What do I care?

On the duty to care between citizens

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Thus, that you may practice charity in action and in will, I in my providence did not give to any one person or to each individually the knowledge for doing everything necessary for human life. No, I gave something to one, something else to another, so that each one's need would be a reason to have recourse to the other. (…) Could I not have given everyone everything? Of course. But in my providence I wanted to make each of you dependent on the others, so that you would be forced to exercise charity in action and will at once.

Catherine of Siena (1980) *The dialogue*. Londen: Paulist Press. pp. 311-312.

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1. Introduction: The changing role of citizens in welfare and care

Ever since its foundation the welfare state in Western societies has searched for a healthy balance between the role of the state and of citizens. Changing views of governments and changes in demographic structures compel welfare states to review the position of the state and of citizens constantly. In the last decades, the ageing of the population, the coexistence of different cultures and the increasing work participation of women made changes in the welfare state necessary, because arrangements in the welfare state were not suitable to the present demands of citizens (Tonkens et al., 2008: 11). At the same time, Dutch government changed its view on citizenship. Since a few years, the dominant ideal of citizenship has been centered on self-reliance, mutual care, spontaneous self-development and responsibility. The state should be ‘inviting’ and ‘connecting’ to citizens, and not ‘caring’ and ‘assuring’, as was more common in earlier decades. In this way, more responsibility and initiative is asked from citizens (Tonkens, 2009: 15).

The welfare state is, as a result of those developments, changing towards a system in which a larger role is played by citizens. When a relatively large part of the population is retired, the costs of welfare for the active population will increase. The interpretation of citizenship as self-reliance and individual responsibility shows that input from citizens themselves is expected in the system of welfare and gives the opportunity to decrease the input from the state, by lower tax rates for example. This changing role of citizens is also visible in the introduction of the Societal Support Act (Wmo) in the Netherlands. This act shows that the accent of welfare has shifted from ‘care in an organization’ to ‘support in society’ (Tonkens, 2009: 99). This means that the welfare system aims towards participation of everyone in society, whether healthy or unhealthy, which is partly done by caring for people in society prominently instead of in hidden away. The Social Support Act is seen by some as a transition from the welfare state to a ‘participation society’. It is not the state that should provide welfare for everyone, but the effort of citizens that should make welfare possible (Van Doorne-Huiskes et al., 2008: 7, 8).

Concentrating on one part of the welfare state, the part of care, the larger role of citizens is visible in changes in the assigned roles of formal and informal care. The role of informal care, which is care from family, friends, neighbors, or volunteers, is becoming larger (Tonkens et al., 2008: 11). In this way, citizens are becoming coexecutives of government policy (Hortulanus, 2002: 16). The policy of governments is that everyone should receive care if someone needs it, but governments cannot supply this amount and level of care on their own. The effort of citizens is needed to care for all who need it. Besides, governments not only want the contribution of citizens because of their own inability to provide for care of all citizens, but also because of the integrating and cohesive function that participation is thought to have (Van Doorne-Huiskes et al., 2008: 12). A more substantial role for informal care is a consequence of and answer to the limitations of formal care and the benefits of informal care.

These developments show that the appeal to citizens in the welfare state and especially in relation to care has changed. Unhealthy citizens are dependent on informal care to a larger extent than before. Besides, caring for fellow citizens is considered as a necessary part of one's citizenship. This gives a new dimension to the role of citizens in the welfare state. Instead of an emphasis on the rights to welfare, it is stressed that citizens have a duty to care for their fellow citizens. To take care of people around you is in itself not an extraordinary thing to do. A loving or intimate relation between two people creates the willingness to take care of each other and a feeling of responsibility for the welfare of one another (De Boer, 2007: 19, 20). People would be displeased if they would not be allowed to care for the ones they love. But this does not mean that it can be expected that you take care of your family. It is not at all clear what the state may expect from family in relation to care. Apart from intimate relationships between family members or friends, most citizens are merely related to each other as citizens. What role do citizens have towards other citizens in the context of care?

The research question of this thesis is: What should the state expect from citizens and what should be the role of the state in the context of care? To answer this research question, it is necessary to explain which vision on state intervention and the role of the state in the context of care I believe is appropriate. This will be done in the second chapter. This vision will give general guidelines for the extent to which the state is allowed to interfere in civil society and the private sphere. The vision of state interference I will defend views the micro level as guiding for what the state, on macro level, is allowed to do. Therefore it is important to focus on this micro level: citizens and their mutual relations, which I will do in chapter three. Before I will look at the interpretation of citizenship in the fifth chapter, I will explore the role of autonomy in the relations between citizens in chapter four. This is important, because the autonomy of citizens may easily be threatened with regard to care, dependency, and state intervention. In the fifth chapter, as said, I will look at the consequences of the vision on the state for a vision on citizenship and state intervention. In the sixth chapter a more concrete content can be given to the role of the state, as supplement of citizens’ actions.

2. A vision on state intervention

This thesis explores the role of the state and of citizens in the context of care. A multitude of divisions of tasks between state and citizens is possible, which all depend on and are influenced by the vision one has on a proper role of the state and its citizens. In this chapter I will argue for a vision on state interference in which citizens have a leading role. After I have made clear which balance between state and citizens should be found in the context of care, a solid basis is made to think about the ways citizens are connected and should fulfill their role as citizen. In this chapter I will explain which models for state intervention can be chosen, and which one I will choose in this thesis.

§2.1: Three models of state intervention

A first way to look at the state is one in which negative rights are emphasized. Negative rights are rights on non-interference and focus primarily on the fact that the state should abstain from action to respect the rights of citizens (Wenar, 2011: section 2.1.8). In the context of care, this emphasis on negative rights is not suitable, because care in itself is not a right that is respected when the state withdraws, but can instead be interpreted as a right that is respected when the state provides a certain service. A second way therefore to look at the state is one in which positive rights are stressed. Positive rights are rights on some good or service (Wenar, 2011: section 2.1.8). In the context of care this means that care is seen as a good or service that citizens are entitled to. The state then has the role to provide this good to its citizens and is allowed to interfere in citizens' lives to give them their rights.

The way I would like to look at the role of the state is one in which citizens and their duties are central to the division between state and citizens. The most important guideline for the state is the primacy of citizens and their duties, instead of an emphasis on rights, whether positive or negative. This does not mean that care cannot be interpreted as a right in this model, but when discussed with regard to state intervention and citizens the focus is first of all directed at the duties that citizens have. Duties can be seen as logically correlative with rights: when someone has a right, an accompanying duty shows what others should do to ensure that right (Simmons, 1979: 14). With an emphasis on duties I do not deny a right to care, but in the context of state and citizenship I choose to give primacy to the side of duties. The first role of the state, then, is one of asking its citizens: ‘What are your duties in the context of care?’. The state has the role of making its citizens aware of their duties in the context of care. This is an important role, but not the only one. In this model, the state will interfere in civil society and the private sphere, to guarantee that care is provided for all citizens. In this way a right to care, which in this thesis I assume exists, is not neglected. This interference does not take place before citizens are aware of their duties. When citizens are made aware of their duties and hopefully have fulfilled them, it is possible that care is still not given to everyone who needs it. At that moment the state will intervene in civil society and the private sphere to make sure everyone in need receives care. The interfering role of the state, then, encompasses a safety net for when citizens and their duties fall short. The best ways in which the state can provide such a safety net will be discussed in the sixth chapter.

This last model for state intervention does not focus on what the state should or should not do, but on what citizens should or should not do. I choose to use this vision on state interference because, as will become clear in the next chapter, we are all affected by care. Everyone needs care in their lives, and this makes it not merely a service of the state to its citizens, but something in which every citizen is involved. In section 6.1 I will give a more complete justification for choosing this model, when more is clear on the character of care and caring relations. The micro level, namely care on the level of every individual citizen, then is guiding for the role of the state on macro level. Thus, the focus of this thesis is on this micro-level, which will give direction for the ways the state is allowed to interfere in civil society and the private sphere.

§2.2: First exploration of the consequences on citizenship

This particular vision on state intervention has consequences for the way citizenship should be regarded. What has become clear from this third model is the emphasis on citizens’ duties. In the first and second model, citizens’ primary focus is on their entitlement to care, but in the third model, this focus shifts towards the duties to care they need to fulfill. In the fifth chapter I will argue how being a citizen may create duties, but now a preliminary exploration of the concepts of citizens and citizenship can be made. In this thesis I will interpret citizens as members of a state, who are consequently related to other members of that state, their fellow citizens. As citizens, people are connected to people with whom they otherwise would not have been connected. The vision on state intervention I will use in this thesis views the social responsibility of citizens to take care of one another as the core business of citizenship. This social interpretation of citizenship however is based on political and personal relations in the context of care. This classification will become clear in section 5.3. Since the state does not regard its own role in the first place as ensuring rights to care, the state gives citizens the first responsibility to care for each other. In the next chapters we will see what the content of this responsibility is and what it is based on.

3. Relations between citizens

Because the basic thought of state intervention in this thesis is that the micro level, individual citizens, determines what should happen on the macro level, the state, this chapter will focus on that micro level. It is necessary to view it from this angle, because when it is clear how citizens live together in the context of care, it is possible to make an argument for the degree and the content of the duties that citizens may be asked to fulfill.

Wherever and whenever people live together in societies, relations between those people are extending beyond the bonds people naturally have. Apart from family relations, people interact with others in the same society and are connected with others whom they would never have met if they had not lived in the same society and shared in the same institutions. In this chapter I will explore all those different relations that people may have in a society. I will concentrate on caring relations in one country, to limit the scope of this research on caring duties of fellow citizens. Moreover, in western societies care and welfare arrangements are still organized at the national level and not the sub- or supra-national level, despite ongoing changes. Therefore, in searching for a right interpretation of caring relations of citizens, the scope of one country is suitable.

