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Creating Caring Institutions: Politics, Plurality, and Purpose

Joan C. Tronto

How do we know which institutions provide good care? Some scholars argue that the best way to think about care institutions is to model them upon the family or the market. This paper argues, on the contrary, that when we make explicit some background conditions of good family care, we can apply what we know to better institutionalized caring. After considering elements of bad and good care, from an institutional perspective, the paper argues that good care in an institutional context has three central foci: the purpose of care, a recognition of power relations, and the need for pluralistic, particular tailoring of care to meet individuals' needs. These elements further require political space within institutions to address such concerns.

Keywords Care; Ethic of Care; Institutional Care; Power; Purpose; Plurality; Particularity; Paternalism; Political Space; Market; Family

In the actions of all men, and especially of princes who are not subject to a court of appeal, we must always look to the end [*se guarda al fine*]. (*The Prince*, Book XVIII, Machiavelli 1979, p. 51)

Framing the Question

In recent years, scholars have made convincing arguments about the need for robust care policies (Engster 2007; Folbre 2001; Hankivsky 2004; Held 2006; Heymann 2000; Williams 1999, 2001) and have provided evaluations of the effectiveness of various policies (Gornick *et al.* 2005). But public policies, as well as less formal care practices, all work through institutions. If we are committed to policies to improve care we need also to be able to answer the question: how can we tell which institutions provide good care? A high school teacher told me

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that she can tell the quality of a school she has entered within 10 minutes of being in the building. ‘How?’ I asked. ‘Oh’, she replied, ‘you can just tell which buildings have caring principals and teachers.’ While I am sure that this teacher is correct, those of us without such tacit knowledge, and, more generally, citizens in a democratic society, also want to be able to judge whether institutions provide good care. Is there a way to articulate the basis for such judgments more systematically? To provide some guidelines is the goal of this essay.

Scholars such as Nel Noddings (2002) argue that the best way to think about care institutions is to model them upon the family. Noddings quotes Lisbeth Schorr to support her point. Schorr concluded, in reviewing social welfare programs that benefit children, ‘In their responsiveness and willingness to hang in there, effective programs are more like families than bureaucracies’ (Schorr 1997, p. 231). On the contrary, I shall argue that while we can turn to family life to intuit some key elements of good care, to provide good care in an institutional context requires that we make explicit certain elements of care that go unspoken and that we take for granted in the family setting.

In recent years, one response to ‘defamilization’ of care (Lewis 1997) has been to turn increasingly to the market. As consumers, patients, parents, casual observers, we often can and do pass judgments about the quality of care in various institutional settings. In adopting many of the patterns of market life in ‘the New Public Management’ (Page 2005), managers in care institutions also have been trying to parse out the effectiveness of institutionalized care. They use such tools as measurements of ‘customer satisfaction’ and the introduction of competition as ways to assure that public services are being well provided. Cottage industries provide evaluations of ‘patient satisfaction’, or ‘customer satisfaction’, and these evaluations are justified, especially by their effect on the bottom line. A recent survey of patient satisfaction with nursing, for example, began by noting that as patients become more like consumers, profits are affected by the quality of the ‘patient satisfaction’ (Wagner & Bear 2009). Universities struggle to measure teaching effectiveness as well (Preskill & Russ-Eft 2005). But satisfying consumers may not be the same thing as providing care adequately. Market assumptions about the consumer—that she is rational, autonomous, capable of making a choice, and possessed of adequate information to do so—may not characterize the situation of people in care settings. In measuring patient satisfaction with nursing, for example, the questionnaires are only to be filled out by the patient, not by a family member. Surely, though, family members can provide insight into the quality of nursing care that might be more or equally useful to the evaluation by the patient. Such assumptions necessarily undermine the prospects for observing and improving care. Similarly, competition may be useful in goading public service providers to compete against one another, but it does not establish standards for care, only that one provider is better than another. If all are undesirable, a market mechanism cannot provide an alternative unless someone else decides to enter the market. Given its complexity, low rate of return, and labor-intensive nature of care provision,

market solutions are unlikely to emerge from such competition. Perhaps, then, the market is not the starting place for analyzing the adequacy of care.

