For Love or Money? Current Issues in the Economics of Care

Julie A. NELSON

Keywords：Care work, Economics, Gender, Motivation, Compensation

Introduction

What is “the economics of care”? One definition of care work points to those activities that involve extended personalized service to dependent individuals, including children, the sick, and the elderly. Childcare and nursing are prime examples. A somewhat broader definition also includes face-to-face services that help to develop a person’s capabilities, including physical and mental health and cognitive skills, in ways that may be more short-term or intermittent. Under this definition, health care, education, and social services are also considered to be forms of care (England, Budig, and Fol-

bre, 2002). There is a general sense that "care activities" are of highest quality when accompanied by, and motivated by, authentic emotional commitments, or "caring feelings."[1] While most obvious in the cases of childcare and nursing, this is true even when the broader definition of care work is used. A modern version of the Hippocratic Oath, for example, charges physicians to act with "warmth, sympathy, and understanding" (WGBH Educational Foundation, 2009). While many working in higher education may not consider themselves to be "carers" in the same sense as early childhood education professionals, they generally still resist the idea of replacing face-to-face, personalized, and motivational interaction with their students with, for example, videotaped lectures. Taking economics to be, broadly speaking, the study of how societies organize themselves to provide for life and its flourishing, we might label the "care economy" as comprised of caring activities, both paid and unpaid.

The first part of this essay explores developments in this "care economy" in the United States, briefly reviewing historical changes in this sector. There is, however, a marked difference between how we often think about care work, and how we often think about paid work in general. The former, it is often thought, is simply "natural" and motivated "by love," while the latter is often thought to require the development of more specific skills and to be primarily motivated "by money." This oversimplified, dualistic conception, it will be argued, contributes to no end of problems in both the care sector and the economy at large.

One pressing current issue, within the care sector, is what has been called the "care penalty"—the tendency for occupations that involve face-to-face healing and nurturing services to pay less than other occupations, controlling for factors such as educational requirements (England, Budig, and Folbre, 2002). The existence of this penalty tends both to disadvantage the people who go into these fields, and to create problems in the quality and size of the care labor force. The next two sections of this paper, then, argue that work *articulating* the skills that care work requires and properly analyzing *motivations* for such work, as they relate to levels of compensation, is critically important. Such an analysis should permit us to begin to make a more nuanced evaluation of the advantages and disadvantages of various ways of organizing care work. Lastly, it will be pointed out that these analytical developments in the economics of care can also give us insight into other important economic issues that are not usually thought of as involving care work.

The Shift from Family to Market

The patterns of need for care are in the middle of a great transition, as analysis of birth rates and life expectancies reveal. As illustrated in Figure 1a, in the 1950s in the United States there was a high number of children relative to prime-age adults. Currently, the U.S. population pyramid shows a relative bulge in prime-age adults relative to children and the elderly. But this is not expected to last, as the baby boomers move into old age. An even more extreme inversion of the traditional age pyramid is predicted for Japan, as shown in Figure 1b. These demographic changes indicate an increasing importance of elder care.