I will start this chapter with a definition of care that I will use in this thesis. Then I will state and prove that people are mutually dependent on each other in the context of care. To clarify these dependence relations I will elaborate on four kinds of relationships of care and the ways in which people are dependent in those relations.

§3.1: Defining care

In caring activities, the well-being of the other is central to the person who cares. Contrary to most activities, like working or relaxing, in caring behavior the other's needs are a starting point for what must be done, as Sara Ruddick states (Tronto, 1993: 105). Caring is furthermore related to the basic needs of persons. In friendships, friends find the well-being of each other also very important, but in general, their relation cannot be defined as caring. In a caring relation, the development and basic biological and social well-being or needs are the direct end of that relation (Engster, 2005: 51). The relation between people exists because of meeting the needs of the other, and not because of, for example, mutual pleasure. This does not mean that caring people will never get any satisfaction or pleasure out of their caring activities, but this is certainly not the aim of this relation.

Care is primarily an activity, a practice, and not an attitude or virtue. However, care is often related to or even identified with virtuous behavior. Care ethicists do not explicitly define care as a virtue, but they definitely see care as closely related to virtues and morality (Tronto, 1993: 57). Care cannot be separated from and practiced without virtues, according to a care ethicist like Joan Tronto. She states that a ‘habit of mind’ is needed to care in a morally correct way (1993: 127). Besides, she claims that care is both a practice and a disposition (1993: 104). However, I would like to state that care is primarily a practice, sometimes accompanied with a disposition. I do not think that care is always both practice and disposition. Although care can be a private, emotional or sensitive activity, in my opinion virtues are not by definition necessary to care for others. What should be central to practices of care are the needs of others and the fulfillment of those needs. By linking care directly to an inner disposition, I believe the practice of care is falsely limited to a private, personal and subjective activity. I would like to state that care can exist and can be good when someone lacks an inner conviction or attitude that would place the one in need at the centre. In the remainder of this chapter it will become clearer what can be seen as care.

§3.2: Dependency of citizens

Although the concepts of care and dependency are often used in different discourses, they can be seen as inseparable (Fine and Glendinning, 2005: 607-608). The concept of care has a positive connotation, but that of dependency is in general not seen as a positive state of being. Most of the public policies are directed at the reduction of the dependent status of people. Perhaps only in the private sphere dependency is seen as a neutral status, because in the private sphere the acknowledgment exists that dependency brings people together (2005: 604-607). In the public sphere, this positive notion is apparently lacking, because of the effort to reduce dependency as much as possible. Different types of dependency can be distinguished, as can be seen in public policies and discourse: economic, socio-legal, political, moral/psychological, physical, and structural dependency are a few of the most important ones (2005: 606).

I would like to argue that in the context of care everyone depends on each other. People may depend on each other in different ways, but I think it can be rightfully stated that everyone needs the help of others in some way and at some point in their lives to fulfill their needs and promote their well-being. In his book *Dependent Rational Animals* Alisdair MacIntyre proposes to see each one of us, to some extent, as disabled (MacIntyre, 1999: 73). In different periods of our lives we are to different degrees disabled and dependent on the care of others. To be disabled means to be limited in the possibilities we have. We cannot by ourselves remove obstacles that limit us, we need others to do that to us and in that way enlarge our possibilities (1999: 73-75). Everyone is dependent from parents or other care takers in their infancy. In our infancy, we have to depend on others for our own well-being. As we grow old, we will be dependent on others for our well-being and survival as well. In other periods of our lives we may also be limited in our possibilities, each to a different extent. MacIntyre states that especially in the periods that our possibilities change and we become more or in different ways dependent, we need other people to affirm that we continue to be the same person, in spite of our changing possibilities (1999: 73).

Although MacIntyre is assuming quite radically that all are dependent and disabled, he is not completely comfortable with this idea. On the contrary, the better part of his book is devoted to the search for a way out of the dependent status of humans beings. He acknowledges that we are dependent rational animals by nature, but that we have the desire to become independent. The transition from dependence to independence is to be found in the development of virtues, according to MacIntyre (MacIntyre, 1999: 5-6). However, the necessary virtues for this transition we cannot develop ourselves. Instead, we should acknowledge that we need others and that our desires are focused on everyone who can satisfy our needs (1999: 83). To admit our failure in independency thus is the first step in the direction of independency. Without the knowledge of the limits of our possibilities, we will never be able to break free from these limits, which are our dependencies, attachments and conflicts. Only when we can acknowledge in what ways we are dependent, we will not be captivated by these limitations and attachments (1999: 85).

This notion of dependency shows that people, apart from being citizens, have a personal, private relation that is characterized by dependency with people whom they are intimate with. Apart from this notion, citizens are as citizens dependent on each other in a more structural way and on a larger scale. In Western societies, care has been positioned in a welfare system in which working people contribute to the costs for people who need care at that moment. Citizens need their fellow citizens to contribute to such a welfare system, to maintain this system. When each of the other citizens refuses to contribute, a welfare system will collapse and no one will receive the benefits of it. Citizens are therefore dependent on their fellow citizens to maintain a welfare system and receive their own share when they need care. Such a welfare system closely links care to dependency. One could even state that such a welfare system creates dependency. Such a dependency is, similar to personal dependency, a mutual one. One period in your life you will contribute to this welfare system, and another period you will receive care made possible by this system. Furthermore, citizens may become dependent on each other in civil society. Civil society is the area between state and market in which citizens voluntarily interact. Associations, or citizens involved in such associations, that are concerned with care may create relations of dependency between each other. These dependency relations, however, do not always exist: only when citizens, voluntarily, become active in the caring part of civil society, relations of dependency are created.

So, on the micro level dependency relations exist in the public sphere as well as in the private sphere. Individual citizens are involved in dependency relations in the roles of contributors in civil society or a welfare system, and in family contexts.

§3.3: Types of care relations

The different forms of dependency described in the last section reflect the different aspects of care that can be distinguished, I believe. Care is not only a matter of giving and receiving, but aspects of ‘caring about’ and ‘taking care of’ are also a part of the concept of caring (Tronto, 1993: 106). These different accounts of care could be viewed as different steps in caring. For a complete understanding of these steps I will describe them, show how dependency plays a role, and explain how they are related to each other. But beforehand I will give a characterization of different kinds of relations citizens have towards each other in the context of care, to portray the complexity of these relations.

Care is traditionally connected to the private sphere, family and households. Naturally, parents give care to their children, in a direct sense, and when parents grow old, their children care for them. This mutual care relation is not based on reciprocity, but is guided by unconditional care (MacIntyre, 1999: 100). The needs of children are unconditionally met by their parents, and normally children care for their parents not to the extent that they received care from them, but to the extent the parents are in need of care. This, however, is not the complete description of relations between parents and children MacIntyre gives. If it were, it would be a far too rosy picture. MacIntyre gives a far more realistic account of personal, caring relations when he marks that all relations have a double character (1999: 102-103). Relations based on sympathy and affections are not only a matter of sympathy and affection. In those relations a degree of hierarchy and power is present as well (1999: 116-117). Parents use their power in some way over their children and children may care for their parents because of some advantage for themselves.

This double character is also visible in relations that are primarily defined by ‘rational exchange’. In those relations, aspects of unconditional giving have their place as well (MacIntyre, 1999: 117). These, more rational and distant, relations can however also be called care relations. Citizens, as citizens, therefore also have care relations with each other. These differences and mixtures of rationality and affections are visible in the following characterization of care, described in four steps: caring about, taking care of, care giving and care receiving.

Caring about means that someone notices the need to care in the first place (Tronto, 1993: 127). Actual needs are not directly met, but this first step is necessary to come to fulfillment of needs. Caring about can be done individually, but a social policy that pays attention to, for instance, the disabled can be called to care about the disabled (1993: 106). Relations that are characterized by ‘caring about’ may exist between people who do not know each other but are faced with each other’s needs in an indirect way, for example through media or mutual friends. Through stories or pictures, awareness may be raised that someone else is in need. When raising awareness is the only step of caring, people can be called to care, but the actual meeting of needs does not occur. Caring about can exist between people who are far away from each other, spatially, temporally and emotionally: people may care about children on the other side of the world, from the next generation and with whom they do not have a personal relation. The aspect of dependency is not clearly present in these kinds of relations. Awareness is needed, and is the first step in a caring relationship, but when awareness is all there is, people in this relation are not involved with each other in an intensive way. As the first step in a caring relation, this ‘caring about’ shows that the needy are dependent on the awareness of the people who are their potential care giver.

Taking care takes caring one step further, by the acceptance of one's own responsibility to meet the needs of others. If a social policy only writes about the needs of the disabled but does not actually meet those needs in some way, it is not right to state that such a policy takes care of the disabled (Tronto, 1993: 106-107, 127). In relations that are marked with characteristics of 'taking care of', dependency is present in a more direct way. People take responsibility to meet the needs of others, by providing the resources for care (1993: 106-107). Examples of such relations are giving money or creating groups that coordinate and administer the actual care giving. People from such groups are not involved in care giving directly, but they make sure that others will give care and other people's basic needs are met. Because we are dealing with the relations citizens have, as citizens, we will not take into account formal care organizations, in which care professionals exercise their jobs. Instead, we look at organizations of citizens who take care of other citizens. Community centers, self-help groups and diaconate from churches are examples of citizens who take care of other citizens. People involved in this kind of care are dependent on the resources others are willing to spend on them. People in need are dependent on people who take care in a structural way. Providing resources to care can be done in formal and informal groups and organizations, but taking care mainly takes shape in the public or semi-public sphere. Private networks are in general not sufficiently capable to provide resources in a structural way (1993: 107).

