The Caring Relationship

Elderly People and their Families

HAZEL QURESHI
& ALAN WALKER

The Caring Relationship

The Caring Relationship

Elderly People and their Families

Hazel Qureshi

Alan Walker

MACMILLAN

First published 1989 by
THE MACMILLAN PRESS LTD
Houndmills, Basingstoke, Hampshire RG21 2XS
and London
Companies and representatives
throughout the world

ISBN 978-0-333-41948-9 ISBN 978-1-349-20264-5 (eBook)
DOI 10.1007/978-1-349-20264-5

A catalogue record for this book is available
from the British Library.

Reprinted 1993

To the elderly people and their relatives who gave us their time so generously

Contents

List of Tables and Figure

Tables

Figure

Preface

This book is about elderly people and their families. Although it has a particular focus upon the care given to elderly people in case of disability or other need, and is thus perforce largely about family care, it will be obvious that we would disown any inference that disability and dependency is the inevitable lot of those who achieve old age, or that becoming a 'burden' is the most likely consequence. The majority of people aged over 74 in the study we report led full and independent lives, and many others were better seen as interdependent than dependent.

The book begins with a description of the overall sample of elderly people, and goes on to discuss the patterns of contact which they have with their relatives and the variety of needs and sources of help which are identified. The second half of the book focuses upon those who receive regular assistance with practical tasks and discusses how choices are made about who will help within the family, what effects increasing disability and dependency are seen to have on relationships, and how statutory help is seen in relation to family help. We conclude with a discussion of the ways in which our improved knowledge of the informal sector might be better taken into account in the policy and practice of the formal sector of care. The policies of central and local government on pensions, benefits, housing, transport, health and social services all set the context in which exchanges of care within the family take place, but it is the services provided by the last of these which seem most often to be considered to be a possible substitute for family care.

The evidence we advance is based on a survey of around 300 people aged 75 or more, living in the community in Sheffield in 1982/3, and follow-up interviews with some informal carers. The

elderly people interviewed were a representative sample drawn with the help of the Sheffield Family Practitioner Committee's central age/sex register. We are grateful to the staff of the Family Practitioner Committee (FPC) and to the Sheffield GPs who co-operated with us.

We are aware that the restriction to one geographical area places limits upon the generalisability of the detail of our results. However, we see no reason to believe that families in Sheffield are greatly unlike families in other British cities. Readers will be aware that Sheffield has a reputation for a prevailing political commitment to collectively provided services coupled, as will become clear, with a widespread traditional view of family responsibilities.

Many people contributed to the successful implementation of the research. In particular, we wish to acknowledge the invaluable contribution of the other individuals who were at various times members of the research team: Josephine Green and Ken Simons who played important parts in the study of carers and in computing and data processing; Eileen Austin, Barbara Bell, Jean Bloor, Margaret Harrison and Nancy Pavey who undertook much of the interviewing of elderly people; and Margaret Jaram and Gloria Walton who were project secretaries. Margaret Jaram was primarily responsible for preparing the manuscript for publication. Nigel Johnson (on an Economic and Social Research Council linked studentship) and Mick Bond (on placement from the University of Surrey) also contributed to the research effort.

The research was funded by the Joseph Rowntree Memorial Trust and a special debt of thanks is owed to the then Director of the Trust, Robin Guthrie, who provided help and support considerably beyond that normally expected from funding agencies. Valuable advice and support were also received from Michael Bayley, Ron Middlestorb and Eric Sainsbury.

The research on which this book is based represented the fulfilment of a long-standing personal ambition for Alan Walker. His desire to conduct an enquiry into the family system of care stemmed both from his practical experiences in working with elderly people as part of his secondary school task force and the early years of his research career spent analysing data on elderly people from Peter Townsend's survey of household resources and living standards. This commitment was reinforced by

his subsequent disappointment with the lack of penetration of sociological research on elderly people into the field of social policy (with the notable exception of the pioneering work of Peter Townsend). Hazel Qureshi came to the project, as Research Officer, from a background in social work and research into the community care of elderly people.

Alan Walker thanks Carol, Alison and Christopher for bearing so stoically the sacrifices necessary for the completion of this book. Hazel Qureshi thanks Martin and Imran for emotional support and distraction.

Our final and warmest thanks go to the elderly people and their carers who gave up their time to be interviewed and received us with such courtesy and friendliness. We hope that this book is a worthy reflection of their views.

