

Rethinking The Care-Market Relationship In Care Provider Organisations

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Abstract

Care provider organisations are under pressure from funding bodies and regulatory procedures to narrowly construct care in ways that preclude its relational, emotional and social characteristics. This process of subjecting care to a managerialist-market logic, however, creates tensions between the organisation and its key stakeholders: care recipients, care-workers and unpaid carers. These tensions are significant and are likely to place organisations under pressure to develop a more holistic approach to care. In addressing this issue, this paper draws upon the concept of bounded emotionality to argue that it is feasible for organisations to be both instrumental and caring, and thereby be responsive to the needs of all of their stakeholders. The paper concludes by discussing some of the practical implications of organisations adopting a framework of bounded emotionality, and suggesting some directions for future research.

Keywords: Emotion, Care, Organisations

The market organisation of care services

Care provider organisations are central to the effective delivery of home and community care services for the frail aged and people with a disability. Their significance, however, is often overlooked or underestimated in research into home care which tends to focus either on the care giver and care recipient, or on particular care programs. Yet, among a myriad of other things, organisations are employers of care workers, they respond to care needs, they allocate care services and they negotiate care with unpaid carers.

Consequently, this research brings organisations back into the frame. It does so by questioning whether organisations can (or do) actually support the provision of 'good care': care that incorporates the relational, emotional and physical needs of both care givers and care recipients. (In this paper, the term *caregiver* refers to all people involved in providing care for someone; *care worker* refers to those caregivers who have a formal, paid relationship with an organisation which is responsible for providing care services; and *carer* refers to the mainly unpaid caregivers who provide care informally - though they may receive a carers allowance - that is with no responsibilities or obligations to a care providing service). I demonstrate that even if organisations would prefer to provide such a notion of care through their services, their dependence upon government funding and their accountability in relation to regulatory frameworks makes this difficult. In effect, organisations are caught up in a restrictive, managerial-market approach to care provision. This paper identifies three tensions in the market approach which suggest that the current direction is unsustainable as well as ineffective at meeting the needs of care recipients, care workers and carer partners. Furthermore, I argue that there are alternatives to the instrumental rationality of market-managerialist logic. What is needed is an approach that can hold together both the rational and emotional elements of care provision. One such alternative is for organisations to utilise the norms and principles of 'bounded emotionality.' A shift in this direction could well open up possibilities for organisations to explore how they might provide a more holistic approach to care, one focused on broad notions of well-being.

Within Australia the types of organisations engaged in the provision of home-based personal care services include government organisations such as Domiciliary Care and Local Governments, not-for-profit organisations, private-for-profit organisations and quasi government organisations. All organisations are required to tender for authorization to provide particular services and attract state funding for programs like Home and Community Care (HACC) and the Aged Care Assessment Program. This arrangement means that organisations are contracted by, and accountable to, the State and Federal governments (depending on their type of funding) for the amount, type, quality and cost of their care services. In order to secure funding it is necessary to anticipate and meet government priorities which are set annually. For example, within the HACC program one 2005 priority stipulates that value is placed on organisations 'with a good track record in or strategies in place to ensure:

- continuous quality improvement practices
- regular review of their services for appropriateness
- compliance with the HACC Minimum Data Set

- financial accountability
- financial viability
- agencies which provide good value for money' (2005a: 27)

The principle of competition between organisations is integral to the tendering process. It encourages them to become more focused on (or some might say distracted by) the efficient management of financial and human resources in order to meet huge demands on care services.

This emphasis on financial management and market principles has occurred throughout the OECD countries as part of the process of the dismantling of the welfare state. Knijn (2000), in an analysis of care provision in the Netherlands, constructs a typology which compares four logics of care: professional, market, bureaucratic and family. She uses this typology to demonstrate that although other logics or imperatives around care provision exist, they have largely been subsumed by market logic. Each of these logics has a different construction of care recipients and care-givers and different ways of approaching issues regarding quality of care and care work (see table 1 for an overview).

