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Family care work: a policy-relevant research agenda

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Abstract

This article addresses the need for policy-relevant research agendas on family care in transaction with formal care and public as well as organisational norms and policies in light of the crisis in caregiving for older adults. We propose a combined institutional and life-course theoretical approach, suggesting seven ways of organising scholarly enquiry to promote understanding of the changing nature of family care in the 21st century, inform policymakers' efforts at supporting family caregivers and improve caregivers' and care recipients' quality of life. These include: (1) moving beyond snapshots of individuals; (2) conducting comparative cross-cultural and crosscohort analyses; (3) documenting social heterogeneity, vulnerability and inequality; (4) capturing individuals' and families' adaptive strategies and cycles of control during the caregiving process; (5) investigating policy innovations and natural experiments; (6) assessing third parties as mediating institutions between regulatory environments and caregiving families; and (7) attending to the subjective meanings of care.

Keywords

care work; context; process; policy

Introduction

'Care work' can be defined as rendering assistance to the frail and dependent members of families, communities and societies, but there is also a socio-emotional component, reflecting relationships and activities. Care work thus consists of a range of both instrumental and emotional supports (Tronto, 2013). It also represents a body of institutionalised beliefs, routines, rules and regulations that constitute collective understandings of the way care is – and should be – enacted in particular societies and at particular historical and biographical times and places.

In this article, we distinguish two types of care work: *family care* and *formal care*. Much care work is informal, performed at home by untrained, unpaid family members, historically daughters, wives and mothers. Formal care work is often accomplished by trained, low-paid care providers (again, typically women) in institutional and home settings as part of public and private health-care policies and systems. These two sources of care work increasingly intersect in complex ways.

Our goal is to propose a policy-relevant research agenda that recognises and responds to the changing nature of the family care of older adults in the 21st century. Four trends are essential to an understanding of the contemporary crisis of care for older members of society in Europe and North America, but also in Japan, China and Asia more broadly. First, informal family care (as well as formal paid care for infirm relatives provided by the state and market, including non-profit and for-profit agencies) is increasing as ageing parents and partners live longer. Medical advances, changing lifestyles and new technologies mean that many now live with chronic and acute conditions that previously led to the earlier demise of older people in prior generations. The challenges of extended life expectancy are further compounded by the ageing of the large boomer cohort, the demographic group of adults born in the US during the post-Second World War 'baby boom' between 1946 and 1964, and earlier (or later) in other countries. Many such boomers are now caring for family members and will themselves require care (Moen, 2016).

A second trend is that most family caregivers in the West are managing jobs even as they find themselves caring for older family members or close friends. Yet, working conditions and career paths are organised as if workers are without any non-work obligations (Moen and Roehling, 2005; Pavalko et al, 2008). This is especially the case in the US, but some European countries have high rates of employed women, even as family care work is expected to supplement more formal forms of care across the diverse cultural and political contexts of different European countries (Sundström et al, 2008).

Third, we are witnessing the declining public provision of care for seniors, together with increased reliance on family caregivers (Van Groenou and Boer, forthcoming). One result is that the conventionally accepted dichotomy between informal and formal care fails to capture the complex, dynamic interplay and increasingly blurred obligations between the two (Johnson, 2008; Szinovacz and Davey, 2008). A fourth trend is the use of technologies that could better enable communications between family and formal caregivers, which are already transforming the nature of medical and 'hands-on' care.

These trends point to the importance of a purposive and policy-relevant research agenda promoting understanding of the multiple ways in which family care plays out over time, in transaction with public and market care, as well as in the context of a complex web of public and market mindsets, policies and practices. In addition, studies are needed of innovative arrangements to support and assist family caregivers, who often serve as 'role-budget' centres (Goode, 1960), organising and managing public or market-provided home health aides, physical therapy, prescriptions, companions, adult day care, social workers, transportation, housing arrangements, doctor's visits, and other medical appointments, as well as undertaking most of the hands-on physical and emotional care of ageing loved ones. We propose a programme of policy-relevant research examining institutional and life-course contexts and processes.

