the care event, is the role played by friends. Friendship is in modern society recognised by a positive will, but a limited responsibility. For example, friends very seldom take on heavy

care burdens.[14–16] The actual help contributed by Anna's friends was indeed modest; their importance for the care event probably had less to do with the sporadic help they actually gave than with the fact that they offered to help. Anna probably wanted to be offered help, but she gratefully turned it down; the friends wanted to offer their help, but probably expected that Anna would politely decline their offers. By this interchange they preserved their friendship without overloading it, and established a common fiction of mutual help, which through their belief in it became functional to the care event by supporting Anna socially and emotionally in her care of Arthur.

The point being made is that the parties involved in a care event participate both as potential care persons and as spouses, children, friends, nurses, home helps, etc. They interact both relative to the needs for care to be met and to the social relations to be maintained. How this social organisation of care affects the care event is underestimated. It may also contribute to the explanation of why institutionalised elderly people who are seldom visited by their children are seldom visited by other family members either. They have fewer contacts with other kin either than patients with no children or than patients with children whom they see often[17,18] The explanation may be that the more distant kin hold themselves aloof from responsibilities they feel the children *ought to* have accepted. Old people with children, who have few contacts with them, may thus be worse off with regard to family resources than are old people with no children at all.

Another example of how the distribution of tasks in care is explained not only by the need for help but also by the social relations involved is reported in a study by Nygård[19] on family care for the aged. The responsible carer often received help from other family members in her support of the frail old person. But when she was paid as a home help for her work, although (or maybe because) it was rather symbolic in relation to the work done, she received much less help from other kin. What is cause and effect in this case is not self-evident, but we find it fair to conclude that the public payment contributed to a redefinition of the relations involved from a purely family care relation to care as a (paid) job, which in turn made it not as 'natural' for the family members to assist in the care event.

A third example of how the parties involved in a care event define their responsibility and contribution according to what ought to be done (i.e. the social relations) rather than what needs to be done (i.e. the care needs), is seen in the role played by neighbours. They may in some cases be important sources of light, practical help but very seldom take on heavy care loads.[20] Neighbourly relations are often 'friendly, but

remote', and a neighbour's potential contribution to a care event will most often be by minor, and often sporadic, efforts. These may in some cases be essential to a particular care event, but they imply that the heavier loads are carried by others. A person without sufficient family resources or public help may find there is no help from neighbours either. Not only because the situation may involve too much instrumental work, but also – and maybe foremost – because it demands a redefinition of their relation to 'more than' a neighbourly relation. And correspondingly, a person who receives help from family and/or public services may find neighbours willingly contributing the additional help 'suitable' for neighbours to do. When neighbours in modern suburban milieux often feel they benefit more from a rejection of contacts, and an establishment of 'unreachability' versus other neighbours,[21] this may be due partly to lack of continuity in their relationship, and the corresponding lack of knowledge of each other's social networks. They do not know what support and help their neighbour may count on from more relevant helpers, and hence they do not know what the risk of overloading the neighbourly relation is.

These are examples of how the activities that 'make' the care event are socially organised. The division of tasks reflects a social order, and in turn reflects back on this order. The care event is thus based on a double effort or 'work', the actual care taking and the taking care of the social relations which the specific tasks presuppose. Hence, we can observe a feedback system through which care 'creates' social relations which in turn 'creates' care and so on.

This social construction of care contributes to the explanation of how care systems change. For example, when the aged seem to expect (and accept) more help from the family in small and close-knit communities than in more modern, urbanised areas,[22,23] this may be understood relative to how the continuity of inter-generational exchanges of help have preserved the norm of reciprocity better in the closer-knit communities.[24] A similar explanation may account for why older women are usually both more likely to help the family, and also receive more help, than do old men.[25–29] The women are reaping their previous investments in social relations.[30]. John Lozier[31] has shown how social investments produce the greatest returns in fairly stable communities characterised by social continuity which makes possible a collective knowledge of the old person's past, and the extent to which he or she has earned a right to social respect and support in old age. Thuen and Wadel[32] speak about 'local social capital' to describe the same phenomenon.

On this basis we may explain how the maintenance and change of

social relations contribute to maintain and change care systems on a general level and over fairly longer periods of time. It is more difficult to establish and in turn prove how and to what extent an actual care event is affected. How much, for example, does it mean to Anna that Arthur shows her gratitude and devotion (as a husband), and is pleasant (as a patient)? What 'work' is involved on Arthur's part to make Anna keep up her efforts?