Care giving can be defined as directly meeting others' needs, and therefore relations of care giving exist between people who are somehow directly related (Tronto, 1993: 107). Most of the time this means that people know each other prior to and apart from the care relation, as family or friends. Relations in which care giving is involved are relations between parents and children, (disabled) family members or friends. The people involved are dependent on each other in a structural, physical and psychological way. In these relations the mutual character of dependency is probably clearer than in other relations. Children are dependent on their parents, parents on their children and siblings and friends on each other for mutual love and acceptance. These relations resonate with the description MacIntyre gives of dependency, which I mentioned in the previous section: we all need others to recognize that we are the same when the extent to which we depend on others changes. But of course these relations can also be asymmetrical: when a husband is severely disabled and his wife cares for him, or when a child has been abused by his parents and nevertheless gives care when they need it.

Care receiving is a response of the one who is cared for and whose needs are hopefully met. Care receiving is logically complementary to care giving. When care is given, care is automatically received by someone else. In practice, however, care giving does not have to mean that the needs of a person are met completely and in the right way. It is possible that a person wants to eat on his own, with some assistance from someone else, whereas the care giver feeds him, because it is faster and less complicated (Tronto, 1993: 108). In a care receiving relation the kinds of dependency therefore are the same as in a care giving relation, but extended with the feature that the care giver is dependent on the demands and responses of the care receiver to see if needs are actually met.

The degree to which needs are directly met distinguish the four steps of care. In the step of caring about, no actual needs are met. In the step of taking care, more practical conditions to meet needs are provided for. In the steps of care giving and receiving, the activity of care is centered on the direct and actual meeting of needs. This order of the different steps of care is also applicable to how close and personal the relation is between the caring one and the one in need. We saw that someone can care about someone on the other side of the world and that care giving and receiving happens in direct and personal relations. Furthermore, I have already described that giving and receiving of care are logically complementary. The steps of caring about and taking care do not have such a complementary relation with one another.

§3.4: Motivation to care

When I gave a definition of care in the beginning of this chapter, I emphasized that a limitation of care to a mental disposition or the necessity of a mental disposition in caring is in my opinion not right. Care may be both practice and disposition, but is primarily a practice. This was made clear by the differences in care relations that exist. We already have seen that care relations may be characterized by a mixture of sympathy, affection, power and hierarchy. Besides, care is not only found in personal relations, but also in policies and arrangements. Care relations exist between family members, but also between citizens, and may even exist between people who have never met each other. In the context of state intervention and citizenship, all those dependency and care relations are of importance. The different steps in care that can be distinguished show diverse accounts of what is needed to speak of care. Care is primarily a practice, but I would like to argue that in the steps of care giving and receiving, when the actual needs are met, a certain disposition is indispensible. This will be shown in the remainder of this chapter.

What, then, can be said about the proper motivation to care? Michael Slote interprets motivation as affectionate when he links care closely to empathy. In his book *The Ethics of Care and Empathy* he states that feelings of empathy are a ‘crucial source and sustainer of altruistic concern or caring about others’ (Slote, 2007: 15). He uses the concept of empathy as the motivation to care, because he thinks empathy is a good moral guideline to ethics of care. Slote states that feelings of empathy have a good correspondence with intuitive evaluations of the moral side of care (2007: 16). The differences in feelings of empathy for people are closely linked to the moral evaluations we make. We use these differences in empathy and our reactions to those feelings to make moral judgments and understand them. When we feel much empathy for someone, we are inclined to help him and evaluate that this is a moral thing to do. Apparently, we think that our feelings of empathy can be a moral guideline for our caring (2007: 128).

I think Slote is right in incorporating empathy in his theory of care. Empathy plays an important role in caring relations, because it can create, among others, an affectionate motivation to care. But I definitely do not agree with Slote’s statement that our feelings of empathy are a good moral guideline for determining in what ways we should care for others. I do not believe Slote has convincingly proven the link between how we evaluate our caring actions in practice and how and according to which standards we should evaluate those actions. I believe it is very likely that our empathic feelings are so corrupted that we have too limited, or not the right, feelings towards others to make them the only guidelines for our actions. Feelings can be manipulated, in such a way that we do not feel related to people to whom we should feel related. An extreme example is the manipulation Nazism used to eliminate the Jews. By dehumanizing the Jews, other people stopped feeling pity for them, because they could not identify with the Jews.

Furthermore, describing empathy and its moral force as dependent on immediacy, in time, place and causality, Slote creates a moral guideline of caring, centered around the closeness of the one who needs care to the care giver. In that way the possibilities, position and feelings of the person who is *not* in need have more influence on a moral decision than is appropriate, I believe. If care is about meeting the needs of others, I consider it not justified to give subjective, and possibly flawed, judgments and feelings of the care giver such a central position.

When care is interpreted as broad as I did, feelings of empathy are not a necessary basis for a motivation to care. When care is taken place in personal and direct relations, I think a kind of mental disposition, or some virtuous attitude, that accompanies the practice of care is indispensible. When care takes place in less direct relations, in arrangements or the giving of money, I do not think a mental disposition is necessary to provide care. In care giving and receiving, however, people need a certain mental disposition to give and receive care properly.

Daniel Engster discusses the relevance of the virtues of attentiveness, responsiveness and respect in the context of care (2005: 54). Attentiveness can be defined as sensitivity to the needs of others, the ability to notice if someone is in need of care. Engster links this virtue also to empathy. Responsiveness points to the quality of engaging in the exact nature of the needs people have and the ability to monitor the reactions to given care. Respect is needed for the notion that others with certain needs are of as much worth as others with lesser needs (2005: 54, 55). To care regularly and so that the aim of caring is achieved, virtues of caring are necessary (2005: 54). It may be possible to give care for a person once without the right sensitivity, for instance by washing someone, but when you genuinely and directly want to meet the needs of someone, you need to listen to their needs and their reactions. Otherwise you may have a wrong view of the needs of a person, and you will not care effectively and properly. Furthermore, without the attitude that someone is as much of worth as you, you may lose sight of the necessity of your caring.

I have shown that citizens all have dependency relations with their fellow citizens, but direct and personal ones only with family and friends. The actual care giving and receiving will mainly take place in the contexts of family and friends. The virtues of care are more likely to be present in such personal relations, because caring relations then are based on pre-existing ties of family or friendship. In less direct and personal relations those virtues will not be completely present. Yet, since in those relations care giving and receiving does not take place, this is not a problem. The main significance of virtues of care is not that it is an instruction to develop those virtues to care properly. Instead, the necessity of virtues of care in the direct meeting of needs is primarily a sign and guideline to clarify in what kind of relations direct care has a place. Besides, the observation that for care giving and receiving virtues are indispensible does not mean that the motivation to give or receive care should be based on feelings. Virtues in care mean that care is given or received with a certain attitude. The development of or an appeal to these virtues can, and should, be done on rational grounds. In chapter five I will discuss whether people should give direct care to people other than family members or friends, and whether they should develop the virtues of care.

4. Autonomy and dependency

The account of care between fellow citizens so far given stresses the centrality of dependency of every citizen. It was stated that every citizen is dependent on his fellow citizens in some way and care should adapt to this fact. Before we turn to the consequences for citizenship and its duties in the next chapter, it is necessary to take a step back and evaluate the goals of care and examine whether those goals create tension with the character of human relations as described in the previous chapter.

The fulfillment of the basic needs of others is central to care, as I described in the previous chapter. Most of the time, the underlying motive of fulfilling those needs is concerned with the autonomy of an individual. People may be dependent and care should be given so that those people will become independent and autonomous (Fine and Glendinning, 2005: 602). At least, in those terms care and welfare are discussed in liberal discourse (2005: 613). Autonomy and independence are the aim of care in this discourse. The fact that all people are dependent, in different degrees and in their whole lives, seems to be incompatible with this aim of independence. It seems that the goal of autonomy and independency can never, or only for a while, be reached. In this chapter I will search for a decrease in the tension between autonomy and dependency by discussing different interpretations of autonomy, the relation with inequality and power, and the application of autonomy in the different steps of care.

§4.1: Defining autonomy

The terms ‘autonomy’ and ‘independence’ do not mean the same. The fact that people cannot be independent in care relations, as I explained in the previous chapter, therefore does not mean that people cannot be autonomous in care relations. Furthermore, I believe that the aim of care is autonomy, and not independence. A general definition of autonomy is the moral capacity to make one’s own decisions, to govern oneself (Christman, 2011: §1.2). To make this concept more concrete in the context of care, attention has to be paid to the meaning of this concept for different parties involved in caring. Autonomy in care is guaranteed when all parties involved have the moral capacity to make one’s own decisions. However, this is an ideal situation, and especially in caring often not (completely) attainable. A person who is dying does not have any capacity to decide anything at all. Aiming for autonomy then makes no sense anymore. Furthermore, when care is accompanied by a duty, as I will argue in this thesis, it may be argued that such duty diminishes one’s own freedom to make decisions. Because of these limitations and difficulties I think it is appropriate to state that autonomy is still the ultimate goal of care, but that sometimes it is simply not attainable. In those situations the new goal then should be to try to attain autonomy as much as possible.

MacIntyre makes a similar argument. Instead of autonomy he speaks of independence as an ultimate goal to aim for (MacIntyre, 1999: 5). He adheres to a paradoxical point of view, because he states that independence can only be reached by acknowledging dependency (1999: 85). He strives for distancing from one’s own desires and the cultivation of virtues to become independent rational animals as much as possible (1999: 5, 73). In this way, MacIntyre permits the continuance of the contradiction between dependence and independence. By holding on to the aim of independency and at the same time acknowledging that this can only be reached by dependency, MacIntyre tries to unite those two.