Instead of using consumer-like measures of good care, then, I shall start from the assumptions of those who are skeptical about institutional care as an alternative to family care. To do so, I shall make explicit some dimensions of family care that are usually left in the background. Families, I shall argue, already make certain assumptions about the purposes of care, about meeting the particular needs of individuals, and about the internal allocation of power. In formal care institutions, however, there may well be conflicting approaches to purpose, particularity, and power arrangements. As a result, care institutions need to have formal practices in place that will create the space for evaluating and reviewing how well the institution meets its caring obligations by being highly explicit about its pursuit of purposes, how it copes with particularity, and how power is used within the organization. From this set of initial concerns, we will be in a better position to evaluate whether care institutions are caring well.

Changing Institutionalized Contexts for Care

Berenice Fisher and I have described care in general in these terms:

On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (Fisher & Tronto 1990, p. 40; Tronto 1993, p. 103)

In the context of institutional care, obviously some care issues are more relevant than others; self-care, for example, does not usually happen in institutional contexts. Nevertheless, while institutional caring is generally provided for the people who Robert Goodin has described as 'the vulnerable' (Goodin 1985), it is still useful to recall the complex and multi-dimensional nature of care proposed by Fisher and Tronto. By describing four phases of care—*caring about*, i.e. recognizing a need for care; *caring for*, i.e. taking responsibility to meet that need; *care giving*, i.e. the actual physical work of providing care; and, finally, *care receiving*, i.e. the evaluation of how well the care provided had met the caring need—we have highlighted many points where conflict, power relations, inconsistencies, and competing purposes and divergent ideas about good care could affect care processes. We have further argued that a care process that was integral and holistic, in which these phases somehow fit together, approached more closely ideal or good care. In her research, Fisher discovered that caring often seems to consist of something 'extra' (Fisher 1990). If caring is the 'extra', then how can we ever discuss it in institutional terms? It would seem that for institutions to provide 'extra' is already to move it from the status of 'extra' to 'routine'.

In foregrounding care as a kind of human activity, we followed many early feminist scholars of care such as Noddings (1984) and Ruddick (1989) in emphasizing care as a purposive practice. But as I have also noted, care is likely to face two dangers, namely those of paternalism, in which care givers assume that they know better than care receivers what those care receivers need, and parochialism, in which care givers develop preferences for care receivers who are closer to them (Tronto 1993). If we bring these two global, political concerns about caring down to the level of more concrete caring relationships, then the problems addressed by caring are the problems of power and particularity. Thus, all forms of caring, institutional as well as personal, require that attention be paid to purpose, power, and particularity. Identifying these three as the critical elements for assessing practices of care grows out of any understanding that takes care as a *relational practice*. Among others, Christine Koggel (1998) and Jennifer Nedelsky (2008) have insisted that we recognize caring as *relational*.

In part because most people's explicit experiences of being in care relationships are rooted in the family, we often take family care as paradigmatic of all care relations. The current phenomenon of shifting care from household to market, state, or non-profit organization is a shift in the *kind* of institutionalized care, because the family, though it often appears 'natural', is also a social institution with a particular history and structure. In recent years, feminist explorations of the nature of the family and care within it have made clear that all such arrangements are deeply embedded in their own times and places (Hays 1996; Ruddick 1995).

But is it still useful to think about this mythic family? What is it that makes family care so desirable? In the first instance, family care seems somewhat automatic. No one questions seriously the *purpose* of family care: helping the members of the family to flourish together and, often in our culture, as individuals. In the second instance, while this care appears to be automatic, in fact, family care rests upon clearly understood lines of *power* and obligation: children and parents, spouses, aunts and uncles, servants, know what they owe to one another. In the third instance, family care is highly *particularistic*: each family evolves its own ways of doing certain things, and part of the pleasure in being cared for by someone in one's own family is that the family member is likely to understand and act to accommodate those peculiarities.

The family was not always such a paradise, but it was the realm where most caring work was done. We should not be too nostalgic for the family, however. While changes in care through the growth of public institutions correspond to the diminishment of the family as the primary institution of care, these changes are also tied to many other changes in the nature of modern life. Until professional health structures grew, for example, people expected to live and die in their homes. Until antibiotics, death was often caused by fast-moving infections as well as by long-term chronic illness. Until recently, children of all but the most privileged classes were expected not to be educated but to become workers and often at a very early age. The field, mine, or work-house

served as day care and schools. Whether these earlier modes are more desirable is not such an easy question.