Table 1. Logics of care

	Professional	Market	Bureaucratic	Familial
Care recipients	Clients	Consumers	Citizens	Kin / significant others
Care providers	Professionals / experts	Entrepreneurs	Public services	Relatives / volunteers
Assumptions / enacted through	Expertise / personal treatment	Efficiency / effectiveness / profit	Justice / equal treatment	Social bonds / reciprocity / normative claims
Mechanisms of Control	Professional ethics	Supply and demand	Democratic	Social and personal

(adapted from Knijn 2000)

Knijn suggests that the welfare state approach, which balanced bureaucratic, familial and professional logics, and was relatively successful in organising care work, has been all but dismantled since the 1980s. Since this time, care work has become increasingly organised around market logic. Knijn observes that the effect of this shift is that efficiency and managerialism have redefined the character of, and the conditions under which, home care is provided. This process has resulted in increasing levels of casualization, deprofessionalization, work pressure and dissatisfaction, and, as a result, 'high rates of burn-out and job diseases' (2000: 246).

Knijn's analysis of the changes in logic could be applied to Australia, where care provider organisations operate within the government's regulatory framework with its emphasis on contractual relations, performance management systems, and economic rationalism. Research by Stack and Provis (2000) has provided critical insight into the impact of New Public Management principles on the delivery of aged care services in Australia. They 'identified cost-cutting techniques, contracting out of services, introduction of fees for service, the establishment of business units and entrepreneurial management practices for efficient service delivery' as the norm in approaches to care provision. Stack and

Provis argue that such an approach has a detrimental impact on care work and care workers, as well as impacting on broader aspects of quality care.

Within care provider organisations, then, managerialism can be seen as acceding to Knijn's market logic, with the professional logic having a presence in the *language* of home care but not necessarily in its *delivery*. For example, care recipients are now called 'clients' even though in practice they are treated as consumers. Within the market logic, a number of factors place boundaries around the extent to which an organisation's culture can be organised around anything other than the pragmatic allocation of care-related tasks. Such factors include: the flexibility of staff rosters, occupational health and safety considerations, risk management, the optimal use of financial resources, systems of accountability, and the emphasis on 'quality'. In essence, organisations are somehow required to remain competitive, meet regulatory demands, *and* meet care receiver (client) needs. As a result, they have become overly focussed on a pragmatic instrumental approach to care, one that is mainly concerned with the physical and health needs of care recipients. An alternative approach would see care linked to overall well-being: meeting not just the physical health needs of care recipients but also their coexisting social and relational needs.

Tensions in the market approach to care

There are three areas of tension in this instrumental, market approach to care that are likely to make it unsustainable in the long term. These tensions relate to three key stakeholders of care provider organisations: care recipients, care workers and carers. Although all three groups have particular needs that challenge the capacity of organisations to limit care provision to the market mode, the newly defined powers of carers – reinforced by legislation and a Carers' Charter – are likely to present particular challenges.

The first tension relates to the ever-growing movement in consumer rights that places the needs of care recipients at the centre of care provision. Over the next few years, baby boomers will enter into the care recipient group in larger numbers (see Hugo, this edition). Having lived in an era of increased consumer rights and individualism, this group is likely to be more assertive in demanding that services be provided at a level and in a way that maximises their sense of well-being and quality of life. These are most likely to be maximised when care need assessments take into account care recipients' emotional and social needs, as well as their (more narrowly defined) health and medical requirements.

This is not to suggest that all care recipients require high levels of emotional and social support. As research on the Disability People's Movement in the UK suggests, recipients have different requirements ranging from those seeking healthcare and technological assistance only, to those warranting high levels of all types of care (Hopkins et al 2005). Incorporating a relational notion of care into care provision, however, would take individual needs and attitudes toward 'care' into account. Relational care is distinct from paternalism and familial care and does not involve the self-sacrifice and sympathy that these forms of care often perpetuate. In contrast, relational care is about constructing a connection between care provider and care recipient that is respectful and reciprocal, where each person is sensitive to the other's needs and expectations and is capable of

reflexively respond to an 'other' (Nussbaum 2001; Miehl and Moffatt 2000). While this form of care is underpinned by the social relations of those involved, it also requires particular skills and knowledge (see discussion in next sections) if care is to be appropriately provided and mutually satisfying.

