

# Journal of Sociology

<http://jos.sagepub.com>

---

## **Individualization, risk and the body: Sociology and care**

Michael Fine

*Journal of Sociology* 2005; 41; 247

DOI: 10.1177/1440783305057077

The online version of this article can be found at:  
<http://jos.sagepub.com/cgi/content/abstract/41/3/247>

---

Published by:

 SAGE Publications

<http://www.sagepublications.com>

On behalf of:



[The Australian Sociological Association](#)

**Additional services and information for *Journal of Sociology* can be found at:**

**Email Alerts:** <http://jos.sagepub.com/cgi/alerts>

**Subscriptions:** <http://jos.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.com/journalsPermissions.nav>

**Citations** (this article cites 25 articles hosted on the SAGE Journals Online and HighWire Press platforms):  
<http://jos.sagepub.com/cgi/content/refs/41/3/247>

# Individualization, risk and the body



## Sociology and care

---

**Michael Fine**

*Department of Sociology, Macquarie University*

### **Abstract**

No longer hidden in the home as a private problem, care and the human services are increasingly important public concerns in advanced societies. Care is also emerging as a significant field of social theory and enquiry with considerable importance for the field of sociology. However, it remains a specialist topic rather than a central concern of the discipline. This article considers these developments and discusses the significance that recognizing the central place of care in social life might have for sociology. To understand what contemporary sociology might offer the study of care, in turn, I draw on the work of a number of leading contemporary theorists to identify four themes that have particular significance for the study of care: the body; individualization; risk; and the new organizational logics. The potential application of these four themes to the study of care is identified and a number of contemporary developments and future options considered.

**Keywords:** the body, care, human services, individualization, risk, social policy, work

### **The emerging sociology of care**

Although the notion of 'care' has a long history in Western philosophy and culture (Reich, 1995) the social phenomenon of care has only recently begun to receive the serious attention it deserves from social researchers. This neglect appears to be the result of care being understood primarily as a family responsibility, the tasks routinely falling to women for whom it was seen as a natural, taken-for-granted behaviour (Graham, 1983). Care seems to have been subsumed under the general topic of social support,

---

*Journal of Sociology* © 2005 The Australian Sociological Association, Volume 41(3): 247-266  
DOI:10.1177/1440783305057077 www.sagepublications.com

with the personal devotion and duty involved being implicitly attributed to gender, operating through the primacy of kinship and marriage. Under these conditions, the fundamental importance of care for social life was easily ignored. But in the latter part of the 20th century care was brought into the public domain as the cumulative effect of a series of fundamental changes reached a point where the availability and provision of care became an ever more contentious aspect of modern life. I argue in this article that the move of care from what C. Wright Mills termed a 'private concern' to 'a public issue' (Mills, 1959), has significance for social theory just as it does for social life.

The rise in care as a public issue seems to be the inevitable result of historic processes of social and cultural change. Foremost is the rise of feminism and the associated social and economic changes, of which the large-scale entry of married women into the paid workforce and the changing domestic forms of late modernity are perhaps the most significant. Demographic developments, especially population ageing and the decline in fertility, as well as a variety of medical and bio-technological developments, have served to accentuate the attention given to care, raising political, financial and ethical issues and dilemmas that seem to reach into every corner of modern life. These changes are not simply questions of perception or cultural meaning. The provision and availability of care has become a practical problem as existing responses prove inadequate or unsustainable and new solutions are sought. Whatever the underlying cause might be, demand for formal care in recent years has been increasing just as the sources of supply of unpaid care at home have been most under pressure.

As concerns about what is commonly termed the 'work-life' or 'work-care' balance suggest (Hakim, 2000, 2001; Pocock, 2003; Watson, 2003), recognition of the significance of care is vital, not just for understanding women's lives but for social life in its entirety, and has the potential to be the most telling of all public issues in the 21st century. This is heightened by the impact and anxiety surrounding developments in medicine and bio-technology, by the effects of demographic changes such as population ageing and fertility decline, and by changing patterns of social policy that are continually redefining the boundary between personal and social responsibility. Care is no longer simply a question of private household preferences. It has become instead an arena for social conflict, both implicit and explicit, marking out important new social divisions and underlying tensions.