Leaving aside our sentimental views of the family, though, the challenge is whether more public social institutions can be similarly arranged so that they provide the same elements of care that the family ideally provided. I will suggest that the same three elements can be present, but not in the same way. While the beauty of relationships in the mythic, glorified family was that they did not need discussion, they evolved out of the ongoing interactions among the personalities in the household. Thus, they could be taken for granted. In any other institution these aspects of care within the institution need to be worked out consciously. This does not make these elements less achievable, but it does mean that they become more visible and require a deliberate, political process to enact them. These three elements, then, are: first, a clear account of power in the care relationship and thus a recognition of the need for a *politics* of care at every level; second, a way for care to remain *particularistic and pluralistic*; and third, that care should have clear, defined, acceptable *purposes*.

As we think about institutional settings for care, we rarely invoke similar language about purposefulness or about power and particularity. As managerial experts have often advised, organizations that focus on the outcome of their work, rather than their profits, often work better. As Richard Ellsworth puts the point: 'A clearly articulated and properly formulated purpose—one that members of the organization understand and value—provides continuity and constancy while placing the need to adapt to changing customer needs at the heart of the company's shared values' (Ellsworth 2002, p. 5). At a second level, if we think about this idea in terms of care, we might reformulate it: care institutions have to think about the nature of the caring process as a whole in order to guide their actions. This requirement does not only demand that the 'needs' of the 'customers' come first but also that the needs of care workers, the allocation of responsibility and proper assessment also happen within the organization.

Indeed, thinking about the organization's purpose quickly requires us to notice the complexity of care, and that of all those people involved in the organization of care. Even Ellsworth's facile formulation of the requisites for 'leading with purpose' disclose that there has to have been a lengthy process by which the members of the organization have come to understand their common purpose and how best to act upon it. Thus, to imagine a world organized to care well requires that we focus on three things: *politics*: recognition and debate/dialogue of relations of power within and outside the organization of competitive and dominative power and agreement of common purpose; *particularity and plurality*: attention to human activities as particular and admitting of other possible ways of doing them and to diverse humans having diverse preferences about how needs might be met; and *purposiveness*: awareness and discussion of the ends and purposes of care. If we keep these aspects of care in mind then we will be able to determine how to think through institutions using the 'logics of care' (Waerness 1984a, b, 1990) that they require.

Seven Warning Signs that Institutions Are Not Caring Well

Nevertheless, it is also fairly easy to see when institutions are not caring well. At the present moment, when the costliness of labor-intensive care is foremost in the minds of citizens (Razavi 2007), we frequently hear about abusive or inadequate forms of care. We can even recognize more systematically what such forms of bad care look like: they are callous, inadequate, rigid. Perhaps it would be useful to list seven warning signs of bad institutional care. When care is situated according to any of these seven assumptions, it is likely to be bad care because it lacks in adequate accounts of power, purpose, and plurality.

(1) Misfortune causes the need for care.

In the minds of most people, care is a concern for those who are vulnerable (Goodin 1985) or dependent. In truth, all human beings require care, all the time. Some are able to care better for themselves. Others are able to command the caring labor of others as ‘personal service’, so while they could clean up after themselves, for example, they hire others to do that work for them so that they can do something less tedious (cf. Waerness 1990). As long as the image of the ‘autonomous career man’ (Walker 1999) continues to exist, then those who are perceived as needing care are marginalized. It is, as many have observed, most recently Knijn and Kremer (1997), quite remarkable that this image of the breadwinning, autonomous adult male so dominates the way that we conceive of citizens because it so obviously does not describe how any humans are for all of their lives. A perspective that recognizes humans throughout the life cycle and with many different capacities and needs better describes people in society and better shapes the needs for institutional care.

(2) Needs are taken as given within the organization.