In the context of care, I believe it is better to speak of autonomy instead of independence, as MacIntyre does. Independence in the context of care would mean that someone in need does not need others to fulfill those needs. In the previous chapter I argued that with regard to care everyone is at some point in life dependent on others. Dependency is a human condition in the context of care. Independency is not possible and furthermore not a favorable condition. I do not believe that being capable of fulfilling all your needs by yourself is by definition a better position than receiving some help or assistance from others. Moreover, aiming for independency can easily result in an emphasis on non-interference (Slote, 2007: 69). Such an emphasis on non-interference places people in a discourse in which the assistance of others is seen as an intervention in the personal sphere, instead of a helping hand. So, the concept of autonomy, to be in charge of one’s own life as much as possible, is a more appropriate concept in this context. It shows that care is not directed at doing everything on your own, which can be called executional autonomy, but on decisional autonomy. A person in this way is autonomous when he can exercise control over the help and care he is given, even though he cannot execute this help and care himself (Fine and Glendinning, 2005: 610).

§4.2: Inequality

Interpreting autonomy this particular way, and holding on to the characterization of human nature as dependent, results in the acknowledgment that citizens find themselves in unequal positions to each other when in one situation one citizen is more dependent on the other, and in another situation this is reversed. This inequality is an inequality of possibilities. People who are in need have lesser possibilities than other people, and are dependent on others to compensate for the lack of possibilities they have. This dependent situation means that you are in a vulnerable position towards the other. But a similar vulnerable position is present when you are the one who cares for someone who is dependent on you. Vulnerability ends the assumption that all citizens are in an equal and autonomous position all the time (Tronto, 1993: 135). Vulnerability means sensitivity to the actions of others. The more inequality and dependency there is between people, the more people are sensitive to the actions of others. When one is receiving care, one is vulnerable to the actions of the care giver: because he cannot care for himself, his well-being is in the hands of the care giver. But this vulnerability is equally true in a reversed situation: when one is giving care, one has to listen and obey to the care receiver.

An inequality of possibilities thus is accompanied with vulnerability. This vulnerability in turn results often in an inequality in terms of power. Eva Kittay even states that every dependent relation is characterized by inequality of power (Fine and Glendinning, 2005: 613). Care relations are ‘framed by power’ and domination of one party over another can easily be exercised (2005: 616, 613). Tronto notices that on the one hand the unequal position that clearly exists between care giver and receiver may result in paternalism, when some decisions are made by the care giver while the care receiver can do this by himself. On the other hand, the needs of some people are more completely met than others, and these differences mainly follow differences in power in society (Tronto, 1993: 145-146). In the next section these difficulties concerning autonomy, dependency and power are explored for the different steps in care.

§4.3: Autonomy in different steps of care

The first step in care was described as caring about. When people care about others, the involvement is mainly an awareness. Because relations of this kind do not have much substance, dependency does not play an important role. People who are in need can be called to be dependent on the others’ awareness to their needs. It certainly is possible to stimulate and cultivate certain feelings and raise awareness, but this clearly does not have to diminish autonomy. To raise awareness the attention of people should be directed at the needs of others. People may be influenced by certain pleads for help that are made to raise awareness, but they will be still in charge of their own decisions. Being influenced does not mean that someone's autonomy is in danger (Slote, 2007: 61).

In the second step concerning care, taking care of, people take responsibility to fulfill the needs of others by providing the resources for care. People in need are dependent on those resources, in a structural and economic way. In what ways could this endanger one's autonomy? To lack autonomy, that is to lack the moral capacity to make one's own decisions, one should experience the influence of another in such a way that one feels impelled 'to do or think *whatever* a person or institution tells you to do' (Slote, 2007: 61). Can the giving or receiving of resources result in something like this? I think this is very unlikely. The contact between the one who is in need and the one who gives resources is not direct. The care taker is not directly confronted with the needs of others, so it is relatively easy for the care taker to remain autonomous and spend no more resources than he or she wants. The one in need sees the resources that are given and is dependent on them. An agency can formulate rules to which others should apply as a condition to make use of the resources. Experiencing some external influence is not an infringement on autonomy, but the setting of conditions seems to be more serious than being just influenced. I think care takers can easily be inclined to focus on their own demands concerning the resources they have given than on the needs of others that should be met. However, condition setting is often executed in the context of care, makes care more effective, and is not bad in itself. When the conditions are, however, not focused on the best way to take or give care, they tend to have more to do with power abuse than taking care of the needs of others. So, when people who give resources are very much involved in the way their resources are spent, it is likely that they abuse their powerful position against the ones who are dependent on their resources.

The step of care giving shows a direct meeting of needs and an accompanying dependency in a structural, physical and psychological way. In the practice of care giving, the needs of the other are more central than in any other step of care. The needs of the other are guiding for the behavior the care giver has, and the care giver sets aside his needs. It is possible that the needs of the other become leading to such an extent that the care giver ignores his own needs so rigorously that he is not able to make decisions in his own interest (Fine and Glendinning, 2005: 614). In such a situation, the autonomy of the care giver is affected. Such a threat to autonomy is likely to occur to many care givers. Because care giving is mostly done by family and friends, who already have a natural bond with the care receiver, it is more likely that they will identify themselves too much with the well-being of the care receiver, than someone who has no such bond. The autonomy of the care receiver is also in danger in relation to the care giver. In the actual care receiving he is to a great extent dependent on the performance of the care giver. Making decisions yourself is quite hard in such a dependent situation.

§4.4: Guarding autonomy

The potential threat to autonomy in the relation of care giver and receiver is a serious problem. A threat to autonomy goes along with an inequality of power and possible power abuse. I have shown that autonomy in dependent relations was possible by interpreting it as decisional autonomy, focusing on being in charge of one’s life. However, this decisional autonomy can be threatened when power differences are abused. Reflecting on the role of autonomy in the different steps of care, I showed that the closer the relation between the two parties involved in care, the bigger the chance of power abuse. Power abuse has its origin in power difference and inequality of possibilities, but inequalities do not have to result in abuse. In my opinion there is one way to diminish the likelihood of power abuse in care relations. Care relations are characterized by inequalities in possibilities, but also in power. Therefore, these inequalities cannot be diminished prior to any care relation to diminish the possibility of power abuse, because when no inequalities exist, no dependency exists, and no care relation will be needed. Therefore, it is necessary that inequalities in possibilities and power are in such a way used that power abuse becomes less likely.

I think the best way to diminish power abuse is to look to power in another way. Both care giver and care receiver can be in the most powerful position and can abuse their power to the other. But when both care giver and receiver regard care as a relation and acknowledge that care is both giving and receiving, they may view their power in another way. Fine and Glendinning plead for perceiving power in care relations as ‘power to’ instead of ‘power over’. ‘Power to’ is focused on empowerment and not on domination (2005: 616). Domination suppresses others, but empowerment strengthens others. The power that people have in a care relation should be directed at the strengthening of the other. One who receives care has the power to impose his will on the one who gives care. Although the care receiver is in greater need than the giver, the care receiver should use his power to strengthen both himself and the care giver. The care receiver, for instance, can give the care giver enough space and possibilities to give good care, instead of commanding and directing every detail of care. The care giver on his part should also use his power to strengthen both himself and the care receiver, by giving the care receiver enough space to indicate his needs and wishes. This attitude resembles the virtues of care, which are mentioned in the previous chapter. The virtues of attentiveness, responsiveness and respect present in both care giver and receiver make it more likely that the interests and autonomy of giver and receiver are safeguarded. Attentiveness is centered on the attention that is paid to the needs of others, responsiveness on the fulfilling of those needs, and respect is concerned with valuing the other the same as you. These three values are directed at the needs of the other, and if both care giver and receiver pay attention to these needs, the power difference between two parties is not interpreted as the power to dominate the other, but to strengthen the other.

In this chapter we have dealt with the interplay between autonomy and dependency in the context of care. When in the next chapters the duties of citizens and the role of the state are discovered and discussed, it is necessary to keep in mind what is discussed in this chapter. In exploring the responsibilities and duties citizens have, it is important to keep an eye on the extent to which these duties are responsive to the mutual dependency as well as to the decisional autonomy of citizens.

5. Duties to care

Now we have focused on the micro level and are made aware of the possible threat to autonomy in dependency relations, in this chapter the consequences of these relations on citizenship and its duties are examined.

People have different roles in care relations, which all are defined by mutual dependency, but in different ways and for different periods in their lives. The role that is central in this thesis is the role of citizen. As citizens, they are dependent on the contributions of their fellow citizens to the state system and to civil society. As family or friends, they are dependent on the presence and physical care of fellow family members and friends. In this chapter the moral consequences of these different forms of dependency are discussed. I will argue that it is the duty of citizens to care for each other, and that this is based on the special relations citizens have. I will argue that this duty to care can be divided into two kinds of duty: a civil and a private one. At the end of this chapter several guidelines will be proposed to specify duties to care.

§5.1: From dependency to duty

To apply the concepts of mutual dependency and care to political theory, we can search for the moral consequences and obligations we can ascribe to these concepts. Because people will not care for everyone in their reach who is in need spontaneously, it is useful to search for a notion of responsibility in the context of care, to make sure that needs are fulfilled. In searching for a framework of duties and obligations, I categorize care consequentially not as a virtue. I have stated that care giving and receiving should be accompanied with virtues to be good care, with a smaller chance of power abuse, but this does not mean that care itself should be seen as a virtue. Instead, I categorized care primarily as a practice, and sometimes as a disposition as well. Care among people is something that should be done sometimes, and one of the many things we owe to each other. Therefore, I want to interpret care in such a way that somehow the responsibility to care is clear.

I want to defend that the fact that citizens are mutually dependent justifies a duty to care. The first step from dependency to duty is one of the central findings so far in this thesis, namely that each person is to some extent dependent on others for the meeting of his basic needs. Caring is an important way to answer to this dependency. We need each others' care to eliminate our dependency and make us as autonomous as possible. The core of dependency in care is that we cannot make ourselves independent of others and we cannot provide for all our basic needs on our own. All people need others, and I believe this is the first step in an account for a duty to care.