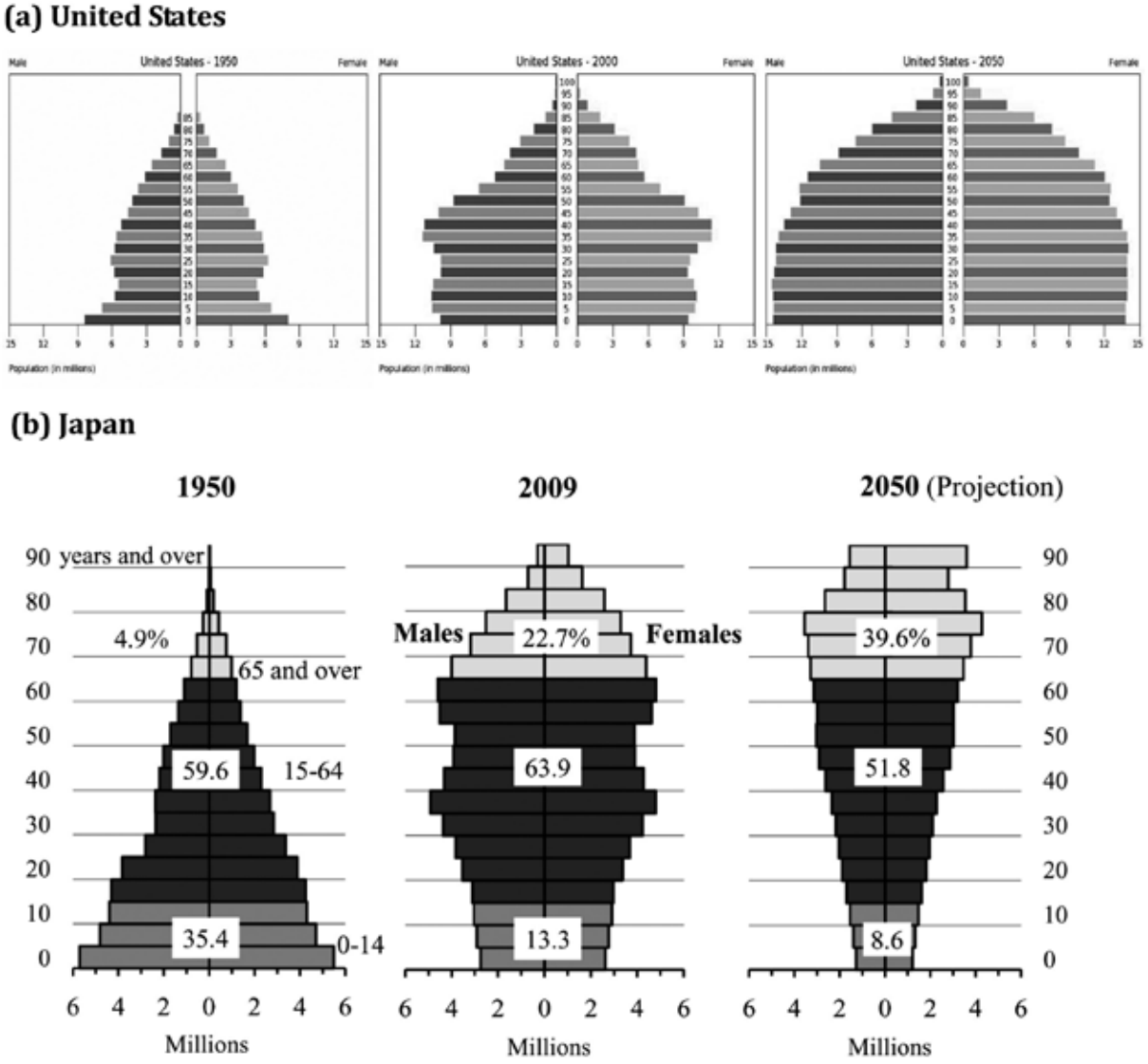

Figure 1. The Changing Dependency Picture

Sources: For the United States, Shrestha and Heisler, 2009. For Japan, Statistics Bureau, Director-General for Policy Planning (Statistical Standards) and Statistical Research and Training Institute, 2010.

The locations in which care is being provided are changing as well.[2] Women historically specialized in full-time home-making, when their families could afford it, so that households were long the primary locations of care for young children and the elderly, and basic nursing services for the ill. Wagman and Folbre (1996) constructed estimates of the total labor force of the United States, including both paid and unpaid workers. They assumed that women devoted about as much productive effort to paid and unpaid work combined as men did to paid work; that 85 percent of all women 16 and over were engaged in productive (paid or unpaid) work; and that those who did not have paying jobs were full-time homemakers. The historical pattern of shifts in the use of women's time that they

found is presented in Table1. In 1870, about 40 percent of the entire productive labor force (paid and unpaid, male and female) was made up of full-time homemakers (Wagman and Folbre, 1996, p. 50). Wagman and Folbre (1996) calculated that this percentage declined through 1930, while the relative importance of paid employment among women increased. Applying Wagman and Folbre's methodology to more recent statistics suggests that these declines continued up until 2000, with the biggest change coming between 1960 and 1990. After 2000, the decline seems to have stopped (or very slightly reversed). By the year 2008, homemaking had declined substantially, but still involved 20 percent of all workers, and 30 percent of all women workers.

Table 1. The Decline of Full-time Homemaking in the United States, 1870–2008

	Homemakers as % of all women workers	Women in paid jobs as % of all women workers	Homemakers as % of all workers
1870	70.2	29.8	40.1
1900	64.4	35.6	35.6
1930	59.7	40.3	34.1
1960	56.0	44.0	29.1
1990	32.7	67.3	22.0
2000	29.5	70.5	19.4[3]
2008	30.0	70.0	20.0

Sources: For discussion of data for 1870–1930, see Wagman and Folbre (1996). For discussion of data for 1960–2000, see Folbre and Nelson (2000). Data for 2008 is from *Statistical Abstract of the United States*, 2010, Table 576.

Moving on to analysis of *paid* care work, many women entering wage employment moved into industries that involve paid care for others. To illustrate this trend it is helpful to create a category of "professional care services" by combining the standard industrial classifications of "hospitals," "health

Table 2. The Rise of Professional Care Service Industries

(Employment by Industry as a Percentage of Total Employment)

	Professional Care Services	Domestic and Personal Services	Other Services	Agriculture, Fishing, and Forestry	Manufacturing, Mechanical, and Construction
1870	--	--	10.4	53.5	22.7
1900	4.0	9.3	16.7	37.6	30.1
1930	7.1	10.7	28.7	21.7	31.6
1960	11.9	6.6	40.7	9.4	31.4
1990	17.6	4.0	45.7	2.8	25.1
1998	19.2	3.4	52.1	2.7	22.7
2009	22.7	2.2	50.8	2.0	22.3

Sources: For discussion of data for 1870–1998, see Folbre and Nelson (2000). Data for 2009 is from the U.S. Bureau of Labor Statistics, *Employment and Earnings*, January 2010, Table 18.