The process of determining *needs* is one of the foremost political struggles of any account of care (cf. Fraser 1989). Until recently, needs-talk was rarely taken as seriously as rights-talk. Michael Ignatieff, for example, has argued against replacing rights with needs (Ignatieff 1984), though his argument presumes that it is easy to discern the meaning of rights in specific situations. Needs, which are much more contested and unclear conceptually, raise many questions. Who should determine the needs of those who ‘need’ care? On one level, we expect people to be able to determine their own needs. On a second level, though, professional expertise may be necessary to make certain determinations of needs. There is a problem if the professional expert differs from the care receiver in what is needed. Further, professionals might have their own agendas in determining others’ needs. Who then should be entrusted with such determinations? ‘Impartial’ observers? Philosophers, such as Martha Nussbaum

(Nussbaum & World Institute for Development Economics Research 1987), who believe they have a better account of basic human needs?

Recognizing this complexity, then, allows us to draw this conclusion: any agency or institution that presumes that needs are fixed is likely to be mistaken and to inflict harm in trying to meet such needs. A number of feminist authors have supported some version of a 'communicative ethics' to guarantee that such needs interpretations will go on well (Seventhuijsen 1998). Nevertheless, even such a commitment is no guarantee that the process will be workable (Bickford 1996). Further, the 'needs' expressed by less advantaged people may be manipulated or distorted (Cruikshank 1994).

(3) Care is considered a commodity, not a process.

Clare Ungerson (1997) has written extensively about the problem of the commodification of care. Usually, the problem of commodification is associated with a certain degree of dissatisfaction with the way that care is provided: here, as in the classic Marxist framework, the problem with commodification is that it is alienating. There is an analytical difference between providing cash within care relationships and the problem of alienation, though Ungerson is probably correct that in the framework of a capitalist society the danger of alienation is great when money is introduced. Nevertheless, it is possible to imagine a system in which alienation does not occur even though money has entered the equation. Diemut Bubeck's work to try to describe care in terms of exploitation points to some of the ways in which care is different from providing other commodities (Bubeck 1995).

There is a great danger in thinking of care as a commodity, as purchased services, rather than as a process. It seems to me that when we begin to talk in terms of commodification we too quickly begin to slip into thinking of the concomitant notion of *scarcity*. Now, I would not deny for a second the idea that there are more needs for care than can ever be met. But that is not the same thing as thinking of care as a scarce thing. If we think of care as a scarce thing then we are likely to imagine that care is *best* distributed by the market mechanism. If we think of care as scarce, then we are likely to think of care as a zero-sum provision. While it is true that care requires copious amounts of time, it is not the case that to increase care necessarily means that one decreases something else. The usual view that arises from thinking of care as commodity is to see any increase in caring time as a cut in time for another activity. If activities such as paid work can be arranged flexibly, then it may be possible to increase both care and other activities. But to do so requires flexibility, creative thinking, and going beyond the zero-sum model. This, it seems to me, is the greatest danger of the model of care as commodity (Xenos 1989).

This model, thinking of ourselves first as consumers (perhaps more insidiously as 'informed' consumers), is most objectionable to me because it seems to deny people the right to make judgments about their needs. But the only way to counter such forces is to provide alternative judgments, sources of legitimacy,

information. These seem to me to be the essential activities of rhetorical, moral, or political, or still better, *public* space.

(4) Care receivers are excluded from making judgments because they lack expertise.

Often, recipients are looked upon as incompetent because they are dependent. Many thinkers have written about the problems of this understanding of dependency and independence (Kittay 1999; Scully 2008; Silvers 1995). Yet the problem remains a real one. People in wheelchairs are addressed as children, there is virtually no discussion of the need to exclude the mentally incapacitated, and so forth. Given the direction of power in institutionalized settings, where experts arrange processes of care for less-skilled care workers to carry out, there is virtually no role for the voice of the cared-for individuals in providing for their own care. Indeed, any suggestions that they might make to thinking about care are likely to be taken to be resistance or obstruction.

(5) Care is narrowed to care giving, rather than understanding the full process of care, which includes attentiveness to needs and the allocation of responsibility.

Although the language of care giver and care receiver is now widely used, these general terms have only come into existence relatively recently with the theoretical writings by feminist scholars on care. Note, though, that in our willingness to accept these labels, we have in part replicated the public/private split by *not* naming explicitly those who are involved in the care process through the two broader phases of care: paying attention and therefore being care attentive in the first place, and assuming responsibility. I propose that any account of institutional care that fails to name explicitly the ‘care-attentives’ and the ‘care-responsibles’ allows those people, and their roles in caring, to pass unnoticed. Such not-naming contributes to the process of ‘naturalizing’ care relations, and to blaming the care givers who may have inadequate resources etc.