However, some care recipients do need high levels of social and emotional support, particularly if they are without access to familial and/or community care. The combination of high levels of mobility in the Australian labour market and low levels of residential mobility amongst the aged is likely to produce high numbers of aged care recipients whose needs are not reliably met by familial or other forms of community care. So while it is clear that the numbers of care recipients are going to increase, it is also likely that this particular cohort will generate new pressures on care provider organisations and care-givers to be responsive and flexible in their delivery of a range of care needs, including the need for social and emotional support.

A second tension is in the ongoing issue of the recruitment and retention of care workers (HACC 2005b, 2003) in an environment where demand outstrips supply. In order to attract (good) care workers, organisations will need to be more cognizant of what it might take to be an employer of choice. This will require knowing more about care workers (particularly home care workers) and the meanings they ascribe to their work. From existing literature it is evident that many of the rewards in care work derive from the practical autonomy that working relatively unsupervised and in someone's home allows; the ability to develop and maintain relationships with clients at whatever level this may occur; and the capacity to see the work as worthwhile: as contributing to the wellbeing and quality of life of another person (Stacey 2005; Ryan et al 2004; Piercy 2000; Stone 2000; Cancian 2000). However, when activities such as showering clients, changing their dressings, or providing respite for carers are routinized and managed to maximise outputs (for example, the number of clients) rather than the quality of interaction, these relational and emotional aspects of care that care workers value risk being sidelined. Indeed, as Meagher (2006: 48-9) argues, 'organisational factors are more likely than anything else to make it difficult for providers and recipients of paid care to establish successful relationships.'

Developing organisational rules that separate out and prohibit these aspects of care is not particularly helpful for retaining care workers. Despite this, organisations continue to be drawn toward recruiting people who are likely to provide relational care, irrespective of whether they will/can provide organisational support for it. In effect, the relational aspects of care work are individualised, while the pragmatic physical aspects accrue organisational support. As a result, care workers often feel obliged to go above and beyond the boundaries of their position description, either to please their clients or to maintain their jobs. This is demonstrated in research by Stone who found that there is considerable stress associated with balancing guilt about not caring in a manner perceived as adequate, with fear of being *caught* caring by the organisation (2000: 111). In other research, Stacey reports on several instances of care workers who 'stay a little longer, lend a little money or take on a little more' arguing that the relational aspects of caring can mask the 'inequality and exploitation of the carework arrangement' (2005: 839; see also Stone 2000). What much of this research demonstrates, however, is that exploitation leading to burn-out and withdrawal is less likely where there is

organisational support for the relational aspects of care work (Cancian 2000; Kangas, Kee and McKee-Waddle 1999; Kahn 1993; Scott et al. 1995). As a range of sources stress, the capacity for care workers to endure the challenges of care work, and to sustain effective caring relations can be greatly enhanced by organisational frameworks that adequately support their workers, both logistically and psychologically (Scott et al. 1995; Kahn 1993).

So far I have argued that organisations that accede to market logic, with its emphasis on rationality and restrictions on the range of care, are likely to be in conflict with two of its key stakeholders groups: care recipients and care workers. The third tension relates to the requirement for organisations to recognise unpaid carers as partners in the care-giving process and as people who need to be supported in their provision of care. This is a relatively new responsibility for organisations and will have an impact on their approach to care provision, not least because more attention will need to be given to supporting familial care. While many carers remain invisible in the formal system, providing care to family members without recognition or assistance from care-provider organisations, those who do come into contact with the formal system are often considered primarily as a resource. Organisations tend to view these carers as the first option for the provision of care to family members, and pressure is often placed on them to maximise their level of caring. Dissenting from this view, the Carers' Association (2003) argues that 'in this model ... carers' rights and needs are not heeded.' The problems with this model are illustrated in the story of Denise McEvoy, a carer on the public record about her caring experiences.

Denise spent 5 years caring for her father Clarrie who had high dependency status due to advanced Parkinson's Disease and Alzheimers'. Her story is on public record in conference papers, media interviews and documentation from the Carers' Association, and this has been augmented by a personal interview with me in February 2006. At the time she wrote her story in 2004, Clarrie was still in the family home because:

... public hospitals will not take what they term 'social admissions' [to provide carers with respite], and nursing homes do not have the staff numbers to monitor him constantly 24 hours a day. This leaves me between a rock and a hard place; because I now have to be 'on duty' 24 hours a day, 7 days a week, whereas professional nursing staff normally work an 8-hour shift (McEvoy 2004).