Until the mid-20th century, formal and informal forms of care were relatively clearly separated. For example, informal care, provided at home, was quite distinct from the formal care provided in institutions. Families relinquished their claims to provide care only when they were no longer able to manage, and institutional care took over. In this form of care family members had no real place and their involvement was discouraged.

De-institutionalization, the new technologies of care and the emergence of community care approaches have broken down these divisions, with the result that formal and informal have gone from being alternatives (either/or) to partnerships, hybrids, new forms of mixed care.

Developments in the patterns of the delivery of care have been accompanied by renewed interest in the meaning and importance of care (Chamberlayne and King, 2000; Daly, 2002; Daly and Lewis, 2000; Feder and Kittay, 2002; Tronto, 1993). Seen in this new light, care is increasingly understood as a topic of such fundamental social importance that its neglect or marginalization within sociology and related disciplines can no longer be defended. The concept of care also provides a perspective that cuts across a number of topics and levels of analysis, linking micro interactions and macro structures, drawing together formal and informal aspects of social relations rather than treating them as distinct, specialized topics. Commenting on the analytic problems arising from state- and policy-focused studies of social welfare, for example, Chamberlayne and King elaborate:

Caring offers a doorway to the study of informal systems of welfare, to the extending of comparative social policy to that level, and to the transcending of the welfare regime approach. (2000: 8)

Yet despite the potential that such a care-based perspective offers, there is still little in the way of a sociological literature that sheds light on either pre-existent practices or the transformation of care and its social importance. Meanwhile, in the face of the new demands made upon them, health and social care services are portrayed as being in almost constant crisis in virtually every advanced society. The result is an ongoing and unsettling process of political crisis management at the local, regional/state/provincial and national levels.

While there has been a strong interest in care from feminists and others writing from a sociological perspective (see, for example Abrams, 1989; Arber and Gilbert, 1989; Daly and Lewis, 2000; Freidson, 1970; Hochschild, 1983; James, 1992; Thomas, 1993; Waerness, 1987) none of the major contemporary theorists in sociology identifies care as a core topic. Since it is impossible to imagine a social world without care, this must be regarded as serious shortcoming and distortion of their approaches. Yet, as demonstrated by Selma Sevenhuijsen's recent rejoinder to Giddens's (1998) political analysis in *The Third Way*, it is possible to identify elements in the general approach that resonate with the theme of care and in turn, to show that addressing the theme of care will enhance the possibilities of the social analysis advanced (Sevenhuijsen, 2000).

Sociological interest in care must manifest an interest in the larger processes of social change and their effects at the level of personal experience. If care is an expression of intense social support (Chappell, 1992) and is to

be recognized and accorded centrality in social and political theory (Tronto, 1993), it is also important that it no longer be seen as a marginal or specialist topic within the discipline. Instead, I argue in this article that it needs to be made central to the sociological enterprise, which means, effectively, that it must be taken up at the level of social theory. It is also important that research in the broad field of care draw on developments in the broader field of social theory.

Drawing critically on the work of major contemporary theorists, in particular that of Giddens, Beck, Castells, Turner and Rojek, this article considers the contribution that sociological theory can make to the study of care. In doing so I focus on the perspectives provided by four major themes in contemporary sociology. The first concerns care and the body: this provides a useful starting point as it reflects not only the recent emergence of interest in the body in sociological theory, but is also an acknowledgement of the immediacy of vulnerability and physical contact that underlies the hard work involved in providing care. Moving from the immediate and micro to the abstract and macro level of analysis, I then discuss, in turn, the themes of individualization and the transformation of personal and domestic life; risk and the new organizational logic. Gender also presents a fundamental point of intersection between social theory and research on care (Blattel-Mink and Kuhlmann, 2003; Connell, 2002; Graham, 1991; Ungerson, 1990, 2000), an issue I have recently touched upon in a related article (Fine, 2005). Although it cannot be fully explored in this article, it is important to acknowledge that gender serves as a basic structural principle for organizing of care; in turn, as Kittay (1999) has shown, the organization of care provides a particularly powerful lens through which to examine the question of gender.