I believe it is appropriate to state that the dependency of others appeals to us morally, because we can recognize our own dependency in the dependency of others. I do not refer to the idea of empathy as moral guideline Slote is promoting, the idea that we should follow our feelings of empathy to define if we should care. A duty to care is not based on feelings, but on the fact that the dependency of others could be ours. We are involved in the care of others, because the dependency of the other could be our dependency, and by caring for others we acknowledge that others need care just the same as we need it. By staying aloof, you would give a statement that the lack of well-being and the needs of another can and will never be your own. You can, however, never be sure whether the misfortune of another will not become your own. Therefore, the needs and misfortune of others point us to our own needs. If we would not care, we would deny a part of reality of human life: our mutual dependency and need of care. Moreover, the fact that you are not in need at this moment, does not justify that you are not involved in the needs of others. No one has a choice in the extent to which he is dependent. Because no one has influence in the level of dependency, in my opinion no one has a right either to more independence or autonomy than someone else. No one therefore has a right to a higher level of well-being that accompanies a higher level of independence. It is therefore just if by the care of one with more well-being the well-being of another is raised.

§5.2: Duty to care

So far I have used the term ‘duty’ to refer to the moral requirement that is attached to the mutual dependency of citizens. This word I did not choose without a reason. I think it is better to interpret the moral requirement citizens have as duties than as obligations, because of an important difference between both concepts. A. John Simmons wrote an influential book on moral and political obligations and categorized obligations as moral only if they are the result of a voluntary act, while duties do not need that requirement (Simmons, 1979: 14). The relations of dependency all people find themselves in are not voluntarily chosen and people did not voluntarily choose to be each other’s fellow citizens. Especially in the context of care, the involuntariness of relations and positions is important, and to speak of obligations in this context would be inappropriate. Simmons categorizes duties as moral only if they are natural duties: moral requirements to all as humans, and not dependent on an institutional setting like a state (1979: 12-13). Positional duties, duties by virtue of holding a position or office, are only moral when voluntarily taken, according to Simmons (1979: 12). I do not want to stick to the dichotomy Simmons created for the morality of duties: either duties to all, involuntarily and not related to an institution, or duties to some, according to your position, but only when voluntarily taken. I believe both can go together, and therefore I want to define duties as moral requirements that arise in virtue of ethical principles and not of a performance of some voluntary act, and can be dependent on an institutional setting (Simmons, 1979: 12, 14; Rawls, 1971: 348; Honoré, 1981: 48).

A duty to care, then, means that it is an ethical principle that people care for each other, regardless of them being family, friends or strangers. The content of the duties to care however can differ with regard to the differences in relations and positions people have apart from a caring relation. In the next section I will explain why.

§5.3: Diversification of duties to care

The basis of our duties to care is our mutual dependency. I established that caring is a duty, because in caring for others we acknowledge that we are vulnerable to the same dependency. This is however a far too general statement, which only recognizes the interpretation of care as duty in general. Care as a duty can be divided into a civil and a private duty to care. I will explain on which basis this distinction can be made. When this is established, I can elaborate on the content of these duties.

The way I defined duties, as not necessarily dependent on an institutional setting, leaves indeterminate if I mean natural or special duties. Natural duties are duties that are not determined by the relation two parties have, but by the act itself. Natural duties apply to all people, who owe these duties to all other people. Independent of earlier actions, promises, or relations, natural duties between parties exist (Simmons, 1979: 12-13). Special duties, then, are dependent on the relation between the parties involved. Two parties have a certain relation, that other random people do not have, and this relation is the justification of a duty (Jeske, 2008: § 3). In the context of care in a state and connected to citizenship, duties to care are special duties. When in the next sections the justification and content of duties to care for citizens, as citizens and as family or friend, is discussed, the leading thought is that these duties are based on the relations these people have. Why especially those citizens should care for their fellow citizens, will not be based and justified by the intrinsic value of care, but by the relations those citizens have.

Special obligations are seen as obligations to some specific persons, and not to humans in general. The relation between the two parties involved is fundamental for the explanation and justification of the obligations that exist (Jeske, 2008: Introduction, §3). Special groups have special duties to each other, because of the specific relations they have. This thesis places care in the special context of citizenship. In this thesis we are not interested in duties to care in general, but in the role of care that should be present in the relations citizens have.

I want to argue that those special duties to care can be specified in a civil duty to care (the care we owe to others as citizens) and a private duty to care (the care we owe to others as family or friends). These two categories follow from the description of dependency and care relations in the third chapter. Special relations justify special duties, and the special and relevant relations that citizens have in the context of care are those with citizens in a welfare system and civil society, and those with family or friends. In the categorization of Simmons these special duties can be called positional duties. Both citizens and family or friends have a duty to fellow members because of the position they fulfill. They did not choose to be in such position, but this does not remove the morality of this position and the accompanying duty, as I made clear in the definition of duties I gave in section 5.2. By this specification of civil and private duties, I interpret the relation as a citizen and as a family member or friend as the most important in the context of care and as relevant to discuss in the context of state intervention and citizenship. Both private and public relations people have in the context of care are important for a determination of citizenship and the role of the state. Care namely takes place in both private as public relations, and people in a state are both citizen and family member or friend. Those different roles cannot be seen as completely separate. Not discussing private relations and accompanying duties, for example, would therefore not be appropriate, because what happens in the private sphere influences the public sphere and the other way around. What happens to you as citizen influences your private life, and what happens in your private life influences your civil life.

To interpret citizenship as fulfilling your duties to care, as I did in section 2.2, is interpreting it as social citizenship. In the next sections, it will become clear that this social citizenship is based on political citizenship, which creates civil duties to care, and on private relations, which create private duties to care.

§5.4: Civil duty to care

As citizens, people are dependent on other citizens for their contribution in civil society and in the welfare system. This dependency can be characterized by a dependency on resources, as I have made clear in section 3.3. In this section, I will discuss the justification of citizenship and accompanying duties. In this discussion, the relations with state and society are important. Attention will also be paid to a very important part of citizenship in the context of care: the responsibility to care for others. This has been addressed shortly in the second chapter, but will be discussed here more extensively.

As mentioned in the second chapter, citizens are members of a state and are in this way related to their fellow citizens. I will argue that citizenship in this political or formal sense has consequences for citizenship in the sense of social responsibility. The position of citizenship depends on the existence of a state. Without a state people cannot be called citizens. This state creates possibilities in the context of care, which cannot be created by another system or person. The state is an independent and disinterested party, because it does not have to receive care itself. Besides, it is a public and overarching institution, that has the capabilities to create a public and overarching system of care services and insurances. The political power of a state makes it possible to guarantee care, force or punish its citizens, establish a level of minimal guaranteed care and make a division in formal and informal care. Since all citizens want to receive care, but are not to the same extent willing to give care, it is necessary that an authoritative institution as the state guarantees that other citizens will meet your needs when it is necessary. As citizens of a state, each has equal rights and receives equal recognition. Caring is characterized by inequality and dependency, but as citizens this inequality disappears, because each has equal rights as a member of this collective body. To reach this equality the status of citizenship is necessary.

Only by being a member of a state, by being a citizen, guarantees and equality are possible. The relation towards the state and to fellow citizens can therefore be seen as a special relation, with accompanied special duties, in which the relation between the parties involved justifies the duties, as explained in the previous section. The state guarantees that other citizens will care for you, by giving resources, or by giving actual care. To maintain such a system and be guaranteed of such care, it is necessary that each citizen will behave as such an ‘other citizen’, and will care for his fellow citizens. A civil duty then means taking your social responsibility as a result of the benefits of your political citizenship.

An argument from another perspective, but with the same conclusion, is made by Tony Honoré, be it on a structural and legal level and not in the context of care. He argues that a citizen can never be independent from a state; no one can deny that he is a citizen, and no one can leave society (Honoré, 1981: 46). Citizens are somehow related and locked into the same system together, not because they chose to be, but because of necessity (1981: 61). Honoré uses the concept of necessity to explain how the relation between citizens is: people have needs, and because other people happen to be their fellow citizens, they are in a position to help those people in need. He compares such a relation with a family relationship, in which family members have duties to each other, without having consented to their relationship (1981: 51, 52).

Although Honoré’s reasoning does not relate to the context of care explicitly, it is useful for the civil duties to care we try to unravel. He states that we have a duty to all we share a system with. He relates this to the legal system in general, but I think it can be applied to the care system and everything related to care as well. It makes clear that we do not only have a duty to our family to care for them, but that we also have a relation and an accompanied duty with other citizens.

The areas in which citizens have to deal with their fellow citizens are the welfare system and civil society. In the third chapter we have seen that citizens are dependent on the resources of other citizens in the welfare system and in civil society. In these areas citizens meet each other, directly or indirectly. The scope of civil duty, then, is all fellow citizens, to the extent that they are in a care relation as citizens. This means that fellow citizens have a duty to care in the welfare system and in civil society, to the extent they are actively involved.

When a welfare system exists, every citizen of a state inevitably takes part in it. I have explained that the contribution of every citizen is needed to maintain such a system and guarantee care. The content of civil duty in both the welfare system and civil society can be determined by the extent to which other citizens are dependent on you. Because our duty to care is based on others’ dependency on us, the extent to which we have this duty is based on the extent to which others are dependent on us. Dependency is a matter of degree, so the duty to answer to this dependency, by caring, is also a matter of degree. The key to determine this degree is the degree to which others are dependent on us. The content of a civil duty in the welfare system therefore is determined by the dependency other citizens have on your contributions to the welfare system.