Manchester HAZEL QURESHI
Sheffield ALAN WALKER

1

Introduction

> But it all really starts in the family, because not only is the family the most important means through which we show our care for others. It's the place where each generation learns its responsibility towards the rest of society . . . I think the statutory services can only play their part successfully if we don't expect them to do for us things that we could be doing for ourselves. (Margaret Thatcher, 1981, p. 3)

The subject matter of this book lies at the heart of current debates about both the development of modern society and the future of the welfare state. As the population ages the issue of the provision of help, assistance and care to the growing number of elderly people in need is directly, and sometimes painfully, confronting more and more families. However, while some light has been shed in recent years on the costs that providing such care can entail 'Equal Opportunities Commission' 1980; Nissel and Bonnerjea, 1982; Joshi, 1987), very little research has been conducted into the social foundations of the caring relationship itself. Why do families (and, within them, women in particular) care for elderly relatives who are in need? On what is the caring relationship founded? Can the family be expected to go on caring for elderly relatives for longer and longer periods? These questions prompted the survey on which this book is based. The answers to them have major implications for the state, as well as millions of individual elderly people and their families.

Since the family is, by a long way, the main unit within which care is provided, there has always been an uneasy relationship between it and the state. As long as public provision for elderly and other people with disabilities has existed there have been

concerns expressed, largely from within the state, about the 'danger' this poses to the family (Anderson, 1977; Flandrin, 1979). These concerns have been particularly forcefully expressed under the Thatcher governments of the 1980s, which have combined neo-monetarist stringency in the public sector with an aversion to state welfare and a belief in 'Victorian' family values (Bosanquet, 1983; Walker, 1987a).

Many years ago, in his classic book *The Family Life of Old People*, Townsend (1963, p. 13) noted this official concern about the growing numbers of old people and the belief that many of them were isolated from their families and from the community:

> It was widely believed that the ties of kinship are much less enduring than they once were and that as a consequence the immediate family of parents and unmarried children, of which the individual is a member for only part of his lifetime, has replaced the larger family of three or four generations, of which the individual is a member for the whole of his life, as the fundamental unit of society.

In the mid-1970s Moroney (1976, p. 125) found that, in the opinion of 'scores' of civil servants and social welfare practitioners throughout England and Wales as well as in Denmark and West Germany, families were less willing to care. Civil servants and planners cited the increases in the demand for social services as an indication of the reduced willingness to care on the part of families. This was also the theme running through a series of speeches by successive Secretaries of State for Social Services in the 1980s (Jenkin, 1981; Fowler, 1984; Moore, 1987) the latest of which, on the future of the welfare state, expressed fears about increasing dependency and reliance on the state.

This research shows, in common with a long line of authoritative historical and contemporary studies, that these fears are misplaced. Contrary to the views strongly held by some politicians there is no *evidence* whatsoever of a significant unwillingness to care on the part of families. Indeed we were struck, first, by the universal nature of the acceptance of their primary role in the provision of care for elderly relatives (particularly by the female kin) and, second, by the tremendous normative pressure on them to do so; which meant that, in some instances, they were forced into a

caring relationship which was psychologically damaging to both elderly person and carer. While we are saying, on the basis of evidence detailed in the rest of this book, that the fears of Right-wing politicians are largely unfounded (and appear to reflect a preoccupation with restricting the size of the public sector rather than ensuring the best care for elderly people) we must also be clear we are *not* suggesting that the family system of care can be regarded any longer as being able to cope, largely alone, with the consequences of an ageing population.

In the first place, the number of very elderly people requiring care is expanding rapidly and a significant proportion of them do not have families. Second, for various reasons, there exists a 'care gap' between the needs of some elderly people and the provision of informal care. Third, as we demonstrate in Chapters 5–8, the responsibility for, and the physical act of, caring are unequally distributed between the sexes and (partly as a result) this often places undue strain on both the carer and the cared for. Alternative policy responses are required to overcome this unfair and, in some instances, intolerable position. The possible policy responses are considered in Chapter 9. Here we discuss briefly the relevant demographic changes and the growing care gap, before going on to describe the survey and sample on which this research is based.

Ageing and dependency

The unique late twentieth-century phenomenon of an ageing population is common to all advanced industrial societies. As Table 1.1 shows, in just 50 years (1931–81) the numbers of people aged 65 and over more than doubled, while those aged 75 and over nearly quadrupled. Furthermore current projections show that the population aged 65 and over is set to increase steadily, apart from a slight decline between 1991 and 2001, until well into the next century. The largest rises, however, are expected in the numbers aged 75 and over and 85 and over: 18 per cent and 63 per cent respectively between 1988 and 2021.