While Denise was viewed as the main care provider, she was provided with 'assistance' from care provider organisations, but only after a battle and a great deal of begging – in her words, 'service providers generally don't offer anything.' What assistance she was offered did not take *her* needs in relation to Clarrie into consideration. For example, she claimed that while twice a week, 2 care workers shower Clarrie, '... they are permitted to spend only 1 hour with him. One hour is often not long enough, so I have to complete their tasks' (McEvoy 2004). In addition, lack of consistency in provision of care workers, meant that each time they came Denise would have to tell them how to shower Clarrie so that he did not become rigid or begin to aspirate – and this would take nearly 20 minutes out of the allocated hour. One care worker provided by an agency was seen as 'particularly rude', wanting Denise to prepare Clarrie for a shower (usually a two person job), so they could get on with the washing, and even then:

... she was treating him really badly. She needed a lesson in understanding the way Parkinson's works and how people can freeze, their muscles just sort of go rigid, and you can't move him, can't lift an arm or a leg. And she was just yelling at him. It was just awful, absolutely awful (interview).

It was then left to Denise to calm Clarrie down, suction him to alleviate the aspiration and finish the showering. Ironically, the way in which paid care was provided in such situations, both by the organisation and by the individual care worker, ultimately had a detrimental, rather than beneficial, impact on Denise's workload.

Denise's story is testament to the myriad of issues that carers can face in providing long-term high levels of care for family members. The system of paid care provision was not *flexible* enough to give Denise assistance to do everyday things such as the shopping; not *extensive* enough to provide her with real respite even when she was sick herself; not *responsive* enough to her physical and emotional needs even when looking after Clarrie caused her sleep deprivation, a fractured lumbar spine, and chronic back, neck and shoulder pain; and not *caring* enough to supply staff who could actually provide the level of care (in terms of health care and relational care) that Clarrie required (McEvoy 2004). The lack of organisational support for Denise placed stress on her relationship with her father, made her increasingly frustrated with an 'uncaring' system and created friction between her and other care-givers. The provision of paid care can therefore have a huge impact on the capacity of carers to sustain and, as is often required, *increase* their levels of caring over long periods of time. Conceding that the existing economic infrastructure cannot afford to provide paid care workers to do all of the caring required, the SA Carers' Recognition Act (2005) is an attempt to redress the power imbalance between carers and the organisation of paid care.

While the UK has had a Carer (Recognition and Services) Act since 1995, Australia is currently following suit. South Australia now has a Carers' Charter (2005) backed up by legislation, and the ACT looks set to do something similar. In many ways the new legislation recognises the integral relationship between care provider organisations and the capacity for carers to sustain their role. The focus now has to be on both care recipients *and* carers. This is evident in the objects of the SA Carers' Recognition Act (2005), which are:

- a) to recognise and support carers and their role in the community; and
- b) to provide for the reporting by organisations of the action taken to reflect the principles of the Carers' Charter in the provision of services relevant to carers and the persons they care for.

Care provider organisations are therefore going to have particular responsibilities towards carers, ensuring that their employees understand the Carers' Charter and that their services reflect this; and that any public sector organisation involves carers in both policy and program development and strategic/operational planning so as to maximise relevance to carers and care recipients.

In effect the legislation calls on organisations to treat unpaid carers as *partners* in the provision of care. This elevates their position to a point where their needs, as well as

those of care recipients have to be taken into account. This is quite different to their previous relationship with the formal system and is likely to place new pressures on organisations responsible for providing care services. Catering for Denise's needs, for example, would require organisations to consider 'care' in terms of her relationship with her father, her relationship to other care-givers and her relationship to the organisation (or organisations). Accordingly, one likely implication of the Carers' Charter is that many organisations will need to incorporate a more robust notion of care into their service provision and their organisational culture.