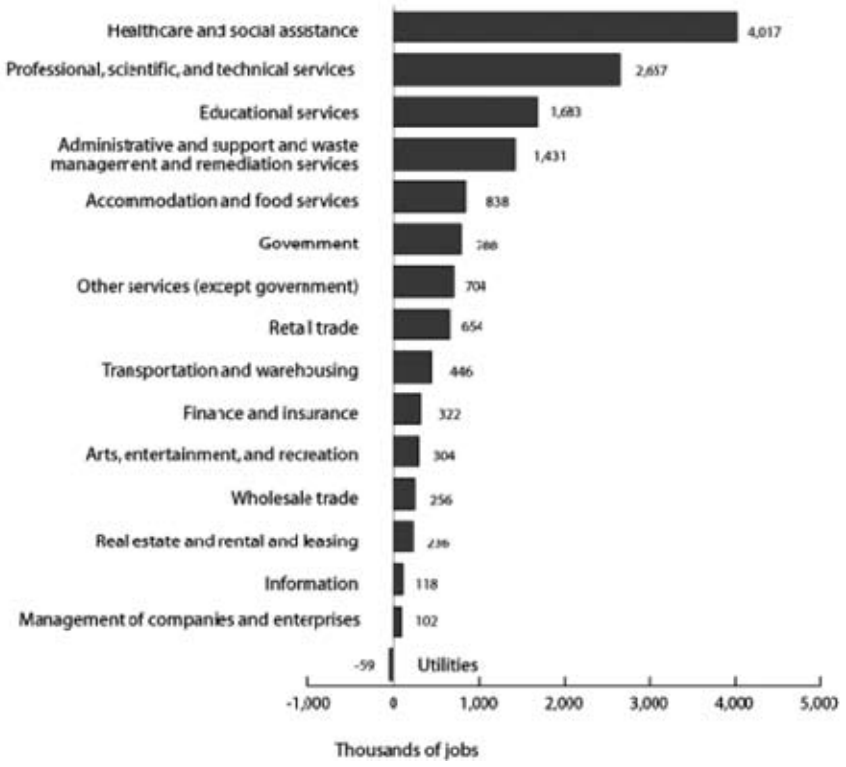

Figure 2. Numeric Change in Employment in Service Industries, 2008–2018 (projected)

Source: U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010–11 Edition*, Chart 5

services except hospitals," "educational services," and "social services." Table 2 puts U.S. employment in this industrial category in the context of the overall labor market. In 1900, about 4 percent of all workers were employed in professional care services. By 2009, over one-fifth of the paid labor force was engaged in a professional care industry. Meanwhile, employment in "domestic and personal services" declined from 9.3 percent of the labor force in 1900 to 2.2 percent by 2009.[4] Clearly, the economic role of jobs that reflect the more skilled and emotionally complex dimensions of the traditional homemakers' role increased dramatically over the twentieth century. Today, hospitals and schools should now count *more* in forming our image of wage employment than factories and construction sites.

Professional care industries still employ women disproportionately to women's share in the overall labor force. Of all women in paid employment, 36.1percent were employed in these industries in 2009; women constituted 47.3 percent of the paid labor force over age 16, but 77 percent of those employed in "hospitals," 78.9 percent in "other health services," 69.4 percent in "educational services," and 85 percent in "social services" (U.S. Bureau of Labor Statistics, 2010, Tables 12, 17, 18).

Professional care industries are also the growth industries of the future for the United States, as measured by employment projections. Primary and secondary sector employment is expected to continue to decline, while service industries are predicted to grow. Within service industries, "health care

and social assistance" is projected by the Bureau of Labor Statistics to have the most expansion in employment, while "educational services" is in third place among the growth industries, as shown in Figure 2.

Conventional Economic Analysis: Love OR Money

Is care work *work*? In conventional economic thought, this may be doubted. In core Neoclassical economic theory, which dominates much academic economics worldwide, work is thought of as creating "disutility"—that is, being unpleasant—and as usually requiring some amount of investment in "human capital" or skills. The main reason one works, then, is assumed to be personal financial gain. Looking after someone—perhaps a child, or an elderly person—on the other hand, is often though of as requiring no special skills and as intrinsically rewarding, especially if it is done at home.

The origin of this dualistic view of work *versus* care has many historical precedents, but one obvious source in Anglo-American contexts is the Victorian ideal of a family, with a male breadwinner and a female homemaker. When, with industrialization, a general pattern of home-based industry was replaced by the factory system in Anglo-American countries, an ideology grew up that strictly divided commerce from family life. A man was seen as a natural competitor in a dog-eat-dog world of self-interested activity in markets, while a white, middle-class woman was idealized as the "angel in the house"—the embodiment of softer and more caring values. The Neoclassical school of economics, established during the Victorian period, not surprisingly, took on these values. Leaders of this school endorsed, for example, the idea that women's wages should be kept low, to avoid tempting them to neglect their duty to build up a "true home" (Alfred Marshall, quoted in Pujol, 1984).

Taking "the economy" to be synonymous with markets, and aspiring to a masculine-biased image of "rigor" in scientific thought, early Neoclassical economists, in fact, systematically excluded from their consideration all parts of human activities, values, and motivations that contained a whiff of feminine "softness." Economics adopted definitions and assumptions built entirely around the masculine-associated aspects of life listed in the left-hand column of Table 3.

Table 3. Conventional Economic Analysis

Economics	*Not* Economics
market	home
mind	body
reason	emotion
autonomy	interdependence
self-interest	care and compassion
knowledge	virtue
masculine	*feminine*

In focusing economics on mental choices rather than bodily needs, for example, economists adopted the Cartesian dualism that regards "mind" as separate from and superior to "body." Feminist economists argue that such an approach, far from being a sign of "rigor" and objectivity, is indicative of a pronounced gender bias at both cognitive and social levels (Ferber and Nelson, 1993; Nelson 1996).

The Challenge to Conventional Analysis: Love AND Money

Are economies really characterized only by the elements in the left-hand column? Are self-interest and other-interest really so opposed? These questions are crucially important in analyzing the economics of care, since the rise in paid caring forces us to think in terms that bridge this divide. Some people fear that the entry of caring work into markets will leave it fundamentally demeaned and corrupted, bereft of true compassion. This can occur at various points on the political spectrum: many conservatives wish women to stay at home, while some left-leaning academics fear the commodification that they believe to be an intrinsic consequence of capitalism. Such views, however, simply buy into dualistic thinking, rather than challenging it.[5]

Elsewhere I have proposed what I call a "gender-value compass" as a way to begin to think past dualisms such as those in Table 3 (Nelson, 1996). Let us start with a simple example, that of economists' aspiration to be "hard" scientists, eschewing acknowledgement of "soft" behaviors or forms of analysis. The aspiration to hardness comes from its association with strength, while softness is associated with weakness. Such a pattern of thought is not only dualistic, it is also hierarchical: the hard or masculine-associated pole is thought of as superior to the soft or feminine-associated pole, as shown in Figure 3.