The significance of population ageing, for individual families and social policy alike, lies mainly in the rising incidence of disability in successively older age groups, particularly beyond the age of 70 (see Townsend, 1979, p. 706). The need for assistance

Table 1.1 *Numbers of elderly people in Great Britain 1901–2021 (000s)*

Year	65+	%*	75+	%*	85+	%*
1901	1734	4.7	507	1.4	57	0.15
1931	3316	7.4	920	2.1	108	0.24
1951	5332	10.9	1731	3.5	218	0.45
1971	7140	13.2	2536	4.7	462	0.86
1981	7985	15.0	3052	5.7	552	1.03
1988	8697	15.8	3736	6.8	757	1.4
1991	8795	15.9	3844	6.9	757	1.4
2001	8656	15.3	4082	7.2	1047	1.9
2011	8911	15.7	4053	7.1	1187	2.1
2021	9956	17.2	4401	7.6	1230	2.1

*Percentage of total population of Great Britain.
Source: Population projections by Government Actuary. Mid-1981 based projections (from Henwood and Wicks, 1984, p. 4).

and care, both informal and formal, associated with disability is discussed in detail in Chapter 4. But one example of the national challenge facing families and social policy over the next 30 years is that the numbers aged 65 and over who are unable to bath/shower or wash all over alone will increase by 40 per cent, and the numbers aged 85 and over unable to do so will rise by 110 per cent (Phillipson and Walker, 1986, p. 7).

While statistics such as these should be taken seriously by policy makers there has been a tendency for responses to take the form of alarmist statements rather than carefully constructed plans of action. Descriptions such as 'the growing burden of dependency' and 'the rising tide' create a misleading impression of both elderly people and the nature of the challenge facing the social services (see Health Advisory Service, 1983). Moreover, such fears are chiefly expressed about the potential demand on the public sector, whilst few official voices of concern are raised about the implications for families. Official alarm at the public sector consequences of an ageing population is not new (Titmuss, 1963) but it is important to distinguish the facts from the rhetoric if responsible policies, aimed at helping families to care, are to be constructed within limited resources.

In the first place, as we demonstrate in Chapter 4, the majority

of elderly people are *not* in need of care and are able to look after themselves without assistance from either relatives or the social services. Nationally more than half of those over 65 have no disabilities and a further 20 per cent have only slight ones. Even among those aged 75 and over nearly half experience only slight or no disablement.

Second, as we show in Chapters 2 and 5, when it comes to elderly people needing care the state is the last resort. The image of infinite demand for social services which some politicians portray is false. Where elderly people in need of care have families, all available kinship sources of help are usually exhausted before recourse to the state.

Third, as Titmuss (1963, p. 56) pointed out, it is paradoxical to conceive of increases in the numbers of elderly people as a threat or burden when this should be a cause for celebration of social progress and, particularly, the achievements of public welfare in putting an end to many of the causes of premature death which prevented earlier generations reaching advanced old age.

Fourth, alarmist statements about the burden of dependency have hindered an understanding of the true nature of dependency in old age. Rather than assuming that the social problem of dependency is necessarily associated with old age and that the problem is growing because the numbers in a particular age group are increasing, it is important to recognise that dependency is a social relationship rather than a biological rule. Dependent status is socially and not biologically constructed. It is partly the product of a particular social division of labour and structure of inequality rather than a natural concomitant of the ageing process (Walker, 1980, 1981b, 1982c; Townsend, 1981a). Of course this is not to say that people do not grow old and suffer from disabilities, some of which might entail physical dependency, but rather that what we regard as dependency and, for that matter, old age is manufactured by society and not a function of the ageing process (this issue is discussed further in Chapter 4).

The community care gap

This book is about the caring relationship between elderly people and their families. This relationship is the bedrock of 'community

care', whether this is used to mean care *by* the community or care *in* the community (Bayley, 1973). According to P. Abrams (1977, p. 125) 'community care' is the 'provision of help, support and protection to others by lay members of societies acting in everyday domestic and occupational settings'. To the extent that care *by* the community can be said to exist, then it is overwhelmingly families, and female kin in particular, who provide it (see Chapters 4 and 8). Outside the family there is little evidence of substantial inputs of care by lay members of the 'community' (Chapter 8; Wenger, 1984). In practice, therefore, community care consists of care *in* the community. This may be provided 'informally' through kinship networks and also, for the less arduous and less personal tasks, by friends, neighbours and volunteers, or 'formally' by the statutory social services. This 'community care' might be defined more generally, as 'the help and support given to individuals, including children, people with disabilities and elderly people, in non-institutional settings' (Walker, 1982b, p. 5). For most of the post-war period the state has tended to apply the term 'community care' to the activities of the personal social services in the domiciliary field, although in recent years it has been attempting to redefine the central thrust of the policy from care *in* to care *by* the community (Walker, 1986; Bulmer, 1987, pp. 10–16).