An institutional and life-course approach

Too little attention is given to the fact that both the contexts and processes of care work are enabled or constrained by the institutional logics and structures of work, families, public

health infrastructures and formal provisions of paid care. Caregiving individuals and families make strategic choices across the life course *in transaction* with three sets of policies and practices: (1) labour market rules and regulations constraining the options of workers who are also family caregivers; (2) public health-care rules and regulations; and (3) the rules, regulations and costs of market care assistance. In this article, we propose that a combined institutional and life-course theoretical approach constitutes an important prism through which to advance understanding of the range and impacts of patterned social arrangements aimed at the care of older people and the need for updated policies and practices. We briefly summarise both.

An institutional framing

Institutional theory ‘asks questions about how social choices are shaped, mediated, and channeled by the institutional environment’ (Wooten and Hoffman, 2008: 130). This is in sharp contrast to classic economic models emphasising choice as a (rational) function of perceived advantage or preferences (cf Becker, 1981; Gruber and Wise, 2004). Although institutional theory is rarely explicitly invoked, there is nevertheless a body of rules, claims, mindsets, risks and resources that open up, support or constrain family care options, thereby shaping family- and individual-level beliefs and behaviour (Moen, 2016). Some forms of family care are more institutionalised than others in terms of public and market supports for families providing informal care. For example, organisational arrangements around childcare, preschools, kindergartens and grade schools assist families raising children, with childcare being far more institutionalised than eldercare in North America and Europe; still, one could argue that in the US, both childcare and eldercare are woefully inadequate (Sundström et al, 2008; Szinovacz and Davey, 2008). The organisation of unpaid family care, public assistance and paid market care for infirm older adults, within as well as across nation states, and how it is changing reflect a set of shifting cultural beliefs and values, formal policies and practices, and customs or routines.

According to Scott (1995: 13), institutions are ‘cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior’. Three things make something an institution: language, customs and a body of rules and laws – all of which serve to ‘regularise’ behaviour (Biggart and Beamish, 2003).

For example, taken-for-granted *language* (about unpaid family and paid formal care) presumes a sharp divide between the two, a dichotomy perpetuating a ‘separate spheres’ mindset (Tronto, 2013), when, in fact, family caregivers are often the organisers, coordinators and payers of market care. The language around care in the community or home care (as opposed to hospital or residential care) and ageing in place depicts family care as both available and optimal, even though the necessary supports are not always offered or obtainable in different jurisdictions.

In terms of both *customs* and a body of *rules and laws*, systems of social welfare and family and health-care policies and practices constitute supports or impediments for family caregivers. These diverse policy regimes continue to define and shape unpaid and paid care with different logics (and not always internally consistent ones). Moreover, it should be noted that workplace supports for employed spousal and adult child caregivers, formal home

care, health-care systems, financing, and the changing demography of those needing and providing care cannot usefully be studied separately since they are closely connected and interdependent, both constraining and facilitating individuals' and families' options as they confront 21st-century risks and realities around family care. Consider, for instance, the assumptions particularly evident in the US that: (1) women 'should' accomplish the care work of society – unpaid, paid and sometimes both (Ward-Griffin et al, 2015; DePasquale et al, 2016); (2) family care work is not really 'work' (Moen, 2016); and (3) family members are willing and able to do much of the care previously relegated to trained professionals (National Alliance for Caregiving and the AARP, 2015).

Institutions may seem static and intractable, but they can and do change over time in intended and unintended ways as a result of both individual (family caregivers being increasingly in the labour force) and large-scale social forces, such as a tumultuous global economy, an ageing population, fewer adult children and technological shifts challenging taken-for-granted institutionalised conventions and practices around family, public and market care. The dynamic quality of institutions becomes evident when considering that language, customs, rules and laws pertaining to both unpaid and paid care provision are currently in a state of flux given unsustainable health-care costs. Such instability points to the importance of more comparative scholarship on policy contexts and change, including Western countries' deinstitutionalisation of nursing homes in favour of home care, often with low-paid health-care providers assisting unpaid family caregivers to maintain ailing adults in their communities, but at considerable cost to their own health and well-being.