(6) Care givers see organizational requirements as hindrances to, rather than support for, care.

Many care-giving institutions split hands-on care giving from higher ‘management’ functions. Managers are generally better compensated than direct care workers, and their work is less subject to control. Frequently, institutions cut budgets by cutting direct care workers, not managers. Care givers frequently complain that they have inadequate resources for their tasks at hand. When care givers find themselves saying that they care despite the pressures and requirements of the organization, the institution has a diminished capacity to provide good care. Many managerial rules may be necessary for the smooth

functioning of organizations, but when they come into conflict with the provision of care, it is time to rethink them.

(7) Care work is distributed along lines of class, caste, gender, race.

One of the main ways in which societies are able to distinguish among castes is by the kind of caring work that people do. The devalued work of dealing with pollution is in most cultures reserved for the least socially appreciated. It is difficult to determine whether care work is poorly compensated because its denizens tend to be the less privileged in society, or whether, given the relative unattractive nature of care positions, people who face discrimination elsewhere in the workforce become care workers. In either case, regardless of cause, the fact that care is still disproportionately the work of the less well-off and more marginal groups in society reflects care's secondary status in society.

Another dimension of this problem is that care is often a result of the irresponsibility and the non-responsiveness of the privileged. Bubeck (1995) has argued, for example, that not only is care gendered but it is also gendered in part because the kinds of practices that care entails, such as paying attention to the needs of others, are viewed as impediments to the project of masculinity in our culture.

What all of these seven warning signs point to, though, is one common conclusion: the intersection of purpose, power, and plurality make it very likely that one unintended consequence of institutional care will be that one or more of these dimensions of what constitutes 'good' care will drop out of the care that institutions provide. Is there a way to bring such purpose, properly balanced power, and attention to particularity back into caring practices if they are organized institutionally? It is possible to do so, but only if we conscientiously create ways for such conflicts to be recognized and resolved in their institutional settings.

Creating Space for Resolving Conflict: What Would We Wish For?

From such harmful possibilities and realities in existing caring institutions it is easy to see what we would wish for within caring institutions. Or is it? At first thought, we might expect caring to be seamless in an institutional setting and to provide integrated, holistic care. We might wish, for example, that caring have some of these characteristics:

- No one's social opportunities or 'life chances' would be constrained by gender, by sexual orientation, by race, by imposed creed. Such a view incorporates the wishes of the goals of inclusive citizenship and social cohesion.
- People would be free to live with and to affiliate with others in intimate arrangements of their own choosing (beyond a minimal age: Marge Piercy suggests in her utopian *Woman on the Edge of Time* that children at 13 be

permitted to choose their own names and mothers (Piercy 1976)). Some of the caring work in society would be organized so that intimates could share such arrangements, but other possible arrangements would also exist.

- All personal service work would be well paid, so that no class distinctions marked the necessity to do caring work or the privilege of receiving it (cf. Waerness 1990).
- Social institutions and practices would be organized so that vulnerable people as well as able-bodied strong, healthy, normative adults can be accommodated. People think about the needs of others, but everyone also has the capacity to state what their own needs are (cf. Fraser on the 'politics of needs interpretation' (Fraser 1989)). There are multiple systems for meeting needs, and individual inclination allows people to choose which way they will meet their needs.
- We would want those who were caring for us to be happy about the fact that they were giving us care. They would find care rewarding, on both personal and, if necessary, economic grounds (either by the amount they were paid, or by some alternative means of economic provision so that they were not concerned about the 'opportunity cost' of caring.)
- We would not want to be cared for according to some set model of standardization. That is, we would want care to rest upon a thick model of our own sensibilities (e.g. respectful of our senses of physical modesty, propriety, spiritual life, etc.) and our real needs.
- We would want some way to acknowledge both the pleasures and frustrations of receiving both good and bad care and we would want to share our judgments with people who would understand them.
- We would want the caring work that we do to have these same qualities of being rewarding, fulfilling, well received, and we would want the chance to share our judgments and experiences about people who knew enough about caring work to make such sharing worthwhile.
- We would not want to be asked to do so much caring work ourselves that there was no space in our lives outside of the circles of care.