## **Care and the sociology of the body**

The recent 'rise of the body' in popular culture as well as in sociological theory, closely parallels the emergence of care as a public issue. According to Chris Shilling (1995), interest in the body reflects a number of contemporary developments: the impact of feminism, with its concern for bodily issues such as birthing, abortion, pornography and the physical abilities of women; population ageing and the link between physical ability and age; consumer culture and the rise of concern for the physical self through exercise, diet and fashion; and technology, both information technology and bio-technical developments extending the concept of life, blurring the boundaries between the corporeal, the mechanical and the virtual. The result, argues Shilling (1995), is that as we have developed extended public and private discussions about what it means to be human and what social responsibilities therefore arise, attention has increasingly focused on questions relating to the body. The development updates earlier sociological

interest in the topic, as well as bringing with it a more fundamental concern for understanding the link between social life and our existence as individual embodied physical beings. This opens important questions about the importance of physical-biological determinants of social life (Newton, 2003; Turner and Rojek, 2001). One of the most important aspects of this concerns the link between care and the body. As Julia Twigg (2000) has argued, at the most fundamental level, care involves a relationship that involves intimate physical tending. Body contact is not incidental, it is the defining and central feature of the most intense and intimate forms of care.

The importance of recognizing the links between the body and care is illustrated in the following brief extract from Julie Godyer's moving account (Goyder, 2001) of caring for patients with Alzheimer's disease:

I had never been so conscious of people's bodies as when I began working in nursing homes. Patients, especially those with dementias like Alzheimer's Disease, were often handled without any awareness or consideration of their 'selfness', handled as if they were only bodies and nothing else ... The intimacy of physical contact necessary for these routines between nurse and patient was something over which patients had no control. They were touched, handled, repositioned, toiletted and so on constantly throughout the day and had no choice over when or where they were touched. Many became limp, immobilised, refusing to move themselves or help in any way even if they could. Refusing also to speak, these patients began to seem like heavy lumps of flesh, nothing else – all body. (Godyer, 2001: 123–4)

Godyer's description highlights both the physical nature of the interaction between care staff and recipients, and the way that 'care' may be reduced through work practices in current aged care facilities to no more than the tending of bodies, especially in advanced stages of dementia where the recipient lacks the cognitive and personal capacity to respond. Yet there is a deliberate invocation in Godyer's work of the pathos and superficiality of this approach. Good care, she seems to suggest between the lines, should go beyond this, engaging with the person and the self behind the body, even when, as occurs with advanced Alzheimer's disease, there is little possibility of true psychological engagement. Through this lens, some of the complexity of the notion of care becomes apparent. It is based on the materiality of bodily contact, but cannot be reduced to it. For care to be more than mere tending it must also involve deep respect for the personal integrity of both caregivers and recipients. The expression of concern and the development of personal trust emerge as cultural values that shape and extend care beyond a simple physical relationship.

The bodily nature of caregiving has been most thoroughly explored in the work of Julia Twigg (2000, 2004), who, following Joscelyn Lawler's (1991) lead, has studied care as a form of 'dirty work'. This involves an approach to care as bodywork that inevitably entails touching, cleaning and comforting the recipient in ways that violate the normal cultural codes of

disgust at bodily functions and fluids, and avoidance of close physical contact. In the culture of Western civilized societies, bodies, it is argued, have come to be regarded in Western culture as private and intimate, bodily fluids and excretions as dirty, polluting and taboo (Douglas, 1966; Elias, 1994). In the physical intimacy of care work these taboos are broken, a feature that Twigg, following Lawler, argues leads to a social ambivalence about the performance of care that requires close physical contact with strangers. When care involves attendance to the physical needs of others, they argue, it is treated as 'dirty work', hidden from others, penalizing those who do it in the process. The work of direct care workers is similarly devalued, the predominantly female practitioners who carry it out receiving low levels of social recognition and poor remuneration (Baines, 1998; England et al., 2002; Franzway, 2003).