In civil society, the public sphere between state and market, citizens associate voluntarily, in for example sport clubs, churches, libraries or community centers. Many of these associations are not involved in caring directly. Their reason of foundation was not to care for each other. But other associations in civil society are founded exactly with that purpose. I want to argue that these associations that exist because of fulfilling basic needs of each other and caring for each other, have a role in the fulfillment of a civil duty to care.

In associations that have the primary goal of care and meeting of basic needs, relations are created that resemble the kind of relations in which ‘taking care’ takes place. Associations like churches, community centers, charities and interest groups coordinate care or resources for care, as an addition to direct care that is given by family and the general structure of a welfare system. The content of a civil duty in civil society is also determined by the extent to which other citizens are dependent on your activities in civil society. A civil duty in these associations, then, means a duty to take care of citizens who are in contact with these associations, to the extent that they are dependent on resources and coordination of these associations. For example, a community center has the purpose of social integration and participation of members of one neighborhood. When those members need that community center to break through their social isolation, this center, or the citizens involved, has a duty to provide the services that are necessary for the fulfillment of these needs.

Nevertheless, such associations are voluntary, and it seems that the existence of a duty depends on your own activity in civil society. If you are not actively involved in associations that are connected to care, you will not create relations by which other may become dependent on you or your association, so you will not have any civil duties to care, apart from a duty to contribute to the welfare system. As long as a citizen does not have any dependency relations, it is unlikely that others become dependent on that citizen, so he will have no civil duty to care. When you are, for instance, actively involved in the neighborhood, you will get involved with your neighbors. When they become dependent on you, as a result of your activity in the neighborhood, caring for your neighbors will become your civil duty. Or maybe you will become friends with your neighbors, and then your duty to care is a private one, as we will see in the next section. When none of these relations, civil or private, exist, I believe it is fair to state that you do not have a special duty to care for your neighbors.

§5.5: Private duty to care

We have seen that most of the time people are confronted with the immediate needs of others in personal and direct relations. People are dependent on the presence of others, who accept them as they are and who give care when they need to be cared for. Care given by people who are close to you is more efficient and effective than when it is given by other people. This can be explained, at least partly, by the virtues that should accompany care giving, as the direct meeting of needs. Attentiveness, responsiveness, and respect are probably present to a greater extent in relations of family of friends than in relations with people who are not related aside from the care relation. In families and friendships, people interact with and relate to each other in a way, with the virtues of care, which will not be found in other relations to the same degree. In no other relations than between family members and friends, unconditional attention, care or love is given. People need such unconditional relations, when the level of dependency and autonomy is changing, as MacIntyre explained. As explained, special duties are based on the special relation people have. These special relations within families and friendships are the justification of the private duty to care. Only in intimate relations care can and will be accompanied by the virtues of care. The content of a private duty to care is, as a civil duty to care, based on the degree to which others are dependent on the ones who can give care. People depend on the presence and physical care of family or friends, and this should be guiding in the content and realization of a private duty to care.

It may sound short-sighted to state that all who have a close relation with dependent others have a duty to care for them. There are however exceptions, which I will discuss in a moment. But beside those exceptions I believe it is fair to state that those who are in the best position to provide for the basic needs of others should have the responsibility to care. Some people are simply more dependent on us than on others, just as we ourselves are more dependent on some than on others. We can recognize ourselves in the need and dependency of others. We can relate to them, and this is even more easily done when we know the person in need also apart from those needs. Thomas Aquinas argued for the virtue of *misericordia*, ‘the grief or sorrow over someone else’s distress’ and he thought this virtue was easier to achieve when there is some pre-existing tie (MacIntyre, 1999: 125).

However, the care giving can be too demanding for a family member or friend. The tasks can be too demanding, because the needs cannot be met by a non-professional, or are very burdensome for a relative, or the relation between family members is disturbed, so the giving and receiving of care is not accepted. Are friends and family in such situations released from their duty, or are they allowed to take care instead of give care? In the next section I will elaborate on three guidelines that can help in determining the boundaries of care.

§5.6: Guidelines for duties to care

After elaborating on the character of duties to care, several difficulties have become apparent. With the diversification in civil and private duties, it is still not clear how far-reaching duties to care are, what their boundaries are, and whether a duty to care can be assigned. In this section of the chapter I will give a few guidelines for duties to care to answer those questions. The guidelines follow directly from the findings in this and earlier chapters.

The first guideline results from the search for a co-existence of autonomy and dependency in the fourth chapter. The inevitable dependency of every citizen can leave room for autonomy in care, when we interpret autonomy not as self-sufficiency but as the moral capacity to make one’s own decisions. This decisional autonomy is most likely to be endangered in personal and direct care relations. When the care for someone else would result in such a threat to autonomy that one cannot make one’s own decisions anymore, because of too demanding tasks, power abuse or a lack of personal freedom, this amount of care is clearly beyond one’s duty. In the context of this topic many scholars stress that one should first of all care for oneself, because everyone knows how to care for oneself better than anyone else (e.g. Slote, 2007: 62). If one does not care for oneself, someone else has to do it, and in this way more need for care giving is created. But the autonomy of the care receiver can also be endangered, and when this is the case, such care clearly is beyond the duty to give care, but also beyond the duty to receive care. A care receiver then can refuse the care that is given to him when it limits his decisional autonomy. Therefore, when the autonomy of care giver or receiver is endangered, as a result of the care given or received, the task of care giving can be assigned to someone else, or the care given or received should be adjusted.

This first guideline points to a second one: whether one should care for another is not justified by strict reciprocity, emotions or affections, but by the general human trait of dependency and grounded on the dependency of others on you. MacIntyre argues that justification by strict reciprocity is not needed and not possible, because we do not know how much care we received, and most of the times we are not able to give care to the ones who gave care to us. We received unconditional care and that is what we owe to others (MacIntyre, 1999: 100). A lack of affective motivation to care for others is not a reason in itself to abstain from caring for others. Such a lack can however be the result of disturbed relations between family members or friends. Past experiences with non-caring parents or friends can sometimes be so negative that it seems very harsh to demand care for those parents or past friends. Is there still a duty to care in those disturbed relations? Remember that the special duty to care for family and friends resulted from the personal and direct relations they have, which made care giving and receiving in those relations more suitable than in other relations. Because of pre-existing ties, family and friends were the best parties to be assigned with care giving and receiving. In disturbed relations in families or with past friends, those ties have existed, but do not have any meaning anymore. The ties that made it plausible that virtues of attentiveness, responsiveness and respect were present, do not exist anymore in disturbed relations. Relations with past friends or family members who you do not recognize as family are not different from relations with other citizens. Therefore, in relations in which family of friendship ties do not mean anything, no special private duty to care exists.

The third guideline I want to propose is the principle of subsidiarity. It has been shown that the direct meeting of needs is done best in personal relations, and taking care and caring about can be done in more indirect relations. The principle of subsidiarity is closely connected to the vision on state intervention I proposed in the second chapter. In the context of care, individuals as citizens have the primary and most important role, and therefore care will be arranged first of all at the micro level. The duty to care therefore can be guided by the principle that care should be given on the lowest level and the smallest scale, where the care givers are closest to the care receivers. When the needs cannot be met on the lowest level, it should be taken over by the second lowest level. Care on the family or friend level can be taken over by care on the level of civil society. What cannot be done on the level of civil society should be coordinated and taken care of by the welfare system, the state, market and/or professionals.

With these guidelines, some principles by which duties to care should be directed are outlined. Are these guidelines however absolute and strict or can duties to care be assigned to others without the reasons mentioned in the guidelines? An obvious example of transferred duties is the adult child whose parents live in a home for the elderly or a nursing home, while their needs are such that care could be given by that child. The moral guidelines and principles for duties that have been displayed in this chapter are directed at guaranteeing care in the best way. When each citizen and family member fulfills his duty to care, caring is guaranteed and is done in a good way. Whether duties can be transferred, then depends on whether care is guaranteed more and is done in a better way than when they are not transferred. When duties are transferred, caring is done on a higher level than strict necessary: instead of, for example, private care within a family, care is given at the level of civil society. The negative sides of such a transfer are a smaller likelihood that virtues of care are present and that care givers feel less responsible. If care by civil society can overcome those disadvantages by benefits, it would be morally right to transfer duties. But I think in practice benefits hardly ever outweigh the disadvantages of transferred care, because the benefits of receiving care from the ones who you love and who love you cannot easily be overrated.

6. The role of the state in realizing duties

So far, the general directions for citizenship and its duties are explored and argued for. In focusing on the micro level, it became clear that people have dependency relations as citizens and as private persons and these relations are the basis for civil and private duties to care. The content of these special duties is based on the extent of the dependency of citizens and family and friends. The state, in the context of care, thus expects from its citizens to fulfill their duties to care, as citizens and as family members and friends. This focus on individuals and the expectation from the state to individual citizens is based on the vision of state intervention I made clear in the second chapter: the state should not primarily be focused on the right to care it should secure, but on the duties its citizens have to care for each other. In this chapter I will justify more extensively than in the second chapter why this primacy of the micro level, citizens and its duties, is appropriate in the context of care. When this is clarified, it will be possible to elaborate on what role is left for the state and the desired level of state intervention in civil society and the private sphere. In the last section of this chapter, I will propose four ways for the state to realize the duties to care.

§6.1: Primacy of individual citizens

What has become clear from the previous chapters is that care has a place in the lives of every individual: citizen, family member, and friend. All people are dependent and need others to fulfill their basic needs. Everyone is affected by dependency, needs, and care. Care is therefore not just a service from the state to its citizens, but something that is ‘done’ (given, received, coordinated) by everyone. Care has an important place in everyone’s lives, and cannot be reduced to a right that everyone has and a service that the state should provide. Care is far more comprehensive than that: it is every practice in which the basic needs and well-being of others is central, as I explained in section 3.1. The actual meeting of needs can only happen between two individuals, and not between two institutions, or between an institution and an individual. Therefore, care is primarily the business of individuals. In the context of the state, the scope of this thesis, these individuals are classified as citizens. Those citizens however are beside citizen also family member and friend, and because also, and precisely, in those contexts care takes place, this classification was not ignored in this thesis.