But the reality is that care is rarely without serious problems and conflicts. Consider some examples:

A daughter whose aged mother has become very frail with osteoporosis, but who refuses to be institutionalized, because where she is the institutions that offer assisted living refuse to allow pets and this mother's life would be greatly diminished by being cut off from her dog. Here, the problem is that institutions treat people in standard ways and have their own expediences.

The manager of a firm that provides home help aides hears complaints that the home health aide whom she has sent to take care of a frail and elderly woman may have taken a small amount of money from the dresser-top. There is a shortage of aides: should she be fired? At first, we might want to excuse such bad

behavior if it occurs; caring work is so poorly paid that the workers are in short supply and almost as vulnerable as the people they are assisting. But: was the money taken or mislaid? Did the aide take it? Or is the elderly client forgetful, anxious about money and therefore accusative, and if we cannot get to the 'truth' of the matter, how shall we resolve this situation?

As these examples make clear, even with the best of intentions and purposes, even with institutions that strive to be adaptable, problems in providing care continue to arise. This leads me to the final point of this paper.

While it may seem desirable to try to resolve care problems by an a priori reference to organizational purpose, to a desire for holism in the care process, and for making the situation more family-like, in fact institutional care is better understood in the context of conflict. As such, care institutions need explicit institutional arrangements to help to resolve conflict as it arises.

The complication is that in institutions of care there are many sets and levels of needs. This possibility of conflicting ends within institutions is a long-established problem with viewing institutions as single-purposed and single-minded. Just as all individuals have many ends, so too individuals within organizations have different ends and organizations have many ends.

Furthermore, what we think of as 'needs' changes. They change over time for particular individuals, they change as techniques of medical intervention change, they change as societies expand their sense of what should be cared for, and they change as groups make new, expanded or diminished demands on the political order. The demands placed upon institutions change. Within institutions, as the particular individuals within the institution change, they have different needs. Workers within institutions have their own needs. There is a large discussion of how professionals create and assess needs (Culpitt 1992). Determining needs is complicated.

Where all of this change leads, I think, is to a simple premise: no caring institution in a democratic society (I include the family) can function well without an explicit locus for the needs-interpretation struggle, that is, without a 'rhetorical space' (Code 1995) or a 'moral space' (Walker 1998) or a *political space* within which this essential part of caring can occur. Thus, one important criterion for investigating institutions includes: how does the institution come to understand its needs? How does it negotiate needs within itself? Which needs are taken as legitimate? How are responsibilities within the organization allocated? Who actually gives the care? How are the reception and effectiveness of care work evaluated?

In a democratic society, furthermore, we would expect these institutions to function democratically, that is, to take into consideration the needs and perspectives of all within the institution. In practical terms, this requirement dictates that hierarchies become flattened in caring institutions. This is more easily said than done, but the end result is that the contradictory needs of institutions can be more easily organized.

For example, home-health care workers, whose work is dispersed within the separate households of the many clients that they see, need to be brought

together, as part of their official and paid duties, to compare notes, raise questions about the kinds of problems we mentioned above, and provided with an opportunity to resolve them. They need, furthermore, to be able to have some input in the ways that institutional controls above them are implemented.

Conclusion

If I am right about the complex intersections of purpose, power, and plurality, then rather than expecting other social institutions to be more family-like in providing automatic ways to meet needs, the chances are good that the best forms of institutional care will be those which are highly deliberate and explicit about how to best meet the needs of the people who they serve. This requirement in turn requires that such institutions must build in adequate and well conceived space within which to resolve such conflict, within the organization, among the institutional workers and their clients, and more broadly as the institution interacts in a complex world in order to resolve such conflicts. Non-family care can be outstanding in its quality, but only if organizations that provide care also care about their own ways of working.

To put this final point more forcefully, let us return to Machiavelli's point that we must 'look to the end'. For in the last analysis, what institutional care makes clear is that the determination of the end of institutional care must itself be resolved through a political process that considers the needs, contributions, and prospects of many different actors. Under these conditions, care becomes contested in many ways, but social provision for care is likely to be better.

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