In the same way that the term 'community' conjures up misleading images of precisely who it is that provides care and on what basis, so the term 'care' is equally value laden and problematic. In fact the bulk of what is actually done in the name of care should more exactly be labelled as assistance, personal aid, help and support or 'tending' (R. Parker, 1981, p. 17). However, although we use some of these terms interchangeably with 'care', we do not want to lose sight of the fact that care comprises a social relationship as well as a physical task. In view of the confusion associated with the notion of 'community care' it is tempting to conclude that it should be abandoned (Wilson, 1982), but its currency is too wide and, for some, too compelling to make this a serious proposition.

Community care has been one of the centrepieces of social services policy over the whole of the post-war period. But it is the failure of successive governments, during that time, to meet the needs of the rising numbers of elderly people (Phillipson and Walker, 1986) which gives rise to serious concern about the preparedness of the welfare state to respond to the challenge of

population ageing over the next 40 years. There has been a long-standing community 'care gap' (Walker, 1982b, 1985c) between rising needs and the public resources allocated to meet them. This has been exacerbated by increasingly wide variations between local authorities in the services they provide. There is a danger that, unless action is taken to ensure enlarged caring resources, the gap between the need for care on the part of elderly people and the supply of both informal and formal care will widen. The main points may be summarised.

First, more and more elderly people are surviving into advanced old age without any children or other relatives. A large number of elderly people, particularly women, are outliving their spouses, but in addition a significant number of elderly people have never had children. Second, the pool of potential family carers has shrunk because of declining fertility in the 1920s and 1930s. Even when elderly people do have children, therefore, there are fewer of them than in previous times. Third, because people are living longer many of those caring for the over-75s and over-85s are themselves elderly and, therefore, less able to withstand the rigours of caring work. Fourth, there are a range of factors – such as divorce, the growth of poverty and unemployment and the continuing upward trend in women working outside the home – that might limit the propensity to care (Walker, 1985c, p. 13). When these factors are considered against a backcloth of continuing restrictions on the social services which should be supporting the caring activities of families, coupled with more exhortations for the community to care, it is obvious that the caring relationship is going to experience increasing strain. It is on the strength and durability of that relationship that the community care of elderly people in need rests and that is why it is the subject of our investigation.

The survey

In order to investigate the role of the family in the provision of help and care for elderly relatives, and the relationship between elderly people and their family carers, it was considered necessary to conduct interviews with both sides of the caring relationship. Thus a two-stage survey was carried out in Sheffield, in 1982/3. In

the first stage, a sample of 306 people aged 75 or more were interviewed. This group constituted the primary sample because elderly people were regarded as the best source of information about their own needs and attitudes towards the different forms of care they might be receiving. Moreover there was a worry that some contemporary research, in the full flush of its rediscovery of the importance of the informal sector, was in danger of regarding older people as merely the anonymous recipients of care (Nissel and Bonnerjea, 1982; Finch, 1984). Certainly some politicians in their (largely rhetorical) enthusiasm for carers had begun to give this impression (Jenkin, 1981; Fowler, 1984).

In the second stage, interviews were carried out with 57 people who had been identified during the first stage as providing elderly respondents with regular weekly practical assistance on an informal basis. A decision was made to interview only helpers living *outside* the elderly person's own household. This was not the result of any underestimate of the importance and interest of the situation of those caring within households, but rather a reflection of the desire to focus upon the kind of everyday, often (but not always) routine, assistance which forms the bulk of informal caring activity, and perhaps to identify some of the factors affecting the formation of, or failure to form, joint households. Also much in-household care is by *spouses*, and a study of carers living in the same household would have to be quite differently focused in order to discuss their perceptions of caring as opposed to the perceptions of other family members, and to distinguish the help given to elderly relatives from all the other responsibilities and tasks associated with caring for other household members. It was known that the situation of carers within households was under study elsewhere (see, for example, Nissel and Bonnerjea, 1982), but an intensive look in the same study at both out-of-household helpers, and the elderly people who were helped, seemed to be a new departure, certainly on this scale.

Source of the sample of elderly people

The sample of elderly people was drawn from the Family Practitioner Committee's central age/sex register, from the lists of six different practices in Sheffield. This was not strictly a random sample because the practices concerned were not randomly selected. One criterion

Table 1.2 *Comparison of achieved sample with census data residents in private households, Sheffield Metropolitan District 1981 census: small area statistics*

	Males (%)		Females (%)		Totals (%)
Age	SWD*	Married	SWD	Married	
74–9	6	15	25	10	56
80–4	4	5	17	3	29
85+	2	1	11	†	15
Total	12	21	53	14	100 (31 104)

Family care of the elderly sample

	Males (%)		Females (%)		Totals (%)
Age	SWD*	Married	SWD	Married	
74–9	6	14	25	11	56
80–4	5	5	16	2	28
85+	2	1	11	2	16
Total	13	20	52	15	100 (306)

*Single, widowed and divorced.
†Less than 0.05%.

for choice was a belief that the GPs concerned would be willing to collaborate in research on elderly patients. However, a considerable attempt was made to ensure both a geographical spread of patients and an appropriate distribution of the sample among areas with differing socio-economic characteristics. Details are given in the Appendix.