A life-course framing

The life course is about age and time (Elder and George, 2016). Its focus is on both contexts and dynamics in the form of transitions, trajectories, biographies, strategies and history. A life-course approach underscores, for example, how demographic and economic factors like increased longevity, women's labour force participation and mounting care costs are transforming the experience of contemporary cohorts of adults providing unpaid eldercare, including its incidence, timing, nature and duration. The life course itself is about pathways over time, but it also reflects different regimes of social welfare, health care and labour market policies that have 'institutionalised' age-graded – and gender-graded – life pathways, structuring the expectations and choices, transitions and trajectories, risks and resources of those providing and receiving care (Kohli, 2007; Herd, 2016).

Unlike occupational careers, however, the 'caregiving career' is often an unexpected endeavour resulting from interdependence in family members' life paths (Chesley and Moen, 2006). Adult children, for example, may respond to a parent's health crisis by quitting their jobs and transitioning to an unpaid caregiving role (Pearlin and Aneshensel, 1994; Aneshensel et al, 1995; Moen et al, 1995) or else purchasing paid care (Johnson, 2008).

What is typically an unexpected caregiving career is further complicated by changes in adults' work and family lives (Bookman and Kimbrel, 2011; Eifert et al, 2016), often being combined with multiple family (eg marital) and non-family (eg employment) obligations. These situational exigencies contribute to the shape of caregivers' life-course and health

trajectories (Pavalko and Woodbury, 2000; Lee and Gramotnev, 2007; Marks et al, 2008; Pavalko et al, 2008; Barnett, 2015; Carmichael and Ercolani, 2016).

Combining the two

Recall that ‘institution’ refers to taken-for-granted beliefs about ‘appropriate’ behaviour – official rules and everyday conventions representing collectively developed patterns of care, including transitions and trajectories of care over the life course. While the life course is often viewed as a developmental trajectory, theorists point out that it is also a social institution shaped by social norms and structures, including those embedded in systems of unpaid and paid care. This is evident in the gendered life course (Moen and Spencer, 2006), assuming women ‘should’ provide most of both the unpaid family and paid public and market care for older persons (Rutman, 1996). Another institutional and life-course assumption is the view of such unpaid family care as optimal for care receivers and society. Care is institutionalised across the life course, with different expectations, durations and definitions of care at different ages and life stages, and across different cohorts (Pearlin and Aneshensel, 1994; Aneshensel et al, 1995; De Oliveira et al, 2015; Eifert et al, 2016).

What can be gained from combining institutional and life-course theoretical perspectives in developing research that can inform policy and practice, including re-imagining both the architecture of care provision and supports for caregivers? We argue that understanding the nature, sustainability and consequences of various patterns and contexts of family care work could be considerably advanced through conceptual, theoretical and methodological reformulations that incorporate an integrated institutional, life-course framing. This framing can move discussion beyond the depiction of family care work as constituting *private troubles* (Mills, 1959) to a focus on its stresses, burdens, costs and rewards as *public issues*, reflecting state and market bureaucracies, cultures, policies, and practices. It would also move the emphasis away from snapshot comparisons of non-caregivers and caregivers to fruitful, policy-relevant research programmes emphasising contextual embeddedness, demographic and other social forces, and the dynamic life-course processes of entering, enacting and exiting family care roles, including negotiations and transactions with paid care systems.

Implications for policy-relevant research

To formulate such an agenda, we identify seven ways of organising scholarly enquiry with possible pay-offs for the development of new knowledge about family care and policy innovations enabling, supporting and substituting for families’ unpaid work. In doing so, we describe several exemplary studies, discussing how they might be extended to effectively capture unpaid care work *in transaction* with existing policies and practices, as well as the role that third parties can play as mediating structures linking family caregivers with formal care arrangements as both respond to the escalating crisis of care.