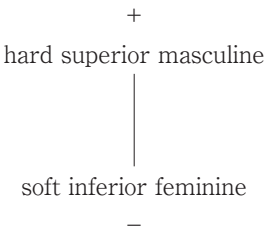

Figure 3. Stereotyped Gender and Valence

The gender-value compass breaks the associations of gender from the associations of value, as illustrated in Figure 4. "Hard" can also mean rigid, while "soft" can also mean "flexible." Instead of an *opposition* between hard and soft, this compass allows us to recognize aspects of *complementarity*. Something that is both strong and flexible is, in fact, particularly resilient. On the other hand, aiming for hardness without flexibility can be rigid, and ultimately brittle and weak.

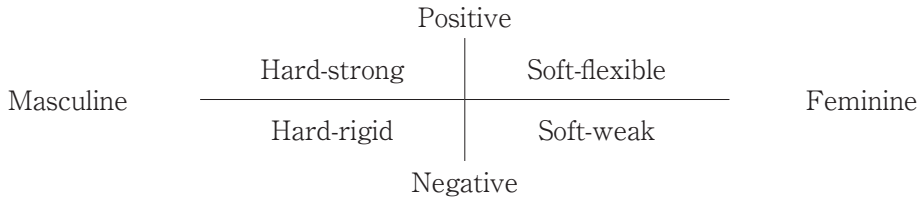

Figure 4. A Gender-Value Compass

Now consider this compass applied to a topic of more relevance for the case at hand: the supposed opposition between self-interest and other-interest. In actual life, neither the extreme of being entirely self-interested—that is, selfish—nor the extreme of being a self-effacing, co-dependent, physically exhausted doormat, bodes well for either personal health or good social relations. A healthy caregiver, for example, practices care and compassion from a base of self-respect and an adequate practice of self-care. This is illustrated in Figure 5.

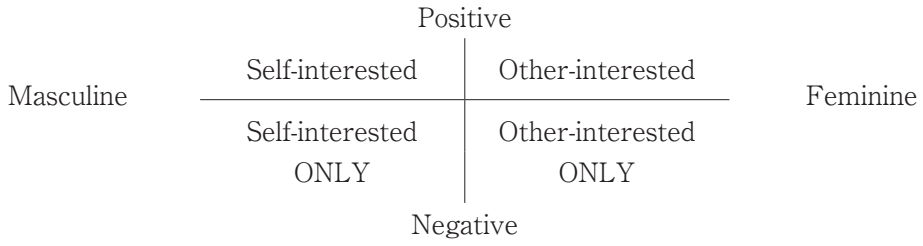

Figure 5. The Complementarity of Self- and Other-Interest

The purpose of the gender/value compass is not to impose a new form of rigidity on our thought, but simply to help us break through old and outdated dualistic understandings. In particular, it can help us find hidden strengths that have been long hidden due to their association with supposed weakness (and femininity). What has been hidden in care work that needs to be brought out in order to facilitate our understanding of the increasing inadequacy of the old love *versus* money definitions of economics? I suggest two major aspects that deserve our attention: the hidden *skills* of care work, and the complexity of human *motivation*.

Articulating Care

Standard economic arguments about "human capital" are often used to attempt to explain why care work is relatively low paying. Economic theory says that jobs with low human capital requirements—that is, low requirements for education and skills—will tend to pay less, all else equal. But, applied to care work, this argument is fallacious: care work requires special and specific skills, though ones which have been cloaked by invisibility by being associated with women and "naturally" arising behavior.

Consider, for example, the case of Registered Nurses, who are nurses with, typically, at least two to three years of university education.[6] Traditionally, in many countries, nursing has been identified with a "virtue script" (Gordon and Nelson, 2006) which emphasizes nurses' compassionate interest in the well-being of their patients. As nursing has become more scientifically and technologically complex, at least partial recognition of formally acquired knowledge and expertise of RNs has been granted. Some of the most important nursing skills, however, have remained largely invisible, while others are under-respected and under-rewarded.

Recall that according to Table 3 and Figure 3, in conventional analysis (masculine) mind has been elevated above (feminine) body, and (masculine) knowledge above (feminine) virtue. Consider Table 4, which lays out four mutually complementary and essential broad skill categories for nursing care in a grid defined by these mind/body and knowledge/virtue dualisms. The theory presented in the previous section predicts that aspects of care that fall on the more respected "mind" and "knowledge" sides of this dualism will be more socially recognized and financially rewarded in cultures dominated by Cartesian thinking, than those on the denigrated sides. And this is what we found.

Table 4. Articulating Some Broad Skill Categories for Nursing Care

	Mind	Body
Knowledge	Nurses use medical, scientific, and technical knowledge acquired through specialized education in diagnosing,[7] treating, and educating patients.	Through direct, repeated, and often tactile interactions with patients, nurses gain important "local" and individualized knowledge about their patients' physical, mental, and emotional states.
Virtue	Nurses help patients and their families by providing personalized counseling and encouragement, often demonstrating compassion and providing emotional comfort.	Nurses assist vulnerable patients with bodily processes. Although these activities often expose nurses to risks and bodily stress as well as unpleasant sights, sounds, and smells, nurses accomplish these in ways that maintain their patients' dignity.

Source: Adams and Nelson, 2009.