It became possible to check the composition of the achieved sample against 1981 census data and this showed that the age, sex, marital status and household composition of respondents was very close to that of the total population aged 75 and over in Sheffield (see Table 1.2).

The sample of carers

The second-stage sample of carers was found by asking the elderly people for the names and addresses of friends, neighbours and

relatives who provided regular practical assistance. The identification of one 'principal carer', although it could be quite clear in many cases, was not always simple. The definition of a 'carer' certainly varies across studies, with some (for example, the Dinnington research) including many types of activity, such as social visits, whilst others consider only those who provide intensive personal care.

To identify a principal carer as 'the person who does the most' can be problematic in two ways: first, since total care needed is variable, a 'principal carer' so defined might be providing 24-hour intensive assistance, or a once-a-month tidying of the garden; second, since caring tasks are qualitatively different it may well be extremely difficult to weigh up one person's contribution against another's. Frequency, intensity and type of task may all vary. The interviews with elderly people determined 'who helped' by asking this question repeatedly in relation to particular tasks, rather than asking what specific people did. The range of tasks undertaken by each relative could then be constructed from the answers to task-related questions. It was then intended, subsequently, to make whatever distinctions between carers seemed appropriate for a particular piece of data analysis.

However, it was necessary for interviewers to make a decision in the field about whether to ask for a particular relative's name and address in order to be able to include them in the carer study. (The unsatisfactory, and probably unworkable, alternative was to expect interviewers to ask in some cases for the names and addresses of all prominent members of the older person's network.) Also, a series of questions about identified principle helpers was included in the schedule, and these had to be asked irrespective of whether the helpers lived within the household or not. Since we did not wish to ask these questions in relation to friends or relatives giving only small infrequent amounts of assistance, the criterion used in the field was that the person should give *sustained practical assistance involving the complete performance of tasks such as laundry, shopping or housework at least once a week, or lighter tasks such as cooking and light housework at least three times a week*. It was specified that this assistance should not be part of routine household duties, such as were performed by many elderly wives for their non-disabled spouses. In the vast majority of instances the identification of principal helper proved unproblematic

but such a criterion excludes, for example, carers who share caring tasks on a fortnightly basis with other relatives (there was one such case). There is further discussion of this issue in Chapter 5.

At least one carer outside the household was identified in 103 cases (33 per cent). The elderly person refused to give (or did not know) their address in 26 instances, and in 8 instances the carer could not be traced from the address given. Among those carers whom we were able to approach for interview 75 per cent agreed to take part in the study. There were 58 carer interviews in all. Further details of methodology, and an assessment of the representativeness of the achieved sample of carers is given in the Appendix.

The achieved sample of carers was representative of informal carers living outside the household and providing assistance. Although most of those interviewed in the carer study were daughters, this is a very clear reflection of the composition of the population of informal carers of interest in this case. Equally, the proportion of non-relatives is also consistent with what would be expected. (Detailed discussion of how and why particular network members came to be the ones who were providing help is to be found in Chapter 5.)

Interviews with elderly people

The first stage schedule, used for the interviews with elderly people, was a structured interview in which a number of questions were left open for verbatim responses to be recorded. The interview fell broadly into three main sections. The first concentrated on the elderly person's family, the second on health, disability and help received and the third on support systems used and their interaction. A conscious decision was made to ask questions about the circumstances of family members before seeking information about the provision of help or assistance. The majority of elderly people, after all, were not receiving intensive assistance from relatives and it seemed desirable initially not to approach the discussion of family relationships and contacts from that perspective.

In the section of the interview schedule about the family a list of relatives was made, and information was sought about the present circumstances of each, especially those not living more than two

hours' journey away. Further details about this process will be given later. The level of contact with each relative was ascertained, and special intimacy with particular individuals was noted. Following this an attempt was made to discover to what extent the 'family' functioned as a whole for that particular individual. A brief family history was sought with a focus on intra-family helping in the past, particularly in relation to key life events such as retirement or bereavement. This section also contained a brief assessment of other, non-family, social contacts. The main analysis of this section of the questionnaire is contained in Chapter 3.