Moving beyond snapshots of individuals

Over the past decade, several researchers (eg Gaugler and Teaster, 2006; Szinovacz and Davey, 2008; Montgomery and Kosloski, 2009; Gitlin and Wolff, 2011; Zarit and Reamy,

2012; Carmichael and Ercolani, 2016; Levine, 2016) have critiqued theoretical and empirical literature on family care for its typical focus on proximal *individual* predictors of outcomes, not larger (institutionalised and changing) contexts, processes and mechanisms. The state of the field is such that the preponderance of research on family care examines snapshots of *individual-level predictors of individual outcomes*, not the organisational and bureaucratic institutional *contexts* and dynamic *life-course processes* shaping both. Needed is scholarship capturing: caregiving trajectories and tradeoffs over the life course; variability in caregiving careers and care contexts; the impact of care work on caregivers, care recipients and families; and the compatibility of caregiving careers with occupational careers and health pathways (Montgomery and Kosloski, 2009; Gitlin and Wolff, 2011; Zarit and Reamy, 2012; Carmichael and Ercolani, 2016).

Speaking broadly about social research, sociologist Robert J. Sampson (2010) notes that survey research tends to emphasise individuals as the unit of analysis. He proposes: ‘The basic idea is take the measurement of ecological properties and social processes as seriously as we have always taken individual-level differences’ (Sampson, 2010: 72). There are a few exemplary studies that look at the broader social welfare context (Eichler and Pfau-Effinger, 2009; Jang et al, 2012; Sole-Auro and Crimmins, 2014; Tokunaga et al, 2015) in addition to exemplars viewing care work as a life-course process (Pavalko and Woodbury, 2000; Marks et al, 2008; Barnett, 2015; De Oliveira et al, 2015; Carmichael and Ercolani, 2016; Glauber, forthcoming). However, emphasis on dynamic processes *and* dynamic institutional contexts could capture what is working and what is not.

More comparative analysis

A research programme based on comparative cross-cultural, cross-cohort and cross-national analysis that includes a wide range of variables (eg comparing social values pertaining to caregiving, such as individualism and collectivism, as well as gender expectations and actual social welfare and health policies) is crucial for revealing the *socially constructed nature* (within a country and cohort) of unpaid and paid care work, as evidenced in the rules, regulations and mindsets about the care of older people. Addressing questions about the way in which family care is differentially institutionalised at various life-course stages and across various transitions, as well as the changing demography of those providing and needing care, requires comparative, historical and cohort research designs.

Comparative cross-national analysis, moving beyond the contexts of North America and Europe (especially China and Japan), is critical for understanding how state infrastructures differ and the implications of these differences for the trajectories of and transactions linking unpaid and paid care. What are the implications of different institutionalised arrangements for family caregivers and the quality of care? Studies documenting disparities in financial, instrumental, social and emotional supports within and across subgroups and nation-states, as well as the well-being implications of alternative trajectories and policies, are needed. They would provide policymakers and the care community with a deeper understanding of the possibilities and pay-offs of different ways for organising societies’ care work – in particular, the mix between family, public and market care provision.

Institutionalised beliefs, expectations, practices and structures shaping care regimes are both deliberately *and* inadvertently changed in transaction with other social forces, including the ageing of the population, new technologies and rising health-care costs. For example, the large boomer cohort is swelling the ranks of older working caregivers and retirees, who are also themselves beginning to need care. Eifert et al (2016) identifies six emerging trends in family caregiving based on the generational impact of the boomer cohort, including: (1) increased use of digital technology for information gathering and support; (2) more diversity among caregivers and care recipients; (3) strained finances and loss of government entitlements; (4) greater complexity of care provision and management; (5) insistence on the development of public policies that address caregivers' and care recipients' needs; and (6) prolonged periods of time spent balancing work, family, chronic disease management and caregiving responsibilities.

Future directions should include comparative and multilevel studies across cohorts, historical periods, Western and non-Western contexts, organisations, and policy regimes to highlight the ways differences and/or shifts in social policies and conventions affect patterns and processes of population and individual ageing, as well as the mix of informal and formal care, along with the mechanisms involved (eg Johnson, 2008; Sundström et al, 2008; Wisensale, 2008).