The actual meeting of needs can only happen between individuals. This shows that it is not at all self-evident that the state intervenes in caring. Such a prominent and obvious role is assumed in the model of state intervention in which the right on care is emphasized. But this would be a wrong assumption, because the most basic, direct, and practical part of caring, the meeting of needs, cannot be fulfilled by the state, as institution. The state as institution is not able to care from person to person. Of course the state can facilitate, coordinate, stimulate, or force the practice of caring, but care giving and receiving has to be left to individuals. Those individuals, citizens and family, then, have to reflect on what their part should be in the practice of care. In the previous chapters we have seen that, based on the special relations of citizens and family members and friends, and the general human trait of dependency, those individuals have a duty to care for others, to the extent that others are dependent on them.

§6.2: Role of the state

What, then, is left for the state to do when citizens have the primacy in caring? If the special duties of citizenship and family ties are leading for the activities of care, what role is left for the state? Is the state then even allowed to intervene in the private sphere and civil society? In the second chapter I made a first move in the exploration of the role of the state, but in this section I will elaborate more on this subject. In section 5.6 it was made clear that duties to care are limited by the possibilities and histories of people. A threat to autonomy and disturbed family relations make that people cannot fulfill their duties completely. When duties of citizens fall short to meet the needs of others completely, the state can use its authority and capacities to add what is needed. The role of the state should not primarily be guided by the right citizens have to be cared for, but by what citizens did and did not do to their fellow citizens.

What became clear from the discussion of civil duties in section 5.4, was that the special character of the state in the context of care was that it could guarantee that every citizen would be cared for. This guaranteeing role of the state underlines that the right to care exists, and should not be denied when the focus of the state is on the duties citizens have. In this thesis, I assume that such right to care exists for everyone.

To guarantee care the state can use different strategies, dependent on the origin of a shortage of care. Before I will elaborate on those strategies, it has to made clear why the state is allowed to interfere in civil society and in the private sphere.

I have made a distinction between civil duties and private duties, based on the difference in relations citizens and family and friends have. Civil duties are duties owed to other citizens, in a welfare system and in civil society, and private duties are duties owed to family and friends in the private sphere. That the state is allowed to interfere in civil society is relatively easy to defend: because of the guarantees of care the state can give to its citizens, citizens have a duty to cooperate to create such a guarantee. As members of the state, which creates benefits in the context of care, citizens are active in civil society. Both in a welfare system and in civil society the practice of care has a place and is guaranteed. The state, as the party that makes this possible, therefore has the right to intervene in civil society and the welfare system. That the state is allowed to interfere in the private sphere may be harder to defend. Private duties are not based on special relations between the state and family members, but between family members or friends among themselves. The state seems to have no part in these relations. What right then would the state have to intervene in the private sphere?

Not without reason I have given attention to both civil duties and private duties, in the context of citizenship and expectations the state may have from its citizens. Both areas are involved in care and in both areas the state has some role. The difference between citizens and family members or friends I made does not mean that those are completely separate roles, as already mentioned in section 5.3. A person is both citizen and family member, and the role the state has in your life as citizen cannot easily be separated from your life as family member, because it affects your life as caring family member. The state, for example, decides what should be seen and coordinated as formal care and what should be seen as informal care. Such a decision influences people both as citizens and as family members. Moreover, the amount of care you give as a family member affects what civil society and the state have to add to meet the needs of your family. Therefore, the state has the right to ask from people to fulfill their duties, both as citizen and as family member or friend. The primacy of caring still lays with individuals, but the state is allowed to act as supplement to make sure everyone is cared for properly.

§6.3: Supplementing civil and private duties

There are several reasons why civil and private duties to care need a supplement from the state. As mentioned in the previous section, the main guideline for the role of the state is to assure proper care for all its citizens. Combined with the chosen vision on state intervention, it is possible to distinguish three strategies for the state to supplement civil and private duties.

The first reason why citizens need input from the state is that citizens may not be aware of their duties. Just the same as people may not be aware of other's needs, as explained in chapter three, citizens may not be aware that their position as family member, friend or citizen creates duties. This may especially be the case when previously the state has focused on the rights on care citizens have. Therefore, the state can make its citizens aware of their duties by asking them what they are and if they want to fulfill them. The first and fourth proposal of the next section connects with this strategy.

The second reason the state may be needed is that the possibilities and capabilities of citizens and family members fall short to fulfill their duties or fall short to give all the care the others needs. Inability to provide all the needs of others may have many different reasons and may happen a lot. One of the reasons it may be more difficult these days to fulfill duties to care than in the past is the development of the fragmentation of traditionally close and connected unities (De Boer, 2007: 14, 15). People live at greater distances from their family or friends. Is this not a sign that caring relations based on family or friendship are not practical in these days? I believe however that this is a limited observation. Modern technologies enable families or friends to live farther away than 'next door' and still be in close contact and of help to each other. This also applies to care: not all care has to be done when you are face to face (think of keeping in touch with medical professionals) and nowadays distances are faster covered than ever before. But these distances nevertheless result in more difficulties to care properly than when people live close by. This either results in a more likely threat to decisional autonomy, or in the neglect of one's duty and therefore an earlier address to civil society and the state to care. When certain distances need to be covered before direct care can be given, care giving is more demanding, in time and resources, than when the one in need lives next door. It is therefore more likely to happen that care givers become overloaded. People also can withdraw beforehand from their assigned task, because they see the heavy duty they have to fulfill. So, more than ideally would be the case, other citizens, as citizens, are addressed to step in where families or friends are not meeting the needs of others completely, for whatever reasons. Fortunately, the care people receive is not completely dependent on the capabilities citizens have by themselves. The state can enlarge their capabilities or add to citizens' capabilities its own. The state can take care of the needs of citizens who are not cared for properly. By giving resources, coordinating care, command care professionals or otherwise, the state gives citizens more capabilities to give care. The state cannot give care directly by itself, but it can take care, as the second step in care I distinguished in the third chapter. In this way an emphasis on duties to care does not undermine the right to care people still have. If care would be completely dependent on the fulfillment of duties and would not be guaranteed by a system of laws and rights, the right to care would be in danger (Dwyer, 1998: 495). However, a stress on duties of citizens is not a way of shifting away responsibility or making care dependent or conditional on the effort of citizens. It is instead an attempt to make care for others a norm. When family, friends or fellow citizens do not or cannot fulfill those duties, there always should be the certainty that the state will interfere (MacIntyre, 1999: 142). Besides, when people have a duty to care, this logically corresponds with rights to care (Simmons, 1979: 15). All the duties that are assigned to people mean that others have rights to receive care from them. In this way, then, it is even plausible to state that an emphasis on duties means that the rights to care are emphasized at the same time. Those state resources, however, should be contributed by citizens themselves, as a part of their citizenship, as we have seen in section 5.4.

A third reason citizens may not fulfill their duties is because they do not want to do so. A lack of motivation may result in a neglect of one's duties and a necessary role for the state to guarantee that care is still given. In section 3.4 I already discussed the subject of motivation and in section 5.6 I mentioned that the fulfillment of duties is not based on feelings. A motivation to fulfill civil duties to care, which are mainly taking care, as mentioned in section 5.4, can be based on knowing your responsibility, instead of feeling it. However, while knowing your responsibility, it may not be very easy to fulfill your civil duties. To stimulate citizens to care in civil society the state can subsidize certain associations. When many citizens voluntarily contribute to civil society, the understanding and involvement of citizens in the compulsory contributions to care will increase (Meijs, 2012: 73, 74). When people are given the possibility to make their own decisions in where and when their resources are necessary, people will be more involved in issues of solidarity and neediness. The value of solidarity will, according to Meijs, be better understood and therefore a better dialogue on the subject of forced solidarity between politicians and citizens can take place (2012: 74).

A motivation to fulfill private duties, however, should be based on the virtues of care, as mentioned primarily in section 3.4. Those virtues are indispensible for a long-term giving and receiving of care. When someone is commanded to give care without the virtues present, this caring relation will not last long. The virtues of care may be get caught up by the high demands of both work and care. When a citizen is charged with care giving, he is probably not able to work as much as he used to do. This means a diminishing of personal income and tax contribution to the government. Care can however be expensive, whether arranged by family or by state. When citizens are urged to work as much as they can to contribute to society with their labor, while at the same time their duty to care is stressed, they likely will become overloaded and their motivation to care will be endangered. To strengthen their motivation, the state can help its citizens by compensating their care, or periods of care increase and work decrease should be incorporated more naturally in work contracts (De Boer, 2007: 143-148; Van Doorne-Huiskes et al., 2008: 43, 44, 50). This strategy is resembled in the third proposal in the next section.

All these strategies for the state are characterized by stimulating and supporting citizens to fulfill their duties, and not by enforcing them. The state should force its citizens as minimal as possible, and instead stimulate them to fulfill their duties, to keep the primacy of care with its citizens and their duties. When the state would force its citizens to fulfill their duties very often, one can wonder how much of the primacy of citizens is left. I believe that in the context of care the state is only allowed to force people to fulfill their civil duty of contributing to the welfare system. Citizens are inevitably part of a welfare system, when one exists, and their duty is based on the guarantee of care the state can and is allowed to give. The content of the civil duty in civil society depends on the voluntary contribution of citizens to it, as argued in section 5.4. The character of civil society is one of voluntariness, so the state is not allowed to force people to be active in civil society. Enforcement in private duties to care is also not allowed, because those duties should be accompanied by the virtues of care. When those duties are present, no enforcement is needed. Only support or stimulating measures then can make family and friends fulfill their duties completely, when they for some reason will not do so. When those duties are absent, enforcement from the state will not create them. The best thing the state can do in these situations is stimulate and convince that it is good to care for family members or friends.