Twigg and Lawler appear to attribute the low status of care work to the need to work directly with the body of the care recipient. As Twigg points out, there is a strong hierarchy of positions among the caring professions, with those able to distance themselves from direct responsibility for body-work by assuming positions that involve management or some form of treatment, such as counselling, that do not require physical contact with the care recipient, accorded the greatest prestige and power (Twigg, 2000). But is it the body of the care recipient that determines whether the work of care is regarded as 'dirty work'? Might not the physical work of direct caregiving be understood better by focusing on the body of the worker rather than the care recipient? From this perspective, much care work can be seen as involving extensive manual work. It is surely important to look also to the deployment of the caregiver's body rather than to reduce it simply to contact with the body of the recipient. Factors such as the level of recognized professional knowledge and skill involved, and other aspects of the labour market involving recognition of the body of the worker, such as the treatment accorded women and ethnic minorities, must also be considered factors determining the social status of the work. A case in point is the social position of medical care specialists, such as gastroenterologists, urologists and proctologists, who enjoy high degrees of power, status and financial reward, despite their responsibility for 'dirty work'. What differs in their case and that of low-paid care workers is not the extent of intimate contact with another's body, but the nature of the physical effort required, the levels of skill and professional monopoly they are able to exercise, and their gender.

In seeking to develop care as a concept that is central to sociology, the body can provide an important and foundational theoretical focus. Turner and Rojek (2001: 109–43) provide an invaluable starting point by emphasizing that the body provides the material form of our social existence and is not capable of being reduced entirely to the ontological status of a 'social construction'. They then draw on this approach to elaborate a theory of

human rights that cannot be simply dismissed as cultural construct of Western modernity that, as postmodern critics allege, lacks credibility and universal applicability. Following Turner and Rojek's approach, it can be argued that, just as the body provides the material foundations of our existence as humans, so must care be understood as a necessary social response to the vulnerability and incompleteness of individual bodies at different points in the life course. The need for care is linked to unavoidable bodily incapacities experienced at different points in the life course – infancy, ageing, disability, mental illness, as well as to episodes of acute and chronic illness. The development of social solidarity can be seen as arising in response to our physical vulnerability and from the need to protect ourselves from other people with whom we compete through crime, terrorism, war and state formation. If this is the case, it is clear that the social arrangements that are implemented to provide this care, and the shared responses to bodily needs, must be thought of as essential elements of social life, the building blocks around which other components of social life are developed. From the perspective of the body, care can no longer be seen as a specialized topic of marginal interest to mainstream sociology; rather, it provides a basic element of all social life.

This is not to argue that all social life can be understood as an inevitable social response to the biological imperatives of the body, nor that all care is dictated by physiology. Physiological need and social form interact, with neither reducible to the other. There is much to be gained by sustaining an awareness that many of the forms and consequences of care are social, rather than bodily, in origin. To extend this logic and assume that the very need for care can be reduced to arbitrary social convention, however, would be to ignore the prior ontology of physiological vulnerability that underlies the need for care in the first instance. Linking research on care to a concern for the body, therefore, provides the basis for a sociology in which care is no longer a topic of marginal or specialized interest. Instead, care is revealed as a central foundation of social life, a building block on which all subsequent social relations and processes depend.