Case 2: Shifting tasks and stable roles

That the division of tasks in care reflects underlying social relations does not mean that these relations will continue to express themselves in the same manner. We must not confuse social roles with how they are expressed at a given time and place. The family members' roles in the care of old people are continuously changing; so also is the role care plays for the family. The development of public services for the aged has increased the importance of care management for the care event, and the role as a mediator or a link between the old person in need of care and the public service system is added to the role of the care provider.[33–35]

While a 'good daughter' used to be one who personally took care of her old and frail parents, a 'good daughter' is in the process of becoming one who (also) sees to it that her old parents get the service and help they need, but she does not necessarily provide it herself.[36] How this change of tasks is negotiated in an actual family is illustrated in our second case, which shows how a daughter who has been actively engaged in providing care for her very old mother tries to cope with her role as a daughter when she leaves her traditional task.

Bertha B. is a woman of 73 years. She lives with her husband and a mother of 94 in a house in the town centre. One morning she practically burst into the social welfare office to see the head nurse, and hardly waited until she was inside the nurse's door before claiming that now, at last, her mother must be admitted to the nursing home. She just could not manage any longer. The responsibility is too great; it is not the work involved that tires her most, but rather the worry about what may happen, and the fear that her mother might die without the benefit of proper medical aid.

Bertha B. had been thinking about this more or less for several months. Her husband and children had long since told her to apply for the mother's admission, but Bertha's conscience would not let her do

so. This ambivalence is probably why she put such energy into it when she finally applied. What triggered off her asking on that particular day was that she had been told by the doctor that her mother was due for discharge after two weeks in hospital. She had broken her leg for the second time in less than two years after a fall on the stairs at home.

I came to know all this from several sources, in part from Bertha herself and in part from others. As I was in the welfare office on that day I overheard parts of the conversation between Bertha and the nurse, and it seemed Bertha did not mind me eavesdropping on them, rather the contrary. On the days following I noticed Bertha in the town engaged in eager discussion with friends and acquaintances, on street corners and in and out of shops. The town is small, so she knows almost everyone living there, at least those of her own age. I got the strong impression that Bertha was now preparing her network for the family transition to come. In short, she was letting it be known that she was applying for a bed in the nursing home for her mother. This assumption was supported shortly after. A few days later my elderly landlady casually asked if I had heard that Bertha's old mother was due for the nursing home, and it was about time too! 'Poor Bertha, she has worked herself out for her mother. That's a good daughter, I tell you. Most daughters nowadays put their parents in institutions by the time they are past 70!'

What Bertha B. in fact had been doing during these days was this: she had been negotiating her role as a daughter in the light of shifting care tasks. First she actually negotiated with the public agency, asking them to take her mother as a patient. Next, and as important, she negotiated her role symbolically with the relevant others in her network, consciously or unconsciously knowing that the news would filter through the remaining network within a couple of days, preparing practically the whole town for what was about to happen. She mobilised the whole network in her endeavour, securing continual respect for herself as a daughter and a person, and for her family as a family. In fact, she probably negotiated so successfully that not only did she get social approbation for having been a 'good daughter' all these years, but she also managed to establish a role as an even better daughter now that she had arranged the proper and skilled attention a very old woman like her mother ought to receive.

Hence, although we have maintained that the family seems to need their old people as well as the other way round, we do not imply that the family of today needs to care for frail old persons in order to remain a family. Neither do we suggest that a wife needs to take care of a sick old husband to remain a 'good wife' as Anna felt she had to. Family obligations and the ways they are expressed vary both by families and

by cultural settings. What we do maintain is that a family, like any social organisation, needs to reproduce itself as a family, and that family members are actively engaged in this process during their interaction with others and each other, among other things through what they do, or do not do, in a care event. How they define their roles will in turn affect the care event, as when Anna could not square her conception of a wife and a woman with her husband being in a nursing home. Even the two-week stay she was offered for Arthur in the nursing home was too much of a challenge to her role as a wife and her well-being as a person. The co-operation between formal and informal care is thus not only a question of dividing tasks, but also a question of establishing and reconstructing role relations.