Documenting social heterogeneity, vulnerability and inequality

There is a range of diverse paths by which older adults experience health conditions and corresponding care needs. Some social structures – such as gender, race, education, income – are markers of location in (institutionalised) status hierarchies affecting the odds of both impairment and providing care. For example, age and gender are not simply characteristics of individuals shaping their preferences; rather, they are themselves social institutions, key axes organising social life 'channelling' social choices. Thus, women and men of different ages and life stages are both *allocated* to and *socialised* to expect and even choose distinctive roles, resources and relationships (Dannefer, 2011; Moen, 2013). While concerns about gender and other forms of stratification are deeply embedded (institutionalised) in care work research, less is known about how social environments tied to these attributes produce and reproduce enduring inequalities (Tilly, 1998). Scholarly analysis of disparities associated with care resources and experiences of those in different social locations is essential; such analysis will spotlight the role of existing and emerging social arrangements in the production and reproduction of inequalities in both health and care provision. However, while race, gender and even education are enduring factors, other aspects of social structure, such as housing, work and social networks, *do* change with age as individuals select or are allocated to different social-ecological niches (see also Brooks-Gunn et al, 1993) over the life course (Pruchno and Rosenbaum, 2003; Clark, 2013; Wrzus et al, 2013; Banerjee and Blau, 2016; Coulter et al, 2016). Moreover, the deleterious effects of social-locational markers can be lessened or exacerbated by events, such as the Great Recession of 2007–09 (Truffer et al, 2010; Grown and Tas, 2011), or with age. For instance, institutionalised age-graded policies and practices like Social Security and Medicare offer an income and health-care safety net for older Americans, which legitimised retirement as a normal life transition in the last century (Atchley, 1982; Costa, 1998). However, both are now being scaled back

(Moen, 2016). Social forces, as well as deliberate policy *changes*, shift social structures, challenging taken-for-granted institutionalised expectations and practices that disadvantage some segments of the population while advantaging others (Blossfeld et al, 2006; Hudson, 2009; Warner et al, 2010; Williamson, 2011).

For example, those without a college education are more apt to experience poor health, but college-educated people live longer, and thus are more exposed to the need for long-term care. Note, as well, disparities in the relationships between family caregivers and market care provision, including the costs to families of paid home care. This shift to home care, while laudable in reducing the costs of institutionalised care and promoting life quality, can be unattainable for some while supporting well-off caregivers in the way nannies have eased the care of young children. Using data from the Health and Retirement Study, for example, Johnson (2008) showed that high-wage adult children are more likely to purchase than provide care for ailing parents. The rising costs and variability of different types of public and market care especially burden less advantaged caregivers, who must seek and manage an array of paid supports while continuing to provide the bulk of home care themselves. Research is needed on the care provision implications of the new 'risk' economy, such as lessening the advantages of middle-class adults with infirm partners or parents, given that both public and private benefits, job security, and health-care protections are eroding (Schmid, 2008; De Vroom and Bannink, 2008; Young and DeVoe, 2012).

Importantly, age, social class, race/ethnicity and gender persist as fundamental organising principles shaping family and public care provision. However, things are changing, such as the fact that 40% of informal care in the US is now provided by men (National Alliance for Caregiving and the AARP, 2015). Research on unpaid family care, paid care and their intersection that overlooks policy and historical contexts or the cohorts being investigated cannot capture the ways in which institutionalised opportunities and constraints – stratified by race/ethnicity, class, gender and other locational markers and by history – affect the outcomes being examined. We need more investigations similar to those from Apesoa-Varano et al (2015), Brotman and Ferrer (2014), Jang et al (2012), Glauber (forthcoming) and Eifert et al (2016) that underscore the importance of accounting for how ethnic and racial cultures, membership in marginalised communities, demographic and institutional characteristics, and cohort membership may differentially affect care work participation and experiences.