## **Individualization**

Moves towards recognition of the body in sociological theory parallel the reawakening of another long-standing theme in sociology, that of the importance of the individual and of the social process of individualization (Lukes, 1973). The process whereby individuals have increasingly come to be seen and held accountable as social beings in their own right rather than as members of some predefined social group, class or category, is an important and ongoing social process that is by no means unique to late modernity (Durkheim, 1984; Elias, 1991; Lukes, 1973). However, as Beck (1992) argues, while individualization needs to be



understood as a longer-term social process, it would be wrong to equate the contemporary process of individualization with the ascendancy of the ideals of neoclassical market consumerism. To identify salient features of the process, Beck uses the term 'institutional individualism' (Beck, 1992; Beck and Beck-Gernsheim, 2002), arguing that individualization cannot be understood as a withdrawal of individuals from social interaction. Rather, it represents an increasing engagement of individuals with society. Institutional individualization, according to Beck, is a process fostered by the state through juridification and through the standardization of welfare, each of which represents the increasing application of rules and procedures that hold individuals, rather than social groups, accountable. Developments in the labour market, in education and in careers have also served as the motor for its development, just as increasing affluence and consumerism in advanced modern societies have accelerated the process. Central to the process is the emergence of the concept of individual rights (Yeatman, 2001) and the demand for people to be treated as individuals. This is why Beck argues that the process of individualization has been accelerated and increased by 'reflexive modernisation' (Beck, 1992; Giddens et al., 1994), and that individualization represents an achievement of ongoing democratization.

Individualization, importantly, is a subjective ideal as well as a social process. It calls for respect of individual autonomy at the same time as it seeks this respect as a mark of social interaction. The linking of these subjective goals of a search for autonomy through the social processes of interaction and recognition are well summed up by the concept of 'relational autonomy' (Mackenzie and Stoljar, 2000). Individualization, in this sense, does not involve a simple retreat of individuals into egocentric isolation from social bonds. Rather, institutional individualization, as Beck and Beck-Gernsheim emphasize repeatedly, arises as an emancipation from traditional constraints and provides the basis for the development of new forms of sociality, in which autonomy, linked to the rights to be an individual, is achieved and recognized through social relations. At the same time, the achievement of the social status of individuality also invokes new forms of obligation and personal responsibility (Beck and Beck-Gernsheim, 2002).

Some of the effects of individualization on social life in late modernity and its potential as a concept for research on care can be glimpsed in Giddens's analysis of 'emancipatory' and 'life' politics, and the search for the 'pure relationship' (Giddens, 1991, 1993). Emancipatory politics refers to the liberation of individuals from traditional (typically legally codified) constraints and involves the reduction or elimination of exploitation, inequality and oppression. Life politics, built on the achievement of emancipation, involves a process of reflexive decision-making and self-direction undertaken by individuals in charting their own course through life. Giddens claims that the ideal of the 'pure relationship' has emerged as the

prototype, the ideal social form, for the achievement of individualized self-identity in late modernity. In contrast to traditional social relationships, which relied on external pressures for their strength, a pure relationship, he argues, is one that exists solely for the rewards that it can provide to each participant. By linking the contemporary preoccupation with a search for meaning in life with personal fulfilment, sexuality, love, eroticism and intimacy, Giddens (1993) develops an account that shows how happiness and the achievement of intimacy have come to be seen as hallmarks of the ideal life. Care, long constructed as a duty and responsibility, has increasingly been portrayed as a 'burden'. Beck-Gernsheim's (2002) analysis of feminism as a process of democratic individualization, in which she describes how women in recent decades have gone from living 'a life for others' to seeking a 'a life of one's own', is a powerful illustration of the way in which individualization serves to link personal goals and social change.

What might the implications be for care? Individualization and the related changes in personal and domestic life constitute the terrain for a new demography of informal care, as well as providing the foundation for a new relationship between human service providers and care recipients. With family units subject to unprecedented levels of change and insecurity, with women increasingly seeking careers and paid employment rather than a life as unpaid housekeepers and full-time family carers, how is the support they once provided to be made available? Can there be a substitution between different sources of care? Or must the solution be found in other ways, such as through reducing the level of need for care by limiting births, enforcing ever higher levels of self-sufficiency on the populace, and by technological intervention that replaces the reliance on human tending?