As described in Table 4, the mind-knowledge aspects are those that emphasize mental knowing, of the sorts that nurses primarily achieve through formal education. Recognition that nursing requires such skills is rather mixed: while the more-informed commentaries on contemporary nursing take this into account, there is evidence that the image of nurses as mere pleasant "pillow-fluffers" still exists, to some extent, in the public mind. The emphasis on mind-knowledge, we can note, also appears in distinctions made among physicians' medical specialties. Specialties such as surgery or cardiac care, which emphasize extended training and are particularly amenable to technological innovation, are often perceived as more skilled than specialties such as primary care, family practice, internal medicine, pediatrics, or gerontology, where face-to-face relationships form a greater part of the work. They are

also more financially remunerative. Table 5 notes that mind-knowledge aspects are *sometimes* recognized as necessary to nursing, and, following the human capital model, are generally, when recognized, financially rewarded.

Table 5. Social Recognition and Financial Rewards in Nursing

	Mind	Body
Knowledge	Recognition: mixed Reward: yes	Recognition: no Reward: no
Virtue	Recognition: yes Reward: no	Recognition: mixed Reward: minimal

Source: Adams and Nelson, 2009.

In Table 4, virtue-mind aspects are described as those that emphasize compassion, but without the inclusion of any physical aspects of care. This somewhat sanitized and ethereal aspect of nursing (when considered on its own) is socially recognized via the "virtue script." However, as has been noted by feminist scholars investigating the phenomenon of "emotional labor" (e.g. Steinberg, 1999), the value of such capacities is largely overlooked when it comes to determining the appropriate monetary compensation for the work.

The top right-hand cell in Table 4 lays out the heart of what may be the most drastically underarticulated aspect of not only nursing care but other sorts of extended care work as well: body-knowledge. Good nurses, along with good parents, childcare workers, teachers of young children, social workers, primary care physicians, and others involved in care require *repeated occasions of bodily co-presence to build up a knowledge base*. They need to "get to know" the physical, mental, and emotional states of their charges or clients, and need to see how these change over time. As one nurse has put it, "You evaluate patients by working with them. What happens when you ask them to put their arm out? Did they seem to understand you? Are they paying attention? Are they restless?" (quoted in Weinberg, 2006: 37). This is not something that can be done quickly, impersonally, and at a distance but rather requires sustained engagement, a relationship of trust, and often physical contact. Similarly, in childcare work, research in early care and education has found that attention, responsiveness, and physical warmth provided by trusted caregivers are not merely sentimental niceties. These physical and relational factors are, instead, absolutely vital, at a neurological level, to the social, emotional, and cognitive development of growing children.

Unfortunately, when people try articulating this aspect of care against a background of strongly Cartesian thought focused on autonomy, these sorts of relational skills are missed. To an unattuned observer, hours of uneventful "checking on" an elderly person or "baby-sitting" a child may not seem like activity at all. The astute and life-preserving work of the acutely observant people in human services often, in fact, seems to be considered little different from attending to inanimate objects. Workers in the United States who care for children and parking-lot attendants—who watch parked cars—

currently both make median wages of about $9.25 per hour (U.S. BLS 2009). Body-knowledge skills, as noted in Table 5, are neither recognized nor rewarded.

The last cell in Table 4 is body-virtue. With physical work strongly stigmatized relative to mental work, hands-on care for challenged, heavy-to-move, and perhaps smelly or otherwise unattractive bodies gets very little respect. It may be considered a "virtue" aspect in a sort of Mother Theresa, self-sacrificing way. Even within the nursing profession, nursing recruiting literature tends to downplay the physical demands. In the United States, this work is often shifted, when possible, from more educated, predominately white native-born RNs onto low-paid and minimally trained (although often quite competent and caring) nursing aides, who disproportionately come from immigrant and minority racial groups. Such an organization of work, however, while reducing labor costs, also reinforces a mind/body hierarchical dualism, reinforces racial and immigrant status divisions, and reduces—perhaps to zero—the sorts of occasions that would allow the more highly educated medical personnel to build relationships and gain the important body-knowledge they need to do their jobs.

As the populations of industrialized countries age, the recognition of the full scope of caring work becomes even more urgent. Gerontology (medical care of the elderly) tends to be a relatively disrespected field, directed as it is to deteriorating bodies and to the social and emotional adaptations aging requires. There are no heroics here, no cures, and not a great deal of scope for the sorts of mind-knowledge biotech breakthroughs that bring prestige. Unless we want our increasing numbers of elderly citizens to get the same treatment as parked cars, it is time to more strongly articulate what it is that real care requires.

Compensation and the Issue of "Intrinsic Rewards"

Another reason, besides a presumed lack of skill requirements, that is often used to justify relatively low wages for care work is the idea that the work is intrinsically motivated. This is the idea that people *want* to do it because they find it pleasant, are moved to do it by emotions of love and attachment, or feel that it is socially valuable. This argument plays out two ways, the first of which has to do with the economic theory of "compensating wage differentials" and the second with what I will call the "protection" argument.[8]

Compensating Wage Differentials

The economic theory of compensating wage differentials says that jobs with better working conditions should, all else (such as education requirements) equal, tend to pay less. Childcare workers, for example, are sometimes said to "take part of their pay" in hugs, while health care workers benefit from the "warm feeling" that they get from helping someone in need. Assuming they have choices, such workers have presumably—according to this theory—made rational, free choices to decline higher paid jobs in favor of ones with lower –pay –plus –intrinsic rewards.

But some people really enjoy using mathematics on their job. So engineering and finance salaries

are low because of the intrinsic rewards? Some people enjoy giving orders. Does the theory of compensating wage differentials explain why managers are low paid? Clearly, there is something not quite right with this argument, since engineering, finance, and management are relatively *highly* paid occupations.