Treating gender, socio-economic status, race/ethnicity, sexual identity, nativity and disability status as individual attributes potentially ignores the ways in which they *systematically structure* the experiences of individuals and families. Examples of this systematic structuring include defining care as a family (and specifically women's) obligation and differential wage rates and advancement opportunities culminating in disparities in life chances and quality around care provision. A research agenda on the multiple layers of inequality as *embedded in institutions* suggests intervention possibilities and policy solutions, rather than continuing to simply document disparities.

The Matthew Effect – the idea that the rich get richer and the poor get poorer – is the basis behind the concept of cumulative advantage/disadvantage, in which there are systematic,

long-term inequities between members of different groups or populations. However, there are also disparities in care provisions and protections that emerge in tandem with growing older. Future study is needed on the ways in which the risk exposure to, and resource vulnerability of, care recipients, as well as the variability and disparities in family and public care provision, are socially distributed by social markers (eg education). Additional research regarding how institutionalised policies and practices can *reduce* and *exacerbate* the care burden and stress of different subgroups would also be informative.

Capturing adaptive strategies and cycles of control

A rich research agenda lies in understanding agency in the ways in which individuals and families strategise to negotiate complicated and often scaled-back institutionalised norms and arrangements around unpaid and paid care. Studies are needed of the impacts of certain informal and formal care regimes on the experiences, risks and resources of care receivers and caregivers in different cohorts, societies and subgroups of the population.

One important future contribution of the social sciences is clarifying the relationships between structured experience, agency and self-concepts (eg Gecas, 2003) over the family care provision process. There is insufficient scholarship on how taking on, living through or exiting care obligations for older family members shape self-concepts, meanings and feelings of mastery or control.

In *Families under stress*, Reuben Hill (1971 [1949]) examined how families adapt to stressful circumstances, along with the implications of various adaptive strategies. Hill's theorisation of family stress adaptations presaged the contemporary life-course *cycles of control* model (Elder, 1974, 1985; Moen and Chesley, 2008). Specifically, individuals and families seek a sense of control and to regain equilibrium ('fit') when needs, pressures or goals outstrip the available resources with which to manage them.

The concept of family adaptive strategies (Elder, 1974; Hareven, 1982; Moen and Wethington, 1992; Conger and Elder, 1994; Hill et al, 2003, 2004) has encouraged life-course and family scholars to consider individuals and families as active decisionmakers, the architects of their own biographies, even as they are enabled or constrained by existing (and often lagging) institutional arrangements. In the face of an older family member's unexpected health condition, workers and their families adapt by fashioning a mix of unpaid and paid family care, making strategic selections from the pool of options available to them. The dominant family care adaptive strategy in the middle of the 20th century for white-collar and unionised blue-collar workers was the *homemaker model*. Middle-class women's lives were governed by the social organisation of time based on the feminine mystique (Friedan, 1963); women's fulfilment came from a lifetime of full-time care of their husbands, children, ailing parents and suburban homes. Betty Friedan (1963) called the *feminine* mystique into question, and middle-class women began instead to view the *career* mystique (offering guideposts to men's lives) as the path to both self-development and equality. In the 1970s, feminists in Europe and North America sought gender equality at school and on the job as women moved into universities and employment in unprecedented numbers. Missing has been any resolution of the care dilemma – both for children and for older adults requiring care.

Investigating policy innovations and natural experiments

Addressing questions about the impacts of the policies, practices and mindsets institutionalising family care in different socio-political environments requires comparative, ecological and intervention research designs examining multi-level collective properties and social processes. Quoting his own mentor, Charles Dearborn, Urie Bronfenbrenner (2005) often said that if you truly want to understand something, try to change it. Kuh and Ben-Schloma (2004: 454–56) and Berkman et al (2011) point to the importance of intervention studies and natural experiments, which can provide the best evidence in terms of causality, the direction of effects and the importance of factors not commonly considered in public health research. Natural and randomised field experiments of changing policies and practices are promising research methodologies permitting scholars to assess the micro-level impacts of meso-level contexts or specific macro-level forces. Scholars need to take advantage of existing opportunities for natural experiments of changing conditions, in addition to studying the impacts of policy and programmatic innovation. Do different policies and practices reduce or magnify inequalities in the resources, support, experience and quality of life of family caregivers and those receiving their care?