Changes in the (re)formation of domestic units resulting from the gradual transformation of the lives of individuals suggest the need for a revision of analyses which locate care as a distinctively, even exclusively, female activity, closely associated with the intimate relations in 'private places' of the home and family (Graham, 1983: 16; Williams, 2004). Optimistically, the domestic relationships within which the overwhelming amount of care-giving takes place have the potential to be less structured by gender and more by the patterns of interpersonal recognition, reciprocity and intimacy. Although the available data suggest that men are taking only marginally greater responsibility for child care or domestic labour (Bittman and Pixley, 1997), it is clear that the amount of care provided by men in the domestic setting has long been underestimated (Arber and Gilbert, 1989). Research distinguishing personal care, the most intensive form of care, from other forms of domestic help, has shown that the resilience of familial support of older people in the latter decades of the 20th-century in Australia, Britain and other comparable countries has been based largely on the assistance provided by co-resident partners rather than non-resident daughters (AIHW, 2003; Arber and Ginn, 1990; Hirst, 2001). Somewhat surprisingly

for many, the proportion of older men who report caring for their female partner equals or exceeds that of women caring for a male partner, although the greater numbers of women living beyond retirement age means that, overall, women carers continue to predominate in old age (ABS, 1999). Similarly, the rapid emergence of formal and informal support networks among the gay community in response to HIV/AIDS demonstrates the viability of care relationships based on very different foundations of intimacy and gender (Layzell and McCarthy, 1992). As the recent research undertaken by Fiona Williams (2004) and colleagues has shown, the forms of domestic life are changing dramatically, but this has not led to a loss of commitment to care. In each case, the availability of informal care is more closely predicted by the individualization thesis than by a projection of traditional gender roles, indicating that the scope for policy based on this approach is far from exhausted.

A second set of issues arises in relation to the reshaping of human services, where individualization already provides a powerful perspective on the reconfiguration of patterns of service delivery. Central to this has been the shift away from institutional care, towards the development of services which provide their recipients with choice and opportunities to maintain or develop control over their own lives. The expansion of community care as an alternative to residential care is of singular importance in this regard, although it is by no means a sufficient condition for its realization. As Goffman's influential critique of 'total institutions' made clear in the 1960s, one of the major failings of residential institutions as a way of dealing with the mental health and other problems of populations was that the result of this mass management programme is that inmates are forced to conform with a totalitarian-like regime that deprives them of individual identity (Goffman, 1968). The result, he noted, was the 'mortification of the self'. It seems no coincidence that, as Goffman states in undertaking the study, his 'chief concern' in this work was 'to develop a sociological version of the structure of the self' (1968: 11).

Individualization has also had an impact on the way that alternative forms of service provision operate. The individualization of human service delivery implies both an attempt to tailor the service to fit the preferences and circumstances of the individual recipient, and the provision of opportunities for the recipient to take part in the decision-making concerned with the planning, organization and delivery of the particular service concerned. Today, most services endeavour to offer greater recognition to individuals than in the past, with the restructuring of service organization along such lines as patient or person-centred care, and an expansion of case or care management and the introduction of a variety of personalized programmes in evidence (Clark, 1998; Feinberg and Ellano, 2000; Fisher and Fine, 2002; Glendinning et al., 2000). In many instances, these have been accompanied by moves for improved legal protection of consumers through advocacy

and user rights provisions. The extent to which these goals move beyond rhetoric and policy to be realized in practice, however, remains a challenge to service providers and policy makers (Hoggett, 2001; Shaddock and Bramston, 1991; Waters and Easton, 1999). A key force in shifting the approach of service providers has been the emergence of consumer activists and broader social movements concerned with the legal rights, quality of life and general empowerment of those dependent on care (Thomas, 2000).