The key to understanding what is going on is to realize that, within the theory of compensating wage differentials, whether pay in an occupation as a whole is high or low depends on the preferences of the *marginal* worker—that is, the last worker hired. When demand for workers in a certain field is high, so that wages in the occupation are bid upwards, workers can get *both* intrinsic benefits *and* high pay. In Figure 6, the supply curve shows the number of people who are willing to provide labor to a particular occupation at different levels of wages. The horizontal "wage elsewhere" line represents what they could make if they took their skills to a different market (that is, to other jobs requiring a similar level of skills). The people represented by the part of the supply curve that lies below this line like some characteristic of this particular occupation enough to take something of a wage sacrifice in order to work in it. If demand is low, this occupation will pay less than other jobs, and people who choose it will have to take "part of their pay" in intrinsic benefits. If demand is high, however, this occupation will pay *more* than other jobs, and many workers will enjoy both a wage premium *and* intrinsic benefits.

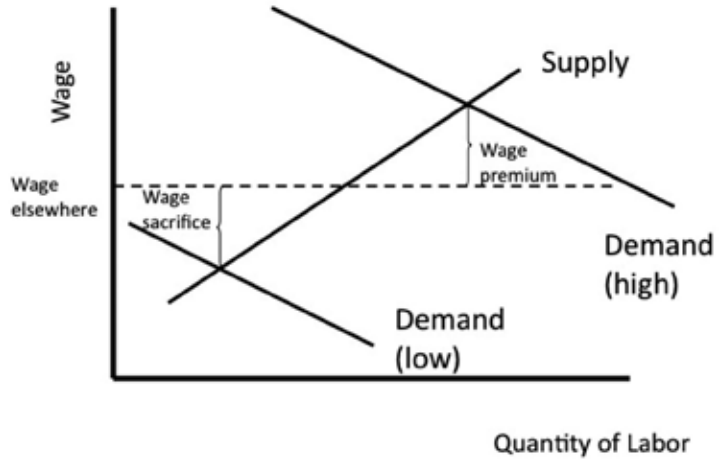

Figure 6. Compensating Wage Differential vs. Wage Premium

This suggests that it is not so much a qualitative difference in *motivation* that depresses wages in care work, but a depressed level of *effective demand* arising from an inadequate devotion of resources to the care sector. The occupations of nursing, teaching, and childcare in the United States tend to suffer from labor shortages. Given patterns of depressed pay, depressed respect, and/or short-staffing, they also suffer from high rates of labor turnover—with resulting harmful effects on patients, students, and young children. The theory of compensating wage differentials in no way justifies starving these sectors of the resources that would keep good workers on the job.

The "Protection" Argument

Ideally, care work should make a recipient feel authentically "cared for"—that is, nurtured, recognized and valued as an individual, emotionally supported, empathetically connected, or, in shorthand, loved. Many worry that, to the extent a worker might take a care job "just for the money," she or he will leave out these important interpersonal dimensions, and instead do the work impersonally and even callously. While this concern is valid, it is, unfortunately, often expressed as a desire to "protect" care work from the presumably corrupting influence of money.

Consider two examples from recent, peer-reviewed economics journals. In "The economics of vocation, or 'why is a badly paid nurse a good nurse,'" Anthony Heyes (2005) argues that since nursing is a "vocation," "increasing wages reduces the quality of applicants attracted." In "Selfish bakers, caring nurses? A model of work motivation," Kjell Arne Brekke and Karine Nyborg (2010) argue that "nurses' wages must be kept strictly lower than bakers' income" to prevent unmotivated people (shirkers) from becoming nurses. These articles both assume that competence in caring is largely a matter of having the correct, loving motivation, and that the quality of care cannot be directly monitored. They conclude that a low wage is necessary to assure that only properly altruistic people will be willing to take the job.

There are two central problems with the protection argument. The first is that it often draws on only selected findings from behavioral economics and the study of human motivation. Economists (and others) who make the protection argument often cite the research finding that, in some cases, extrinsic motivators such as monetary rewards can "crowd out" or reduce a person's level of intrinsic motivation. The example often given of this is a study in which paying for blood was associated with a decrease in blood donations. What is missed, however, is that the context of the payments matters: the crowding-out effect is associated with payments that are perceived by the recipient to be *controlling*—that is, as a means for someone else to manipulate one's own actions. When, on the other hand, monetary payments are perceived of as *acknowledging* of a person's own efforts and character, within a relationship of trust, they can "crowd-in" or encourage intrinsic motivations (Frey 1997; Fehr and Falk 2002). Care workers, in fact, often interpret the *low* pay they receive as indicating a *lack* of such acknowledgment of the social importance of their work, which may encourage them to leave the field. The larger behavioral literature suggests that increased financial support could *increase*, not decrease, care workers' intrinsic motivations.

Secondly, the "protection" argument seriously neglects the role of non-selfish factors in determining a worker's reactions to wage offers. Implicit in the "protection" analysis cited above is the idea that the further up one moves on the supply curve for caring work (that is, the higher the wage offer must be to get a person to take the job), the more selfish are the worker's motivations. This is shown in Figure 7.