The three tensions identified here challenge the wisdom of pursuing market logic in care provider organisations. The increasing empowerment of care recipients highlights the need for organisations to be more responsive to different needs in relation to care, including the relational, emotional and psychological aspects of care. Difficulties in relation to the recruitment and retention of care workers suggest that organisations need to find ways to support these workers in providing the care required of them by both care recipients and unpaid carers, including the relational forms of care. Meanwhile, the Carers' Charter, backed up by legislative requirements, imposes a bureaucratic logic of care while simultaneously recognising the value of the familial logic of care, demanding greater collaboration with, and responsiveness towards, unpaid carers. There are, then, pressing and legitimate reasons for rethinking the relationship between care and the market at an organisational level. The question is, how can organisations operate such that the efficient and effective delivery of services *includes* providing support for the development and maintenance of caring relationships?

Rethinking the organisational approach to care service provision

In this section I examine how care might be supported in an organisational context. In arguing that there is scope for organisations to develop a system of care services that incorporates both relational and emotional aspects, I draw on the work of Mumby and Putnam (1992, 1993) and propose a framework of bounded emotionality as a way forward. The key to this framework is the recognition that organisations are both rational and emotional arenas. As demonstrated earlier, tensions in the managerialist approach are occurring because market logic is primarily based on rational principles which either disregard emotions or view them as useful only when they are instrumental in achieving market objectives. In contrast, the concept of bounded emotionality recognises that there is a need for organisational structures and mechanisms that are supportive of workers and their emotional attachments to, and practices within, the workplace.

The term 'bounded emotionality' is a deliberate ploy used by Mumby and Putnam to disrupt the conventional association between rationality and organisations. In some ways the term is a misnomer because Mumby and Putnam also recognise the importance of rationality in the development of individual and organisational identities. Indeed, they argue that neither rationality nor emotionality 'should be a privileged conceptual and experiential frame for organisations' (1992: 480-1). Maintaining a balance between rationality and emotionality involves shifting 'rationality to include intersubjective understanding, community, and shared interests' (Mumby and Putnam 1992: 481). This shift has two dimensions to it. Firstly, there is a need to recognise the emotionality of

rationality. Rather than being objective or value-neutral, rational decisions are subjectively constructed and influenced by what Mumby and Putnam (1992: 480) call the 'consensus that emerges through the communicative practices of organisations.' Secondly, there is a need to develop a more rational conception of emotion. This would involve recognising the 'knowledge-producing dimensions of emotion' (Mumby and Putnam 1992: 480). For many care workers, the knowledge they have of care recipients is either learned through their emotional connection with one another or because they have the skills to interpret the recipients' emotions. From this perspective, the relational dimension of care demands the incorporation of emotions and feelings and recognises these as skills: learnable, transferable and valuable.

Bounded emotionality is a mode of organising based on nurturance, caring, community, supportiveness, and interrelatedness (Mumby and Putnam 1992). While the emotions required to engage in these kinds of activities are recognised and valued, they are not given a free rein. Emotions are bounded by the intersubjective constraints required to ensure that individuals respond to others within the organisation in ways that sustain the organisational community (Mumby and Putnam 1992: 474). An organisation which exemplifies a system of bounded emotionality will display particular norms, which include (Martin et al 1998: 8-10; King, forthcoming):

1. A *tolerance of ambiguity* and capacity to grasp two or more points of view simultaneously in decision-making
2. A *heterarchy* (ie multiple, non-hierarchical categorization) of goals and values which are organised and governed by the contextual relations within an organisation
3. The facilitation of an *integrated self-identity* for organisational members through breaking down the separation between public and private domains, and nurturing and supporting members as whole people (with emotions, bodies and rationality)
4. A labor process which is constructed within a *community*, and maintained through the legitimation of feelings and caring relationships amongst its members
5. Valuing those *work feelings* governed by relational feeling rules and which are supported by organisational structures and cultures.

Of these norms, the idea of work feelings is likely to be particularly relevant to care work. This point is taken up further later in the article.