The way that care is constructed at the level of interpersonal relationships is also being reshaped. A rethinking of the more traditional carer-dependent paradigm is already well under way, affecting both informal and formal forms of care (Fine and Glendinning, 2005). In place of the hierarchical pattern in which care is seen as requiring the assumption of responsibility and control by the carer, and passivity and gratitude by the care recipient, a role pattern theorized by Talcott Parsons as 'the sick role' (Parsons, 1951; Gerhardt, 1987), a more engaged, active, conception of the relationship, is emerging, based on the recognition of the rights of both parties as individuals. Care, in this sense, needs to be seen not simply as one-directional activity undertaken by the caregiver, but as the outcome of a relationship between the different parties in which mutual respect, and the fostering of the capabilities and autonomy of the recipient are foremost. The emergence of concepts such as 'self-care' and the 'co-production' of care as capacities which are already present and need to be respected and fostered (Wilson, 1994) are suggestive of these sorts of changes. Contemporary developments, such as the tailoring of care to fit the individual, the introduction of individualized care plans and the introduction of legal safeguards such as charters of patients' rights, and complaints and appeals procedures, all appear to extend this logic of individualization.

## **Risk and the new organizational logic**

The themes of risk and the new organizational logic, prominent in contemporary sociological theory, must also be considered as central to developing a sociological approach to current dilemmas in the way that care is conceived and delivered. Risk in today's world, according to Beck, 'may be defined as a systematic way of dealing with hazards and insecurities induced and introduced by modernization itself' (1992: 21). This concept, based on the logic of approaches to the management of uncertainty in advanced modernity, links in with the political-economic developments and changes in what Castells (2000) terms the 'organizational logic' of global societies. By this term Castells, following Nicole Biggart, refers to the 'legitimizing principle that is elaborated in an array of derivative social practices ... the ideational bases for institutionalized authority relations' (Biggart, cited in Castells, 2000: 164).

According to the risk society hypothesis advanced by Beck (1992), as science, rationality and the ideals of democracy have enabled advanced societies to find ways of managing, controlling and directing nature, and as individuals, both men and women, benefit from the acknowledgement of increased rights and responsibilities, life has become ever more conditional, uncertain and risk filled, in the sense that all domains are now subject to deliberate decision-making. Nothing can be assumed, any longer, to be simply beyond our control. Instead, we face the consequences that our lives are subject to ongoing processes of decision-making that bring with them uncertain outcomes, despite the predictability and general reliability of most features of modern life. The key to understanding the link, it may be argued, is that now life is no longer understood to just happen. This new understanding of life has been taken up in judicial processes and jurisprudential reasoning, and has legal implications. For every aspect of modern life, at every level, someone is responsible for the decisions made (Douglas, 1992). This has the potential to produce somewhat contradictory outcomes.

Neither risk nor the idea of risk is new, although, as both Beck (1992) and Giddens (1991) point out, concepts of 'fate' and 'fortune', of the unpredictable character of 'acts of nature' have previously operated to explain the tribulations experienced by and opportunities understood as beyond human control. The risks faced in the present period, the 'risks of modernization', are said to differ in both their global scale and our understanding of the nature of their causes. Ideas about risk are increasingly widely applied to social policy and health care, and are a major factor shaping the future response to care needs. It is argued that the process is already well established, and that risk is replacing need and equity as the central concept of the system of public services. Hazel Kemshall, for example, argues that social policy now is increasingly 'about prevention of risk and displacement of risk management responsibilities onto the "entrepreneurial self" that must exercise informed choice and self-care to avoid risks' (2002: 22). Risk management, she argues, is evident in human services such as child protection and aged care through: the introduction of increased accountability procedures for staff; requirements to ration services through sharpened targeting and assessment; strategies for harm minimization and risk management; and through the promotion of paperwork, standardized pathways, procedures for what Hoggett (1990) has termed the 'remote control' of local agencies, through setting performance targets and developing performance management procedures. Risk, in this way, is intricately and inevitably tied to the development of new organizational forms and logics that underlie the way that services are organized, managed and held accountable for the way that care is provided.