Hans Bertram (2012) suggests that the criteria for successful policy development should be the well-being of both caregivers and recipients. This necessitates the development of appropriate measures of well-being and the conditions promoting them. It also requires investigations of the rules and regulations constraining effective care and innovative policies and practices that remove barriers to and facilitate sustainable, high-quality care (family and paid), not just for children, but also for infirm partners, ageing parents and others needing it. For example, the multiple levels of bureaucratic rules and regulations around the provision of care for the infirm in the US are unnecessarily complex and obscure.

Bertram (2012) also emphasises the pragmatic importance of family economic resources, the absence of which limits the ability to sustain care. As he points out, time, money and infrastructure are arenas for policy innovation. This includes the inflexible clocks and calendars embedded in the ways employers, health-care provisions (such as, in the US, Medicare eligibility at age 65) and social norms organise jobs, unpaid and paid care, and the gendered life course (Moen and Roehling, 2005; Moen, 2016). Such arenas prompt important questions, like: ‘What organisations and agencies are introducing transformative innovations in the linking of unpaid family care with paid care?’; and ‘What innovative policies regarding work time, health care and family supports might enable working caregivers to accomplish both their jobs and care responsibilities?’

Assessing third parties as mediating institutions

Some (Durkheim, 1951 [1897]; Berger and Luckmann, 1966) see institutions like the family, religion and community organisations as essential *intermediary mechanisms*. They serve as mediating institutions that buffer individuals from the larger bureaucratic forces of markets and governments, including, we add, institutionalised unpaid and paid care regimes. Thus, a vital topic for future research in the coming decades is: under what conditions do families, social networks and community organisations *buffer* family caregivers from the stresses of

dealing with state and market bureaucracies around eligibility for and the costs of family care?

Kahn and Antonucci (1980) first introduced the concept of *social convoys*: that lives are always lived in tandem with others, as networks of kin and friends move together through time. Although Kahn and Antonucci viewed these life-course convoys of relationships as supportive, we theorise them as potentially providing support but also inducing strain through family care obligations, especially of wives caring for their husbands (Stoller and Miklowski, 2008; Glauber, forthcoming). We theorise social convoys as another form of time norms and activity, representing beliefs and expectations about appropriate time to be 'spent' in relationships such as in caring for infirm spouses or ageing parents. Moreover, individual lives are always *linked lives* (Elder, 1985); one person's successes, failures and transitions, including health-care needs, can become focal points, even turning points, in other family members' lives (Chesley and Moen, 2006).

However, fundamental changes in the institutions of marriage and the family (cf Cherlin, 2009) and in family demography, in the form of fewer children, delayed parenthood, increasing divorce and remarriage rates, growing legitimacy for same-sex marriages, the high proportion of unwed pregnancies, and marriage or parenthood forgone, are challenging established norms about filial responsibility and reducing (or sometimes expanding) the networks of kin available and willing to care for ailing relatives.

These kin networks constitute care convoys, a collection of individuals who are personally connected to care recipients and manage or oversee their daily care, provide them with instrumental and emotional support, and advocate for high-quality medical care (Kemp et al, 2013). What has yet to be fully fleshed out is the potential or actual role of non-profit organisations as care convoys, serving as intermediaries between families and formal care systems. Care convoys reflect person- and family-specific, dynamic, evolutionary collaborations that are influenced by factors at the societal, community, industry, care setting, formal-informal network and individual levels (Kemp et al, 2013). Advancing understanding of how the structure, functions, norms, assumptions, negotiations, expectations and preferences of care convoys unfold over time, and their effect on care convoys' adequacy, caregivers' outcomes and care recipients' outcomes, represents a pivotal future research direction.