Under health, disability and help there were simple checklists of common physical conditions, and symptoms of forgetfulness, confusion, depression and anxiety. There were also two scales to assess aspects of morale. One was that used by M. Abrams (1978), namely the acceptance-satisfaction scale; the other was derived from the Philadelphia Geriatric Centre Morale Scale (PGCMS) and covered the individual's reaction to ageing. Loneliness and difficulty passing time were dealt with in separate questions. With regard to physical disability, the functional disability scale was based on the work of Townsend (1962), S. Sainsbury (1973) and Walker and Townsend (1976) and was integrated with questions about the sources of help which attempted to compensate for different aspects of functional disability. This sub-section gave rise to a list of helpers and an assessment of their relative importance. Details of help given by the elderly person to others were also recorded. Information from this section is to be found primarily in Chapter 4, with more detailed analyses of different patterns of informal care and the factors underlying them in Chapters 5 and 6.

In the third section, support systems used, there was a common core of questions on reactions to disability, and on likely (or actual) sources of help in a variety of (not too improbable) situations. For those who were receiving help from home-help or warden services there was a short series of additional questions designed to determine satisfaction with the service and whether formal helpers had taken on informal roles. People receiving regular informal help were also asked a series of questions in relation to their informal helpers, including questions about the history of helping. Respondents were also asked about preferences regarding different sources of help, including financial or material

help. Material from this section of the questionnaire is contained mainly in Chapter 7.

At various points in the interview information was sought on the elderly person's own financial and material circumstances, housing conditions and feelings about old age.

The interviews with carers

In contrast to the interviews with elderly people, the smaller numbers involved made it possible to use a less structured approach in relation to carers. Although there was a core of structured information to be collected about circumstances and help given, the major part of the interview was conducted as a focus interview, using tape recordings which were later transcribed. The topic areas in the interview guide were: how helping began, perceptions of alternative sources of help both within and outside the family, degree of flexibility for helper and felt indispensability, the quality of the relationship with the elderly person and considerations of reciprocity, the opportunity costs helping, norms about caring and expectations about the future.

Information about relatives

Each elderly person was asked to give detailed information about up to 10 relatives, to include all children, any other relatives with whom there was at least monthly contact and up to three siblings (even if contact was less than monthly). Since it was accepted that elderly people might feel emotionally or psychologically close to relatives with whom they had infrequent physical contact, they were also invited to include any relative to whom they felt especially close. People listed just over four relatives on average, giving a total of 1,221 relatives in all.

Although independent grandchildren were listed separately, information about dependent grandchildren and spouses of children was included with the information about the relevant child. Thus, if a person listed only one relative, there might be other family members in the elderly persons' network. In calculating the size of the family network, spouses of children were counted separately.

In order to facilitate analysis, the 1,221 relatives were sometimes treated as a group: a sample of relatives of people aged over 74.

This is of course quite distinct from the carer sample. In the latter our information was obtained from direct interviews with carers, whilst basic information about all relatives and the extent and methods of contact with them was obtained through the report of the elderly person only.

Plan of the book

This book is primarily intended to report the findings of our survey of the family care of elderly people. As a result the central section of it (Chapters 3–8) concentrates on the key dimensions that the research set out to illuminate: the social contacts between elderly people and their families (Chapter 3), elderly people's need for care and assistance (Chapter 4), determinants of the supply of care within the family (Chapter 5), responses to both receiving and giving care (Chapter 6), reactions to increasing disability and dependency (Chapter 7) and the role of other sources of informal and formal care (Chapter 8). As far as possible in these central chapters we try to allow the elderly people and their carers to speak for themselves. In Chapter 9 we draw together some conclusions from the research and suggest some possible policy responses. In the following chapter we set the scene for subsequent analyses by examining the role of family care for elderly people in a broader policy context.

2

Family Care and the State

Since social policy is concerned with the collective organisation of welfare provision, both public and private, it tends to concentrate on the activities of the formal bureaucratic social services. The paradox facing social policy with regard to the care of elderly people is that, although they are the major consumers of the public social services, the vast bulk of the care they receive does not come from the public sector but from their own families. Within the family it is female kin who are by far and away the main providers of care (Land, 1978; Finch and Groves, 1980; Walker, 1981a, 1982a). Although a significant change has taken place recently in the official recognition of the role of family and other formal carers (see, for example, DHSS, 1981b; Fowler, 1984), in the past an overemphasis on the public social services, by policy makers and policy analysts alike, helped to create a misleading impression of elderly people as welfare dependants and an equally misleading rigidity in the distinction between the formal and the informal sectors. Both of these false constructions are clearly exposed by an examination of the care of the elderly people, as is the inadequacy of a social policy analysis based only on the public services. In practice the formal and the informal sectors are interdependent. On the one hand, the formal sector depends on informal carers: if only a small proportion of those with major caring responsibilities for frail elderly people – in excess of one million people (Henwood and Wicks, 1984, p. 12) – metaphorically downed tools and ignored their emotions the personal social services would be swamped. On the other hand, the caring capacity of the informal sector is partly a function of the availability and distribution of social services as well as of the broader social and economic policies of the state (Walker, 1982b).