The family has kept and reproduced its central position in the production of care despite vast changes in economic and social conditions. The strengthening of public services seems not to have undermined family solidarity,[37, 38] probably in part because we have underestimated the family's role as a 'primary basis for security for the normal adult', to quote Parsons (cf. Shanas 1979).[39] The family as a refuge is probably more important than ever, and hence family integration and solidarity are not necessarily mothered by economic and instrumental necessity. Family solidarity may even be strengthened by the relief of practical burdens and constraints. Worach-Kardas[40] concludes in the case of Poland that older people are reluctant to ask for help from their children for fear of overloading their relationship. She suggests that immediate family will have its most essential role in care in the future on the socio-emotional level, while professionals and paid personnel to an ever larger extent take over the practical burdens. This brings us to the question of how the social organisation of the care activities and tasks corresponds to the care needs they are supposed to meet.

Acts and actors

When Arthur wants Anna, and no other, to take care of him, this has nothing to do with her instrumental skills. It is rather despite her shortage of skills. Arthur would not trade her for a skilled nurse, and a skilled nurse and the nursing home would probably not have possessed the complexity of skills and social qualities that make the care of Arthur more than bed and bread.

Gerontological studies have usually found a clear preference for help from the immediate family and, in the case of a child, from a daughter.[41–45] More distant kin, friends and neighbours play a very

modest role in the practical work of a heavy care event. Friends may, however, have particular qualities as 'buffers' in emotional crisis, say Lowenthal and Haven.[46] Tobin and Kulys[47] suggest that confidants who are *not* family members are particularly important sources of emotional support, Rosow[48] finds common age/generation a good basis for neighbourhood integration (and subsequent motivation for self-care?). The anthropologist Wadel[49] suggests that even distant friends and acquaintances are actively made use of in close-knit, small communities by, for instance, 'taking a walk on the town' when one is upset and in need of social support. He sees this as a special case of 'social work'.

Although gerontologists may disagree on who are the 'right'or 'best' helpers, there seems to be a fairly common consent about the conclusion that the social quality of a relation may prove essential for the outcome. It is not implied in this that the closer is necessarily the better. The relation between helper and helped may be too intimate, which explains why bartenders are shoulders to cry on. Bengtson and Kuypers[50] conclude that there is surprisingly little evidence that close family interaction improves the morale and psychological well-being of the aged. They stress the ambivalence of family relations, and 'caution against (the) simple notion that more is better or that closer is happier' The ambivalence of family relations is probably the explanation for what Rosenmayr and Köckeis[51] term 'intimacy at a distance', implying that old people prefer to live alone, but close to their children. 'They don't approve of sharing kitchens with anyone, old or young', to quote Shanas.[52] Hence, the decreasing proportion of shared households across generations probably result from a missed opportunity rather than from a lack of family solidarity.

The person who is the right or wrong actor may depend upon the particular care need requiring skilled attention. It may also vary with personal and cultural factors. Preference for service providers has been proved to vary by sex, class and ethnicity.[53] Norwegian studies have shown the preference also to vary by type of community.[54,55] Urban communities show higher preference for help from the formally organised service system than do the rural communities.

The variability and change in the interplay of acts and actors in care is also seen from how the preferences for service providers seem to have changed during recent years. Judging from a ten-year follow-up interview, the proportion of the over-70s preferring public help to family help has increased tremendously.[56] This is largely explained by the vast strengthening of the public services for the aged during this period, as the attitudes to public services seem to be more positive the more

developed the services are.[57] The decreasing preferences for family help may also, like the decrease in shared households across generations, reflect actual opportunities rather than family alienation.

Preference for a particular provider does not therefore mean that he or she needs to be essential for the care event. It may not even be a 'good choice'. There are lots of examples of dysfunctional care relations, under both informal and formal care. However, in situations where socio-emotional aspects are vital, the preferred caregiver may have qualities which may be hard, or even impossible, to replace, just as parents are nearly non-replaceable for small children, and Anna seemed to be non-replaceable for Arthur. The possibility that actors may be as unsubstitutable in care as are activities, places special restrictions and challenges on the organisation of care in society.

Theoretical and practical implications

Studying care as a care system gives more weight to the organisational conditions for the care event. These are often underestimated and not properly taken into account in the planning and implementation of policies concerning older people.