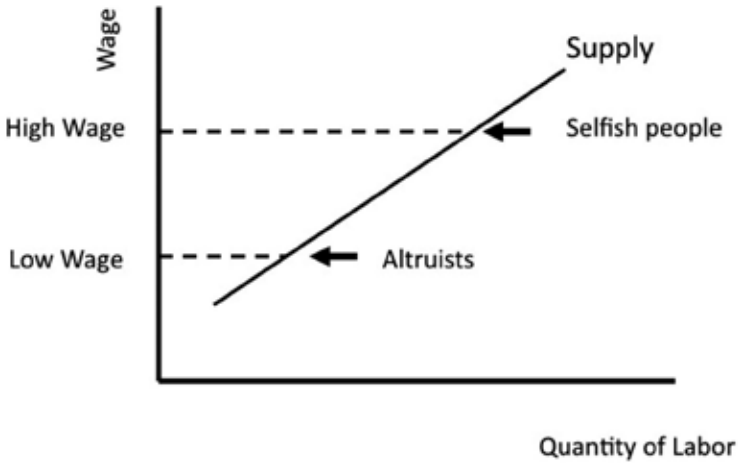

Figure 7. Bad Pay Attracts Altruists?

But after the Heyes (2005) article on "vocation" and my response articles co-authored with Nancy Folbre (Folbre and Nelson 2006) on pay for nurses were published, a number of nurses joined a discussion of them on a nursing blog. One nurse wrote: "I AM called to nursing. … I am also a mother that has three children who LOVE to eat." ("Bindy" quoted on allnurses.com 2006; emphasis in original.)[9] Caring people who have high family financial responsibilities require a high wage, and it makes them no less caring. Also, people who would be competent at caring would also likely be competent at a variety of other jobs. They will reasonably weigh the opportunity cost (that is, lost wages from alternative occupations) of entering a caring job, and choose alternative employment if that cost is too great. High wages, then, are necessary to make it possible for many caring (feeling) people to care (activity). People at the low end of the supply curve may not be so much unselfish people, as people with low responsibilities (such as young workers who may need to change jobs as their family financial responsibilities grow) and minimal skills. A more likely supply curve is shown in Figure 8.

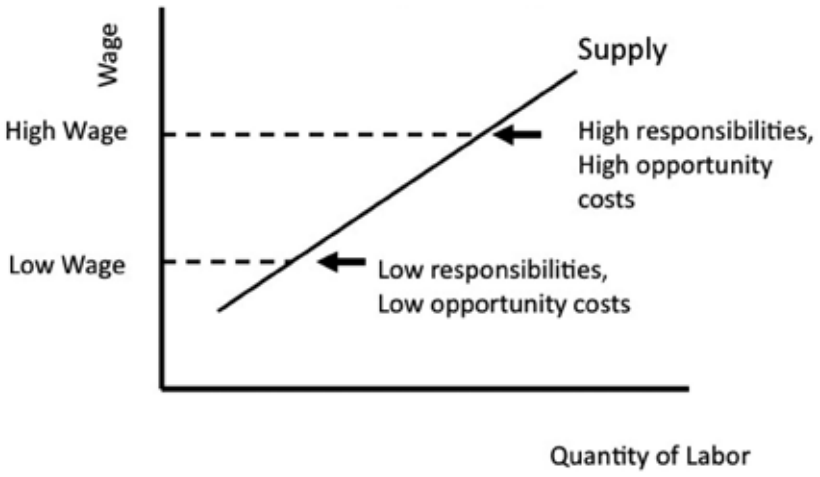

Figure 8: A Good Wage Allows Caring (Feeling) People to Care (Activity)

A third point is a bit more technical. The key assumption in the models created by Heyes and Brekke and Nyborg does not, in fact, have anything to do with the issue of care. Rather, the key assumption is that the quality of nursing or the effort put into nursing is somehow less observable than in other occupations. This forces reliance on a second-best way to monitor quality—in this case, using self-selection based on offering a lower wage. Oddly, however, an older literature in economics on "efficiency wages" has long proposed a different—and opposite— solution. If an employer pays a worker *more* than the worker can get elsewhere, this literature suggests, the higher wage will inspire better performance motivated by loyalty to the firm (and/or an increased fear of being fired). It is quite a dramatic example of the dualisms between male/female, and self-interest/altruism, that the proposed solution to unobservable quality for workers in general, no doubt pictured as male, is to pay more, while the solution proposed for nurses, no doubt pictured as predominantly female, is to pay less!

Advantages and Disadvantages of the Private-to-Public Move

One obvious benefit of creating more public and marketed alternatives to family care is the greater freedom it allows for women, who were traditionally expected to do the bulk of such work, irrespective of their own individual variations of interest and talent. In taking the burden of care off particular women, who had been assigned to it by status considerations, the increasingly for-pay provision of care could contribute to the costs of care being more widely and equitably distributed. The provision of care could in some ways be accomplished more effectively because of advantages of specialization. A traditional at-home caregiver is a generalist, and unlikely to have the child-development knowledge of a preschool teacher, the medical skills of a gerontologist, the counseling skills of a trained social worker, and so on. Shifting at least some aspects and intensities of caregiving to those with specialized training and experience (and who receive the pay that rewards their investment in skill) should raise the quality of care. Even the relative impersonality of paid care may sometimes be perceived as an advantage. Senior citizens in the United States, for example, sometimes express a preference for being cared for by a paid "outsider" rather than a family member, because this enhances their feeling of independence. Finally, as care work comes to be recognized as a type of work, rather than as a naturally occurring phenomenon that can be taken for granted, more attention may be paid to what constitutes care *quality*.

On the other hand, reliance on more public sources for the provision of care does not guarantee a high quality of care, without attention to the actual institutional structures through which the care is provided. While economic theory assumes that people can make informed choices and refuse unsatisfactory services, many direct recipients of services—children, the very ill, and the very elderly—are not in fact in control of decisions about their care. Even working age adults may find it difficult to monitor care quality—for example, when choosing a doctor for themselves or a childcare center for their child. Some of these problems might be ameliorated by better regulation of the locations in which care is provided, and through the sorts of workplace management techniques (such as regular

evaluations, and compensation structures that "crowd in" intrinsic motivations) that encourage quality.