The norms associated with bounded emotionality can be empirically identified and discussed, as in Martin et al's (1998) research on The Body Shop. Martin et al found that The Body Shop's pro-feminist, pro-environmental ethical orientation resulted in the development of organisational norms that recognised the value of emotional expression and work feelings and that viewed employees as 'whole people' (complete with mind, body and emotions) who often had family and community roles. Although not all of the norms associated with bounded emotionality were evident in The Body Shop, most were. These helped to create an organisational environment that was positive for workers, who had high levels of work-satisfaction and enthusiasm, loyalty and commitment. At an organisational level, there was greater stability in the workforce, higher levels of trust and communication, and improved efficiency in areas such as information exchange and customer service (Martin, Knopoff and Beckman 1998).

Parallels between The Body Shop and care provider organisations in having an ethical orientation, a need to be financially viable and obligations to external stakeholders, suggest that the development of organisational systems that are supportive of the relational as well as physical aspects of care are possible. Given the predominance of religious and not-for-profit organisations operating in the field of home and community care, the idea that organisations can be based on rational *and* emotional principles would surely be appealing. Such a framework is likely to be less alienating for care workers, for whom care and other forms of emotionality are central to the performance of their work roles and to their identities as workers. This is not to deny that there are likely to be ongoing tensions between emotionality and rationality within organisations. However, as Mumby and Putnam argue, the challenge is actually to keep them in balance rather than allowing one to dominate the other.

One of the premises of bounded emotionality is that work related emotions are legitimate and need to be structurally supported. These work related emotions refer to more than just emotional labour, which has long been recognised as integral to care work, both as a source of alienation and a basis for work satisfaction (eg Hochschild 1983). Indeed, Mumby and Putnam are critical of organisations that view emotional labour as the only valid expression of emotion. They argue that within these organisations, emotional labour is structured according to primarily rational principles to the extent that an individual's emotions are organisationally controlled and ascribed (see Table 2). This results in feelings being commodified and only viewed as useful if subjected to instrumental purposes such as efficiency, profit and productivity (1992: 471). This instrumental view of emotions in the workplace cannot incorporate (and therefore cannot support) the 'individual experience, the relational context, and the intimacy that typifies [the] expression of personal feelings' (Mumby and Putnam 1992: 472) that are particularly pertinent to forms of work such as care work. The alternative proposed by Putnam and Mumby (1993) is to value workplace emotions through the concept of work feelings.

Table 2. Models of emotionality in organisations

Emotional labour	Work feelings
Organisationally controlled	Spontaneous and emergent
Feelings as commodities	Feelings as interrelatedness
Organisationally ascribed	Meaning-centred
Instrumental reasoning	Practical reasoning

(adapted from Mumby and Putnam 1992: 477)

In care work, many of the feelings that are associated with work are spontaneous and emerge from what Mumby and Putnam would call the 'ongoing process of task and social activities rather than from organisational control' (1992: 477). Within care work emotions are primarily communicative involving a range of skills (listening, negotiating, understanding other people's feelings) that encourage interrelatedness and mutual understanding between co-workers, workers and clients, and management and workers. The purpose (or reasoning) behind such work feelings is therefore always practical in that it aims to maintain intersubjectivity (such as respect for others) and mutual understanding. As these are key components of the provision of good care, work feelings provide a means of discussing organisational emotionality in supportive, cognitive and

operational ways. An organisation does not, therefore, have to tell care workers what are and are not permissible emotions or feelings. Instead, because both organisation and workers have a mutual understanding of what constitutes good care, feeling rules become meaning-centred, allowing individuals to 'interpret and adapt to organisational contexts and relationships' (1992: 478).

The work feelings approach facilitates a way of viewing organisational emotionality in ways that limit the potential for dissonance and burn-out and optimise the ability to provide practical support and recognition. In addition, the approach also enables the kind of spontaneity and autonomy required for responsive caring, as opposed to mechanical performance of tasks. The development of such an approach requires juxtaposing rationality with bounded emotionality to the extent that instrumental goals become embedded within a heterarchy of organisational values (and therefore not permitted to become hierarchically dominant). This requires organisational commitment and recognition of the importance of emotions in providing the levels of physical and relational care expected by care recipients, carer partners and care workers.

Toward a practice of bounded emotionality

The provision of home and community care needs to be responsive *and* effective, appropriate *and* efficient, and meet relational *and* physical needs. The current market-managerialist model preferred by government funding bodies focuses on being effective, efficient and meeting physical needs. It therefore often fails to meet the expectations of care recipients, care workers and carer partners. The tensions that this creates for service provider organisations are unsustainable and unnecessary. There are ways of organising care services that enable organisations to also deliver responsive, appropriate and relational care. Bounded emotionality provides one example.