When a care event 'fails' or does not function well, it is not necessarily because the efforts put into it are too small. It may as well be because the social relations involved are incompatible with the tasks the various actors are supposed to undertake. Hence, we should worry not only about the total efforts invested, but as much about how the efforts are organised and coordinated. A division of tasks which challenges the social relations involved may fail despite the practical burdens being lightened. This was the case for Anna, who could not make her role as a wife compatible with her husband being in the nursing home, even for a two-week period. The actual conflict could in this case probably have been solved by a more thorough preparation period, with time and effort spent on Anna's job of coping with the relational implications of the change of tasks. In short, the shift in care tasks required that the social relations involved had been taken care of. The care work presupposed work with the social relations.

How the organisational aspects of care affect the care event is may be seen most clearly in the care provision of the public care system. Use of public services presupposes that the potential clients themselves, or their representatives, demand the services. The result is an under-consumption of public benefits, in particular by people with few resources, and little knowledge and skill about how the system works.[58]

Old people seem to be particularly reserved and 'incompetent' and are low consumers of public services in relation to their needs.[59,60] Their low consumption is also in part explained by their belonging to a generation to whom public help and services are a social stigma. Each new generation of old people will likely bring with them a more positive view of public services, and a higher skill in negotiation with the public service. The challenge of the future thus lies not only in the increasing number of old people, but also in their increasingly positive attitudes to public help and services.

When the public services are strengthened and are offered to a larger proportion of the aged, this will also affect the family's attitudes. Public services like home helps, which are now provided to nearly one in four of the over-70s[3] are increasingly seen as services one has a right to, and the obligation of a good daughter or a son will consequently be to help their parents receive these rights.[61]

The bureaucratic structure of the public service system, and the existence of limited resources, demand that services must be rationed and distributed according to an evaluation of the need for help. These are factors which limit the use of the services, and may also, paradoxically enough, lead to over-consumption. Potential clients learn how to 'beat the system'. They adjust their presentation of needs according to the system's wish for partial and specialised information.[62] The system's sectorised responsibility structures result in gains in one sector (e.g. community care) becoming larger burdens in other sectors (e.g. institutional care). Further examples of how the attempt to reduce the use of services may in fact create higher consumption, are the clients' reluctance to report that they no longer need the services, because they fear they might not get the help they need if and when they should come to need it again. And likewise, the long waiting lists for public care services, as for admission to old age homes, are probably a consequence of the shortage of services. Studies have shown that the majority on the waiting list for institutional care in Norway are not in immediate need of institutionalisation.[63,64] They are rather preparing for their anticipated needs, and if they in fact should be offered a place, would probably be afraid to say no and let the chance go by. According to a study in Oslo, most family caregivers who had applied for institutional care for their sick old family members withdrew their applications when they were promised help the moment they needed it. The families had applied for help 'just in case', but when given an actual choice they preferred someone to share the responsibility with, rather than to be relieved of the responsibility all together.[65]

This is at the same time an example of how the care system is

often based on a *complementing* type of co-operation. By care complementation we mean that the contribution of one party is conditioned by and in turn conditions the other. It is a 'both–and' type of co-operation, implying that one party may participate in the care system on the condition that other parties also do so. This was the case for Anna. Her efforts would have been meaningless and of no use to the care event without the assistance of the home nurse, and vice versa: the home nurse arrangement would not have been functional without Anna's (and other care persons) taking on the hardest job at home. The role of friends and neighbours is also given its place in a complementing type of co-operation. Their will and ability is of a complementing rather than a substituting kind. When most studies of care concentrate on care provision and the main providers among them, the sporadic and supporting tasks solved by friends and neighbours tend to be judged as of almost no value.

Care systems are not always balanced and conflict-free organisations. Under the present circumstances in modern societies, they are rather the opposite. Social changes create conflicting obligations, in particular in the interplay of the two most important care providers – the immediate family and the public care system. Shanas[66] and Brody[67] have, as mentioned earlier, shown the substitution hypothesis between public and family care to be a myth. The relation between the two is rather of the complementing kind we presented above. The increase of public services has not replaced the family involvement in the care for the aged. We should not, however, be blind to changes in the way family obligations are expressed. It seems that public services may have been substituted for some family efforts in care provision, but this substitution requires a complementing type of co-operation between the public and the family in the sense that the family caregiver must often mediate between the old person and the public care system.

