Carework: Brief Notes on Enduring and Emerging Issues for Medical Sociology/Sociology of Health and Illness

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Preamble

By way of a personal introduction to this commentary piece I would like to thank the team at Medical Sociology online for inviting me to write for MSo, my first contribution to an online publication. I have participated over many years in BSA Med Soc meetings with many fond memories of beloved colleagues and founders who are no longer with us and the refreshing presence of stimulating contemporary colleagues. I have been an enthusiastic, envious MSN reader since Paul Atkinson’s editorship, on through the Agony Aunt Marjorie columns and into the new cyber moment, enthusiastic because I have always found stimulating ideas and a treasure trove of information, envious because Yankee medical sociology/sociology of health and illness (hereafter MS/SHI) has had no such publication.

Introduction

Of the numerous concepts which underpin, propel and challenge MS/SHI, care and caregiving cut across a wide range of critical issues. They move from intimate levels of interaction to state policy and programmatic agendas. They implicate crucial concerns about the intersectionality of race, class, gender, age, sexual orientation, disability. They invoke fundamental questions about moral issues in our fields. Whilst recognising currently critical questions in formal caregiving, this commentary focuses on informal or hidden caregiving, though recent scholarship usefully modifies the formal/informal categories, noting “women’s multiple positions as care labourers within and across public and private domains” (Litt and Zimmerman, 2003: 159; Lan, 2003; Zimmerman, Litt and Bose, 2006a). My emphasis on informal caregiving here allows me to focus on what these issues mean for MS/SHI and for my own long standing concerns about the implications for stratification in health care systems (Olesen 1989).

Numerous social, health based and economic trends influence informal caregiving - aging populations, the burdens of chronic illnesses, shifts of care from institutions to the home, diminishing numbers of potential caregivers as women seek other work (Olesen, 1997: 404-406). These trends have been widely discussed in the caregiving literature, so will not be scrutinised here. Rather, I will briefly note processes of globalisation and informal caregiving
and try to suggest implications for MS/SHI.

**Brief History**

Much of the history of MS/SHI can be read as a history of care/caregiving starting with the earliest work on doctor-patient relationships, health visitors, the “formal” caregivers. Absent from the early explorations, and for some decades, were informal or unaffiliated providers who, unrecognised in these analyses, were nevertheless, providing significant amounts of care, to the ill and the healthy. That care was both undervalued and devalued. Later scholars using large datasets estimated the 1997 value of informal caregiving in the US as $196 billion, far larger than the value of formal home health care or nursing home care (Arnot, Levine and Memmott, 1999). Full credit for calling attention to these hidden providers in the early 1980s is due British feminist sociologists, Helen Evers, Hilary Graham, Meg Stacey, Claire Ungerson, Janet Finch and Dulcie Groves. Simultaneously, U.S. scholars, Emily Abel, Margaret Nelson, Berenice Fisher, Joan Tronto, Eva Kitay, were exploring similar questions. Since then, there has been an outpouring of feminist work on care from Francesca Cancian, Stacey Olker, Shirley Hill, Madonna Harrington Meyer, Jacquelyn Litt and Mary Zimmerman.

These were essentially US-UK focused, as were most later explorations, though that has changed significantly with recent work noted below in the section on Globalisation and Informal Care Work. Analyses of care in non-Anglophone societies, such as there were, were not easily accessible, perhaps because the dominant English language publications translated few articles and many Anglophone scholars do not read literature in other languages (Social Science and Medicine’s international and cross disciplinary orientation usefully countered and continues to counter this). Moreover, the anthropological literature, potentially quite valuable, was not seriously explored, a regrettable indication that scholars in medical sociology and medical anthropology were, and are, too often unaware of relevant work in one another’s field. For fuller details on this history, see Olesen, 1989: 5-6; Olesen, 1997: 398-406; Olesen, 2005: 219.

The growth of scholarly interest in care, caregiving and care work has been substantial. News of regional conferences in Britain as well as American feminist sociologists’ Carework Network conferences on care work¹, suggest growing numbers of interested scholars. Since 1997 there have been 15,582 entries on care, etc. in Sociological Abstracts. Between January and March, 2007, there were 155. It is not easy to know precisely how many articles appeared on what type of caregiving. An informal guess, based on quick survey of most recent years suggests that work on informal caregiving has become increasingly prominent. Important explorations continue in the realm of formal caregiving, as an excellent bibliography compiled by Tamara Smith of Albany University shows (tsmith@albany.edu).

Though care and caregiving remain widely used terms, increasingly, perhaps since the mid 1990’s, scholars foreground the concept of “carework” to include both formal/paid and

¹ the 5th forthcoming at ASA in New York, August 2007, [http://www.carework-network.org](http://www.carework-network.org)
informal/hidden/unpaid care. Particularly with regard to informal or hidden caregiving, this conceptualisation takes care as a topic in the analysis of work, hence realising opportunities to understand the complexities and opening new spaces for inquiry. It sidesteps the problem of essentialism found in some care literature (Olesen, 1997: 398), and makes possible social, economic, emotional and cultural analyses of informal care (Zimmerman, Litt and Bose, 2006b: 4).

**Globalisation and Informal/Hidden Carework: Implications for MS/SHI**

One of the human faces of globalisation is that of the careworker drawn from impoverished settings to international contexts where a better life seems possible for her/him and those at home who receive their remittances. These remittances constitute a crucial resource for their home state as, for instance, the significant migration of Filipina nurses and domestics (Parrenas, 2000; Gueverra, 2003). Zimmerman, Litt and Bose conceptualise some of the consequences of this movement as “crises of care” (2006c: 10). This refers to multiple issues, among which are: what happens to the elderly, chronically ill, or children for whom the carers had cared, and who are left behind in the “care” of others? What care work, formal or informal, does or does not come into play?

It also speaks to the too frequent vexing and painful situations the migrating caregivers themselves experience, such as sexual, economic and social abuse, and poses the question of who cares for these care workers?

It raises questions about how informal care workers are helped to deal with the biotechnical complexities of contemporary western medical practices when these are transferred from medical settings to the home (Kaye and Riessman, 1991).

It should refer, but does not, to the fact that informal care work, as so insightfully conceptualised by Hilary Graham (1985) is also productive work in that it produces conceptualisations of health, illness and how to be ill etc. The migrating careworker doing informal care work helps create those conceptualisations.

It asks for renewed attention to the gender, racial and ethnic characteristics of informal careworkers whose labour frequently sustains the more privileged classes.

These issues, all of interest to MS/SHI, also invoke questions about the organisation and stratification of health care systems in all societies on which globalisation impacts. In aging western societies informal health care work may become ever more dependent on globalisation’s migratory processes. This has major implications for structures of care, regulation, and at the most basic level, humane care for the suffering. In “donor” societies from which careworkers migrate, informal health care work may alter in ways which also shape the structures and possibilities of humane care for the suffering. As Zimmerman, Litt and Bose so forcefully and elegantly argue (2006), issues of informal care work are not tied only to one society, but reflect multiple dimensions in numerous societies linked by globalisation’s vectors.

This challenges MS/SHI to explore new ways to understand the complexities posed by informal care work with the same vigour applied to inquiries about formal care-giving. Recruitment of informal workers, their status and performance, their impact on definitions of health and illness, their well being, their place in and contribution to health care systems are familiar questions with new meanings and implications for a greater understanding of the care of the well and the suffering.
References


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