Attending to subjective meanings of care

Sometimes, there is loose coupling or decoupling (deliberate disconnects) between the ways in which family caregivers *and the organisations serving them* define goals and the means to achieve them (Boxenbaum and Jonsson, 2008). In 'Social structure and anomie', Merton (1938) theorised that widely accepted, socially legitimate goals and the institutionalised means available to attain them are often mismatched. For example, some population segments lack the means and are thus unable to achieve certain goals, or do so in less legitimate ways; others seek different goals, but without the institutionalised means of achieving them. However, in family caregiving, are goals typically clearly articulated, much less the means with which to achieve them? A fertile field of future enquiry consists of studies on: (1) differences in family caregivers' goals (if any) and access to the

institutionalised means of achieving them; and (2) how family caregivers' goals and means are related to exposure to and the duration of health risks, vulnerabilities and protective factors.

Subjective meanings and experiences are also tied to sample selection in the study of family care, a major theoretical and methodological issue. Who is 'selected' into or out of research samples is critical in estimating the implications of the findings, as is the perceived voluntariness of care work. Studies comparing caregivers who willingly take on that role, as compared to those feeling that they have no choice, may find them to be healthier or in possession of more resources (eg money). Not considering the degree of voluntariness and choice of those recruited to participate may increase the risk of selection bias.

Leopold, Raab and Engelhardt (2014) also note the importance of tracing the *process* of caregiver selection. When considered in a family context, family members who experience the transition to unpaid care work may differ from other family members on attributes (eg gender, competing demands in work and family spheres, employment in a health-care profession) that, in turn, affect caregiver outcomes (Leopold et al, 2014; Ward-Griffin et al, 2015; Zarit et al, forthcoming). Relatedly, Zarit et al (forthcoming) have cautioned against drawing inferences about the mechanisms and impact of caregiving without consideration of sample composition. For example, studies on heterogeneous groups of family caregivers who provide relatively minimal and intermittent care (eg caregivers recruited in large national studies of the general population) will likely have different implications than those based on family caregivers in more specific, highly demanding or stressful care situations (eg dementia care).

Conclusion

While much has been written about both unpaid and paid care, family care for older relatives is, as is family care for children, too often treated and studied as a private trouble, not a public issue, particularly in the US (Eifert et al, 2016; Levine, 2016). Mere recognition of family care work by employers, practitioners, health-care providers, government officials and policymakers, however, is not a panacea. Rather, it 'is just the first step' (Levine, 2016: 381). On the rare occasions when family caregivers are acknowledged, challenges still arise from, for example: inadequate or weak policy responses; fragmented and uncoordinated cross-sector initiatives; poor integration and inconsistent treatment of family caregivers as active partners in health and social care; oversight of, or inaccurate assumptions about, marginalised family caregivers' experiences (eg lesbian, gay, bisexual and transgender [LGBT] caregivers); and limited attention to removing barriers and optimising supports within caregiving contexts, such as in different ethnic and racial cultures (Bookman and Kimbrel, 2011; Zarit and Reamy, 2012; Brotman and Ferrer, 2014; Apesoa-Varano et al, 2015; Eifert et al, 2016; Levine, 2016). These and other challenges underscore the need for innovative, policy-relevant research that can begin to render an invisible, unpaid workforce visible.

We have suggested seven ways in which a combined institutional and life-course approach can advance understanding of family care work in the US and Europe as a life-course

process embedded in multilayered institutional *contexts*, with both individuals *and* institutions *changing over time*. Drawing on one or more of these suggested agenda topics could point to the intended and unintended consequences of existing and proposed policies and practices.

How can we engage in policy-relevant research demonstrating policies and practices that support and supplement family caregivers, thereby promoting the quality of life of both those providing and receiving care? Doing so would be an important step in responding to the realities of this growing societal need. We have presented an agenda for policy-relevant family care work research incorporating a combined institutional, life-course approach. Future research could profitably consider: (1) multilayered institutional contexts, including how public and corporate arrangements both support and constrain options; (2) life-course processes playing out in caregiving careers (eg family caregiving role transitions) shaped by both the situational exigencies of individuals and families, *and* institutional structures and cultures; and (3) assessments of inventive policy initiatives aimed at promoting both family caregivers' and care recipients' quality of life.

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