Care substitution may have two forms which may be described as 'competition' and 'relief'. When one party's contribution counteracts the other's, we have a competing type of substitution, when too much care provision may weaken the ability and will for self-care. Relief is a non-competing type of substitution, in which other parties may take over a care provider's job, or part of the job, in a co-operating or complementing way. A special case of competing substitution is the relation between the family and the institutions for the aged. The way these institutions are organised often prevents co-operation from kin, and they also counteract the patient's ability for and will to self-care, making him more helpless than necessary. The practical challenge of this is to organise the two sub-systems in a complementing way, by

inviting the families to 'join' the staff. When one is relieved of the practical burdens of care, *and* is given time and opportunity to negotiate a new social position relative to the relevant others, there may be both ability and will for such a co-operation. What prevents this co-operation today is, in large measure, the social relations involved and how they are defined.

Several studies have found support for what has been termed a compensation hypothesis. More distant kin seem to compensate for closer family relations to some extent.[68, 69] Unmarried people have closer relations to siblings than do the married. When widowed, they also get closer to siblings, but not as close as the never married. Such compensation is found to take place outside the family as well.[70]

We shall not discuss the validity of this and other hypotheses concerning the types of relations between parties involved in a care event. We are presenting the different type of relations to illustrate the importance of studying the organisation of care efforts, and how this organisation affects the care event. We do not only need concepts for activities and tasks like care provision, self-care, care management, etc., we also need concepts that link between the acts, between the actors and between acts and actors. Some of these concepts are here termed complementation, substitution, competition and compensation. An essential question for continued research on care systems is: what are the conditions for the different types of relations?

Conclusions

The perspective we have tried to develop through this paper emphasises that a care event is often dependent upon contributions from a collectivity of actors, and that this collectivity, and the way they co-operate and interplay, reflects a social order. The care event depends not only on the care tasks being done, but also on the social relations involved having been taken care of. Co-operation in care is not only a question of dividing tasks, but as much a question of maintaining role relations. A concrete and practical conclusion may be that we utilise the total resources better if we establish contracts, first of all between the two major care providers, the immediate family and the public care system. These contracts should recognise the family's primacy in a care event at home, and that the public involvement is only assisting in this effort. The contracts should also promise relief when the family caregiver feels she needs it. Under such a situation we shall probably find that the family is able and willing to carry heavy burdens. Friends,

neighbours and others may also find a suitable niche for their minor, but still sometimes essential, contributions, when they do not have to fear being overloaded.

NOTES

1 A paper from a study supported by a grant from NAVF (National Council for Science and the Humanities), no. 12.68.70.045.

2 Becker, H. S. Art as a collective action. *American Sociological Review*, **39**, 6 (1974), 767–776.

3 Longino, C. F. and Lipman, A. Married and spouseless men and women in planned retirement communities: support network differentials. *Journal of Marriage and the Family* **43**, 1981, 169–177.

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5 The cases are presented in a way that prevents identification of actual persons.

6 The cases are selected from a study on the interplay between formal (mostly public) and informal (mostly family) care, with special reference to the role of the elderly as active contributors to care events. The main method was anthropological field work with participant observation during a one-year stay in the particular town (1980–1). This particular town was selected for several reasons, one of them being that the town was part of a large survey done ten years earlier,[23, 55] which provided comparable data for a ten-year follow-up. The town was chosen also because the researcher knew it well, as he was born there, and has family and friends still living in the town. This proved to be a great advantage, although we are not unaware of the problems involved.

The town is part of a municipality which includes 'the town', 'the environs' (close surroundings of the town) and 'the district', which are the more rural areas. A total of 8,800 inhabitants live in the municipality, of whom 12.3 per cent are above the age of 70.

In addition to the field work concentrated in the town, we did an interview with a random sample of approximately 100 of the over-70s living at home in the town and the environs. This represents a follow-up of the survey done ten years earlier. We also collected comprehensive statistical data from public records and files of services for the aged (home help, home nursing, old people's homes and nursing homes). These data cover the whole population of the over-70s in the municipality.

The distribution of services among the aged in the municipality is given in table 1.[61]

TABLE 1. *Percentage of the population above 70 provided with the institutional care or home services by places of residence (N)*

	Nursing home	Residential home	Home nursing	Home help	No services	Total (*N*)
Town centre	7.8	5.9	5.7	22.7	57.9	100.0 (387)
Environs	6.4	5.4	3.9	15.2	69.1	100.0 (204)
District	6.5	4.1	5.5	15.3	68.5	99.9 (489)
Total municipality	6.9	5.0	5.3	18.0	64.8	100.0 (1080)

7 Wærness, K. The invisible welfare state: women's work at home. *Acta Sociologica* **21** (1978), 193–208.
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