Restructuring organisations around norms associated with bounded emotionality is more likely to create an environment where organisations can meet the needs of its care recipients, care workers and carer partners. Firstly, it would support the provision of care that is attentive and responsive to the emotional, social and physical needs of care recipients. Secondly, it is likely to improve the retention and recruitment rates of care workers. Organisations would have the structures and cultures required to meet the needs of good quality care workers by providing a community that values relational autonomy, having the capacity to meet the relational and physical care needs of care recipients and providing support for workers to use their skills to make a difference to care recipients' lives. Thirdly, it would respond to the needs of (unpaid) carers and their right to be considered as partners in care provision.

In this respect, the system of bounded emotionality affords a unique opportunity for organisations whose core business is the provision of care and care services. For these organisations, care *is* central and it needs to be supported and understood if it is to be sustained. Care recipients, care-workers and carer partners all have different needs in relation to care. While the physical aspects of care are an important component, the emotional, psychological and relational aspects are equally important. Delivering holistic care involves understanding the skills required to identify the appropriate types and levels of emotional engagement for each individual and to manage a care relationship in ways that will optimise the outcomes for both the physical and emotional aspects

of care provision. Such skills are based on effective communication and emotional and social competencies (such as those used in emotional intelligence – see Goleman 1998). As with any form of work, however, care work requires organisational support for it to be effectively delivered. It is a core premise of this article that care work cannot be effectively provided (and sustained) if the organisational structures and cultures are ‘uncaring’.

Given that the provision and, I argue, the support of care are core business for care-provider organisations it would be presumptuous to assume that bounded emotionality does not already exist. While it is evident that the managerialist logic of care is the dominant one and certainly the one expected from funding bodies, the religious and charitable background of many non-profit care-provider organisations is undoubtedly conducive to the principles of bounded emotionality. It is possible, perhaps even probable, that some organisations already implicitly embed principles of bounded emotionality in their structures and cultures. In developing a more empirical research agenda it would be interesting to examine the extent to which care provider organisations already utilize bounded emotionality and the impact this has on employee morale and retention rates, on the capacity of the organisation to meet recipient needs and on its relationship with carer partners. At another level, there is also a need to explore the impact on the experiences of care workers, carers and care recipients; the financial viability of organisations; and organisational cultures and structures.

While this paper has canvassed the perceived advantages of organisations adopting systems of bounded emotionality, there could also be disadvantages. An obvious issue is the potential complexity of balancing emotionality with rational principles and norms. Identifying the practices that organisations use to prevent one being subsumed by the other would help to make the concept of bounded emotionality more robust and transferable to other organisational contexts. This would also be enhanced by research into the means by which individual organisations might maintain systems of bounded emotionality within the context of inter-organisational interdependence. Organisational boundaries are permeable and therefore subject to pressure from ‘outside’; how organisations counteract (or accede to) this pressure would provide interesting insights in relation to inter-organisational power and influence, as well as any changes to the broader value of ‘care’ in society.

Other, perhaps more practical, issues would need to be addressed if research on Australian care-provider organisations found that bounded rationality was indeed useful in rethinking the provision of care. For example, what might be the best process for organisational change? What are the cost implications and how might these be managed? How would the boundaries around work feelings and emotional labour be organised and reviewed? Beyond the organisational aspects of bounded emotionality, the approach also affects care givers and care recipients. For example, how would the different stakeholders construct and reconstruct the boundaries of care? How could care givers be trained in the appropriate provision of emotional, social and relational care – to take into account their own as well as the care recipient’s needs?

There is still much to be learned about the ways in which care provider organisations can best be structured in order to deliver and support ‘good care’ to the frail aged and people with disabilities. Care is not only relevant to the relationship between care-givers

and care recipients, even though this is the most obvious point of transfer. There is a need for organisations to also care, and in this way to support the capacity for care-givers to sustain the level of caring that we as a society are demanding. The concept of bounded emotionality provides one way of thinking through how this might be possible.

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