The main purpose of this chapter is to examine the relationships between the family and the state in the provision of care to elderly people in order to provide a context for the subsequent examination of the caring relationship in action. We discuss the nature of family care, the impact of state policies (particularly in the personal social services) on the care provided by families, the role of other informal carers and recent government policies on community care. Discussion of a possible alternative basis for policy, which does not exploit the duty felt by families and female kin in particular to provide care for elderly relatives, is reserved for the concluding chapter. At the heart of this analysis is the ostensible conflict between elderly people and carers. We argue that, in so far as a conflict can be seen to exist, it derives primarily from the failure of the state to meet the needs of *both* elderly people and carers adequately and to strike a balance between these needs.

The family system of care

As we pointed out in the previous chapter with regard to the general situation in Britain, and as we demonstrate in Chapter 4 on the basis of our own data from Sheffield, the need for care by elderly people is increasing. In itself this should not be a cause for alarm; however, when coupled with the substantial existing shortfall in both informal help and formal service provision (Walker, 1982b, pp. 20–1; and see also Chapter 4) we believe that there should be serious public concern about the adequacy of care for elderly people in need. In addition there are two other factors which contribute to the urgency for a radical reappraisal of present community care policies: on the one hand, various social and economic changes outlined in Chapter 1 are resulting in a contraction in the pool of potential carers, and on the other hand there is the continuing (grossly unequal) gender division in tending and caring.

In the field of social care the terms 'community' and 'family' have for too long masked the fact that it is female kin who carry out the bulk of caring and tending (see Chapter 5). This means that, in addition to doing most of the unpaid labour involved in tending or caring for elderly people, women bear the main burden of guilt and worry which usually accompanies the ties of love and

affection involved in caring *about* close relatives (Graham, 1983; Ungerson, 1983a, 1983b). A postal survey of carers by the EOC (1980, p. 9) found that there were three times as many women carers as men. A recent study of elderly people using short-term residential care found that 85 per cent had female carers (Allen, 1983). A detailed study of a very small group of families caring for severely disabled elderly relatives found that the average time spent on care activities on weekdays was 3 hours 24 minutes, of which 3 hours 11 minutes was spent by wives and 13 minutes by husbands (Nissel and Bonnerjea, 1982, p. 21). Fifteen of the 22 wives spent at least two hours a day caring for their elderly relatives, but none of the husbands spent this amount of time on caring work. These gender inequalities were even greater with regard to those activities which are the most arduous and difficult and which put the greatest stress on those doing the caring. On average wives spent 2½ hours on these 'primary' care activities and husbands only 8 minutes.

The burden of care falling on women appears to be increasing despite the upward trend in women's participation in the labour market. In a survey of women's employment, Hunt (1968, p. 109) found 5 per cent of women aged 16–64 were responsible for the care of at least one elderly or infirm person in their household and 6 per cent were responsible for at least one person outside the household. In the recent Office of Population Censuses and Surveys study of women's employment, 13 per cent of all women aged 16–59 were found to have caring responsibilities for sick and elderly dependents, a proportion that rose to 21 per cent among those aged 40–59 (Martin and Roberts, 1984, p. 112).

Caring and tending tasks include physical work, particularly where incontinent relatives are involved, such as lifting, extra washing, cooking, cleaning and shopping. Then there is the mental effort involved in dealing with sometimes confused elderly people. Finally, there is the burden of bearing the total responsibility for the provision of care and medication with little help from other relatives or statutory services (Deeping, 1979). Although many of these caring tasks are similar to ordinary housework it cannot be assumed that they can be performed simultaneously with other tasks. For example, the elderly person may not live with the relative or may require special treatment, such as a diet. Moreover all caring and other household tasks may require greater time and

effort because of the need constantly to keep an eye on the elderly relative (EOC, 1980, p. 15). Providing care to older family members often has a disruptive impact on family life and on other members of the family. One study of the family care of elderly relatives found that four in every five families were experiencing problems and two in every five severe problems. Half of the families found that their social life was restricted (P. Sainsbury and Grad de Alarcon, 1971). This picture of tension between members of the nuclear family was confirmed by Nissel and Bonnerjea (1982), who found that in two-thirds of families there was considerable tension. As well as anxiety, physical and mental stress and interpersonal conflict the provision of care often results in a lack of privacy and strained relationships with any children because less time can be devoted to them. Moving an elderly relative into the family home in order to care for them can result in cramped accommodation for everyone, lack of privacy and increased tension between family members (EOC, 1980, pp. 32–3).