The level of financial resources devoted to marketed and state-supported care is also a crucial issue. When care is done for pay, but under conditions of low pay, excessive work loads, and high worker turnover, workers suffer, and the quality of care suffers. Nancy Folbre (1994) has pointed out that quality care is in many ways a "public good," creating important externalities that cannot always be captured in individual transactions. For example, many people share in the benefits when children are brought up to be responsible, skilled, and loving adults who treat each other with courtesy and respect. When nurses do a good job, patients' families and employers benefit. It is well-known, however, that in the absence of collective coordination, the existence of "free riders" will cause markets to supply less than optimal levels of public goods. This suggests that substantial public financial support, not merely reliance on market provision, is necessary for quality care. Decent pay and reasonable work loads are also necessary for the benefit of the workers themselves: the possible advantages of the movement of much care work out of the home would be much diminished, if it came to be supplied largely by an underclass of exploited workers.

Larger Lessons from Care Work

As we have seen, paid care work challenges the old Victorian division between work as a masculine, competitive, self-interested pursuit, and care as a feminine, compassionate, virtuous one. I hope the discussion above has persuaded you that that thinking in those terms is now passé and even dangerous, when applied to issues of caring labor. I would like to end, however, by making a couple of points that go beyond the care work discussion, as it has so far been framed. These may be provocative.

Consider the behavior of corporations, and particularly the behavior of, and compensation of, corporate chief executive officers. The dualist ideology that says that business is about the unfettered pursuit of self-interest has become so predominant in the United States that many mistakenly believe that profit-maximization is mandated by law, or is an inviolable mechanism of capitalist economic systems (Nelson, 2010). Those who, on the other hand, still believe that businesses are social citizens, with corresponding ethical responsibilities, are in a minority and must fight an uphill battle to be heard. The idea that self-interested CEOs, mostly males, will only look out for the interest of the *corporation* if they are paid huge performance-tied *bonuses* has led to a rapid increase in the value of CEO compensation packages in the United States in recent decades. Note, however, the contrast between this theory and the argument presented above that said that nurses, mostly females, will only look out for the interests of their *patients* if they are paid particularly *low* amounts. Why not, instead, write an article about "Why a badly paid CEO is a good CEO?" Presumably, only the CEOs who were willing to put the corporations' interests first would then take the job. The recent financial crisis, if nothing else, should lead us to question whether the idea of an ethics-free business sector is really so viable after all.

Much of my work has also looked at the behavior of economists, and our professional attitude towards ethics. The idea that knowledge is somehow separable from care has come to the fore in recent discussions of the economics of climate change. The argument has been made that, purely on objective and scientific grounds, it is optimal for the United States to *not* immediately engage in serious mitigation policies. That this view very likely consigns both citizens of poorer nations and those in future generations to extreme hardship goes unacknowledged.

I raise these points because I think it is tempting to study care work, in the sense of face-to-face intimate care for individuals, in isolation, and emphasize its *differences* from other kinds of work. What I would like to suggest, instead, is that in our contemporary global and densely interconnected world, in which the actions of each of us impact others, *all* work involves, in an even larger sense of "care," caring responsibilities. All work, to be done properly, and in the service of not only ourselves but also the common good, requires a sensitivity to interdependence, attention to virtue, and the expression of our compassion. That we do not recognize this, and in fact often may do our other sorts of work in ways that are directly *harmful* rather than caring, is not due to some fundamental difference in the nature of the occupations. Rather, it is due to our currently abominably low ethical standards for economic behavior.

Conclusion

The shift of much caring activity from family to markets represents an enormous social change. Markets on their own are unlikely to provide the particular volume and quality of "real" care that society desires for children, the sick, and the elderly, or guarantee the sorts of relationships that make education, social, and health services most effective. The increasing intertwining of "love" and "money" brings the necessity—and the opportunity—for innovative research and action. The actual skills involved in care work need to become better articulated, and myths about the motivations for care need to be dismantled. Issues of market structure, work environments, incentive schemes, regulatory requirements, and, most importantly, adequate financial support for care cannot be neglected. This is true not only for the sorts of face-to-face care on which this essay has largely focused, but also in the more general sense in which our work, in whatever area, connects us to each other.

(Julie A. Nelson, Associate Professor, Department of Economics
University of Massachusetts, Boston)

Notes

1　The distinctions between care as an activity and care as a motivation have been discussed by Joan Tronto (1987), Kari Wærness (1984), Susan Himmelweit (1996), and Nancy Folbre and Thomas Weisskopf (1998).

2　This analysis draws from and updates Folbre and Nelson (2000).

3　The figure for homemakers as a percent of all workers in 2000 corrects a typographical error that appeared in Folbre and

Nelson (2000).

4　Employment of workers as maids and in-home childcare providers, while it exists in the U.S., is not as prominent a part of the U.S. economy as it is elsewhere. Government statistics for 2000, for example, suggest that only 0.4　% of native born workers, and 1.8% of foreign born workers, work in private household service occupations in the U.S. (Mosisa 2002, Table 8).

5　For more on this, see Folbre and Nelson (2000), Nelson (2006a,b).

6　This section draws heavily on Adams and Nelson (2009).

7　The term "diagnosis" here refers to nursing diagnosis as distinct from medical diagnosis.

8　This section draws on Folbre and Nelson (2006) and Nelson (1999, 2001).

9　Other nurses were quick to point out that nursing requires competence as well as good intentions; nurses can concentrate on their jobs better when they aren't worried about bus fare; and higher wages bring in a larger pool of people for employers to choose from (allnurses.com 2006).

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