§6.4: Four proposals to realize duties

The best role of the state in guaranteeing that the duties to care are fulfilled is a stimulating and supportive one. My elaboration on the different duties to care points to a division of duties in which the emphasis of caring, the direct meeting of needs, is put in the private sphere. So, thinking of implementation of this diversification of duties, the emphasis should lay on making the private sphere suitable for the giving and receiving of care. I would like to propose four ways to implement these different duties to care, which emphasize the implementation of the private duty to care.

The first proposal focuses on a general internalization of the practice of care in society, by a cultivation of a norm to care. In a society in which care is normalized, societal arrangements are in such a way realized that mutual care between relatives, friends and citizens is possible when needed. Family and friends would benefit from a society that has incorporated the fact that all citizens are dependent on each other and that care is an answer to this dependency. One step in the direction of a norm to care is the weakening of divisions between commercial, public and private spheres (Tronto, 1993: 165, 166). Care is first and foremost given and received in the private sphere, and should be of importance for what is done in commercial and public spheres. The fact that care is a highly private activity does not mean that it should not influence other spheres. We have seen that duties to care are especially situated in families and among friends, and these duties should influence how civil society and business is organized. Another step is to integrate the norm to care in education programs. A change in mindset of an entire society may start with the ideas and convictions children have and are educated in. When it is taught that dependency and care are a normal and integral part of one’s life, it may be more natural to incorporate care giving and receiving in one’s life.

A second proposal is to listen to care givers and receivers, to be aware of and attentive to their experiences and problems concerning private care. The care that is given by family and friends is called informal care, in contrast with formal care, which is care performed by professionals. Canadian research concludes that where formal and informal care co-exist, formal care complements informal care when the informal network cannot provide enough care (Chappell and Blandford, 1991: 314). Other research shows that in the Netherlands formal care is to a large extent dependent on informal care (Van Doorne-Huiskes et al., 2008: 28). From those two researches it becomes clear that formal care cannot do without informal care networks. Much of care tasks are executed by family and the formal care system only can exists when much of the care tasks remain to be executed by family. Furthermore, three-quarters of health care in the Netherlands is given by family or friends and 30 percent of the Dutch population comes into contact with structural family care. Many people therefore have experiences with care for family or friends, and undoubtedly have ideas of how they can be supported in the best ways. Acknowledging the importance of personal and private experiences and developments is in line with the principle of subsidiarity. In this way subsidiarity is not some useful guideline how to arrange complex systems and roles, but a principle based on human dignity. Human capacity is such that humans are ‘fellow architects’ of society (Borgman, 2013: 110). By listening to their experiences and ideas, they are seen in their full capacities. Especially people who receive care are easily seen as less capable than others, but using their experiences shows that this is not true, at least in this context. Listening to care givers and receivers can take place in visits to a general practitioner or a social worker, or local governments can create platforms in which ideas from care givers and receivers are expressed. Those ideas can be taken into account in new local policy or initiatives.

A third proposal is the adaptation of work arrangements to private care. The principles of care and work should be made less conflicting to make family and friends, but also citizens, willing to fulfill their duties to care. When people are willing to care for their loved ones, but are not able, because the burdens are too heavy, arrangements should be made to enable people to fulfill their duties. Besides, when burdens to care are less heavy, people who at first neglected their duty, can be compelled to fulfill their duty. One could think of more flexible work arrangements, in which employers work part time for a limited period (Van Doorne-Huiskes et al., 2008: 43, 44, 50). In this way care giving is easier for both men and women.

The fourth proposal I would like to make is based on the idea of family group conferencing, and originated in New Zealand (Chandler and Giovannucci, 2004: 218).

Guiding for family group conferencing is that the social network of the one in need is involved in solving problems and fulfilling needs. In one or a few meetings, the social network and the one in need meet and discuss in what ways each can contribute to the fulfillment of needs. Both the one in need and the persons in his network then share responsibility for solutions. At the end of the group conference, a plan is written that outlines the tasks and responsibilities of every person involved (2004: 19). This way of discussing problems with family and friends and taking responsibility for solutions can be applied to every person who has complex needs and is dependent from others to fulfill those needs.

7. Conclusion: What do I care?

The quote of Catherine of Siena at the beginning of this thesis shows a careful observation of this Roman-Catholic medieval philosopher and theologian, namely that people need each other and have to take care of each other. Whether this situation is brought about by divine providence, as she interprets it, or is the grievous result of human's limitations, or exists without particular reason, it is an observation that is central in this thesis. In the search for citizenship and the role of the state in the context of care, it became clear that citizens should fulfill their duties, which are determined by the extent that others are dependent on them. In this conclusion I will collect and summarize my findings of relations between citizens, care, dependency and the role of the state. This will answer the central question of this thesis.

In this thesis, I have focused on the relations and duties of citizens in the context of care, and not on a macro level, because care is a practice that affects everyone and happens primarily between individuals. The role of the state in the context of care is therefore determined by the relations citizens have and the duties they fulfill. People are dependent on others in different ways, to different extents and in different periods, but the situation they all have in common, is their mutual dependency in the context of care. Care has different aspects and can be divided in caring about, taking care of, giving care and receiving care. Those different steps of care take place in the context of dependency relations that differ in closeness and directness. Giving and receiving of care has to happen in direct relations. In those direct and personal relations, virtues of attentiveness, responsiveness, and respect are present to genuinely and directly meet the needs of others. People in such relations are dependent on the practical physical care and the presence of each other. Caring about and taking care is possible without such close ties, and virtues of care are not necessary to provide these forms of care properly. People in relations characterized by a caring about are dependent on others' awareness of their needs. When people take care, others primarily are dependent on their resources to care. When people care about others, they are aware of the needs of those others, and people in need are dependent on this awareness, to be reached by others who can help them.

To care for others is an answer to and way to deal with dependency. The inevitability of mutual dependency seems to question the possibility to become autonomous. The interpretation of autonomy as independency and self-sufficiency is indeed contradicting the feature of dependency. When autonomy is interpreted as a more relational concept, and as decisional autonomy, instead of executional autonomy, it can still be seen as a goal of care. To acknowledge that people will remain dependent makes all parties involved in caring vulnerable. The more parties in a caring relation differ in their dependency on the other, the more vulnerable they may be to an infringement on autonomy and abuse of power. The more direct care relations are, and the more needs are directly met, the more likely it is that the autonomy of one of the parties is endangered. It is the responsibility of both care giver and receiver to strengthen both parties instead of dominate the other. The virtues of care are necessary to accomplish this.

People are not able to withdraw from these relations of mutual dependency. Everyone is inevitably dependent, and in the dependency of the other we can see our own dependency reflected. Because the dependency of others could be our own we are involved in each others' dependency. People did not agree to be dependent on each other, and they did not choose to be more dependent on some than on others. Therefore, it is right to erase the differences in dependency as much as possible and make others more autonomous. The concept of duty reflects the moral responsibility people have in situations to which they did not consent. In a state, citizens have the moral responsibility to care for others, because they find themselves in relations with fellow citizens and family members or friends which create benefits in the context of care which outside those relations cannot exist. Citizens have a special relation with their fellow citizens, because their political citizenship gives benefits and guarantees care, which would not be possible without such a citizenship. The benefits of this political citizenship influences the social responsibility citizens have in the welfare system and in civil society. This civil duty is characterized by taking care of other citizens, by giving resources or coordinate care to the extent that others are dependent on you. The relations between family members and friends are also important in the context of care. The private duty to care is directed at those personal relations in which people are to a great extent dependent on others and needs are directly met. The fact that some people are closer and more dependent on us than others creates a diversification in the duty to care and gives a special duty to people who we know and love.

Guidelines that can direct the duty to care and draw boundaries are securing autonomy for all parties involved, basing care on dependency of others and not on affections, and the principle of subsidiarity. This means that not the mere fact that people are family is enough to create a duty to care. It is primarily the closeness and the pre-existing ties that make people in the private sphere most dependent on each other. Therefore this sphere is most suitable for care giving and receiving. When, however, a family relation is disturbed and the virtues of care are not present, the special duty to care ceases to exist.

The role of the state in the context of care should primarily be characterized by ensuring that citizens fulfill their duties and supplement its citizens to guarantee that care is given to all who need it. To create such guarantee the state is allowed to intervene in both civil society and the private sphere by stimulating and supporting its citizens. Besides, the state is allowed to force its citizens to contribute to the welfare system. Forcing citizens to fulfill their civil duty in civil society and their private duty is not allowed. Instead, the state should make its citizens aware of their duties and stimulate them to fulfill them.

To enable especially family and friends, on whom the first and most direct duty is laid, to fulfill that duty, several things can be done. The cultivation of a norm to care that influences society can help family and friends to incorporate care better in their lives. Listening to the actual care giver and receiver for input in public policy, and adapting work arrangements to care are other innovations that facilitate a private duty to care. On the level of one person who needs care a group conference can be held to distribute different duties to care in one social network.

The research question of this thesis, ‘what should the state expect from citizens and what should be the role of the state in the context of care?’ can be answered quite clearly. The state should expect from its citizens that they give substance to their social citizenship, which is the fulfillment of their duties to care, which consist of civil and private duties. Because of the special relations citizens have with their fellow citizens, and the special relations family members and friends have with each other, citizens have a special, positional, duty to care for others. The content of these duties depends on the dependence of others on them, whether they are fellow citizens or family members or friends. The role of the state, then, is characterized by guaranteeing that the needs of citizens are met, by intervening in civil society and the private sphere in a supporting and stimulating way.

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