It is now well documented that for women acting as principal carers, often married women with children, caring and tending can involve considerable economic, physical, emotional and psychological costs (see Walker, 1982a, pp. 24–5; G. Parker, 1985, pp. 42–65; Joshi, 1987). But, of course, caring involves a relationship between at least two people. Descriptions of caring from the perspective of the carer tend to concentrate, not surprisingly, on the often considerable burdens that caring entails and sometimes present a picture of the elderly person 'taking over' the household (see, for example, Nissel and Bonnerjea, 1982, p. 40). While important advances have been made recently in documenting the previously latent role of carers (Oliver, 1983), we still know very little about caring from the perspective of the elderly person being cared for. This deficiency has been redressed to a considerable extent by the present research.

Elderly people do not give up their independence easily; with few exceptions they are reluctant subjects in caring and dependency. Determination often overcomes severe physical handicap (Townsend, 1963, p. 60): indeed this resilience may itself be the cause of some strain in caring relationships. Elderly people desire, often more than anything else, the preservation of their independence yet, at the same time, they usually want to remain in contact with their relatives. This common attitude has been described, in a

famous phrase, as 'intimacy at a distance' (Rosenmayer and Kockeis, 1963). Two-or three-generation households require considerable adjustments on the part of elderly people as well as their kin (Williams, 1979, p. 49) especially, as we show in the following chapter, since it is as likely to be kin who join the elderly person's household as vice versa. In addition the flow of care and tending is not only one way towards elderly people; they are themselves the providers of care for other elderly people and sometimes for younger people (see Chapter 4). Thus in one study it was found that 30 per cent of the elderly were receiving help from others of their generation (Green, Creese and Kanfert, 1979). Elderly people also provide a great deal of practical help to their children, including child care, shopping, cleaning and cooking (see Chapter 4 and Townsend, 1963; Butcher and Crosbie, 1978; Hunt, 1978). Indeed reciprocity remains an important feature of the relationship between elderly people and their families, and inability to reciprocate creates a reluctance to accept help (see Chapters 4 and 6 and Townsend, 1963, p. 70).

The dual approach to the analysis of caring we have adopted in this book suggests that it can be a difficult and rewarding experience for *both* carers and elderly people. Rather than concentrating on the needs of one group over the other – which can result in inequitable policy proposals (see, for example, Finch, 1984) – this sort of analysis indicates that both share a common interest in opposing the current organisation and practice of 'community care' which is instrumental in imposing dependency on carers and elderly people alike (Walker, 1982c). The failure to provide alternative sources of community-based care, or to support the caring activities of families adequately, removes any effective choice for carers and elderly people and increases the likelihood of tension between relatives and breakdown on the part of carers. The majority of elderly people are opposed to residential accommodation which, not surprisingly, they associate with loss of independence (Chapter 7 and Tobin and Lieberman, 1976, p. 19). But as long as the whole responsibility for care continues to fall on one person, this prospect is likely to face increasing numbers of elderly people. For their part, women have borne the often considerable physical and mental strain of caring and tending alone for far too long. In order to understand why this unsatisfactory pattern of care has developed it is necessary to examine the

role of the state in the care of elderly people and the promotion of family care. As a first step we look at the relationship between the formal sector and the informal sector of care.

The formal and the informal systems of care

Of the four sectors from which welfare services might be obtained – statutory, voluntary, informal and commercial sectors (Wolfendon, 1978) – the informal sector (the world of relatives, friends and neighbours) is distinguished most sharply from the other sectors both in terms of principles of organisation and also its suitability for fulfilling different types of need. Indeed, P. Abrams (1978a) suggested that the differences between the formal and informal sectors were so great as to place considerable difficulties in the way of attempts to integrate the two.

First, he pointed to the differences in the criteria for eligibility for services: informal care is directed towards a particular person on the basis of their social relationships with others – care for a mother, a sister or a friend, for example – whereas formal (statutory or voluntary) care is organised to be delivered to all people in particular, defined categories of need.

Second, in the formal sector, acceptable types of intervention and outcome are prescribed, whereas in the informal sector these kinds of intervention are more diffuse and less well specified. Of course, this does not imply that there are no 'rules' operating in the world of informal care. On the contrary, it is clear that there are complex sets of social expectations and obligations which influence much of the activity in the informal sector and which will be considered at more length later. But it is characteristic of the rules of such social exchange that they are not well specified (in particular they are not found in written form), and that, although social sanctions may be imposed upon those who do not comply, there are no formal procedures for obtaining redress against those felt to have failed to discharge their obligations.

The disadvantages of formal services are those associated with large bureaucratic organisations: developing rigidity of approach, inflexibility (particularly with atypical cases), difficulties in achieving a quick response and the professionals' usurpation of power. At the same time, of course, the resources and expertise of such organisations are often valued by consumers. Typically within