Other examples of the ongoing introduction of procedures for risk management include the emerging emphasis of evidence-based practice; the use

of service contracts (and contract-like agreements) between central funding agencies and local services, and between local services and their clients; the negotiation of care plans; and the emphasis on outcomes rather than inputs of services. Each of these approaches serves to standardize and direct the activities of direct care staff, setting limits to formal responsibility and minimizing the risk of blame for personal or (quasi) professional decisions in this terrain of the potentially dangerous interventions that the provision of formal care services represent. Given the increasing sense of social rights and the litigiousness evident in the Australian legal system, as in the USA and elsewhere, it is difficult to imagine that the management of risk is not going to play an ever greater part in the organization of care in the 21st century.

Giddens points to a further implication of risk management that is important for care, linked to the increasing ascription of risks to the individual citizen/consumer rather than the state. Embracing risk is seen as a central challenge for the Third Way. 'Risk is not just a negative phenomenon – something to be avoided or minimized. It is at the same time the energizing principle of a society that has broken away from tradition and nature' (Giddens, 1998: 63). Risk, he argues, is not just hazard. Opportunity and innovation, both part of risk-taking for Giddens, are positive features and need to be encouraged as part of what he calls the 'active exploration of risk environments'. Avoiding the dependency that arises from paternalistic approaches to welfare requires clients to take more risks and assume greater personally responsibility for their own well-being. Rights, he argues, must be counterbalanced by an acknowledgement of the responsibilities that risk entails.

Requiring welfare clients to accept and manage risks on their own is argued to be a way around the fostering of welfare dependency while providing an effective remedy for the fiscal crisis of the state in the face of ever increasing demands for support. But it may also mask cost-cutting and serve to shift blame for failure onto the client. There is, effectively, no place left to hide from these dilemmas, which are experienced at the personal or micro-level as much as at the macro-level of the state. Yet it is not a forgone conclusion (for Third Way or any other politics) that confronting risk in the 21st century must mean abandoning collective approaches to care. An explicit recognition of the nature and likelihood of risk can provide a positive contribution to the development of progressive welfare policies. Attempting to rely on private payments for aged care, or private insurance coverage for those at high risk of needing long-term care, for example, is simply unrealistic, as experience with attempts to introduce private long-term care insurance in the USA and UK has shown (Fine and Chalmers, 2000). Social insurance for long-term care, along the lines of the approach taken in the Netherlands, Germany, Israel and Japan, instead shares the risk between all potential users of the service, as well as providing the means for

potentially ensuring that future collective care provisions remain financially viable and will not fall victim to the effects of changing demography on the state's capacity to finance future care services.

The organizational logic that Castells (2000) identifies as characteristic of informational society is, put simply, that of the network. This is a logic that promotes flexibility, innovation and access to multiple sources of information in the place of the organizational forms that have previously dominated – bureaucracy, hierarchy, and the authority of tradition and precedent. New and innovative forms of organization, including service networks, partnerships between formal organizations, hybrid forms of care provision linking informal care arrangements with formal services (Fine, 1994), contracting and performance-monitoring regimes, case management, quality control and consumer participation strategies that have emerged in the human services field, provide solid evidence of how the new organizational logic is beginning to make itself felt in the way that both formal and informal care are provided and are beginning to entwine. I confine the account here, however, to a consideration of the employment and workforce implications of the new globalized network economy.

Castells argues that, as a result of global political economic developments, a major transformation is evident in labour process and employment patterns. Rather than increased productivity leading to the 'end of work' or the 'deskilling of labour', as some writers had predicted, what has emerged is a dynamic, unstable and segmented labour market in which labour provided by women, migrants and older people is increasingly significant, with important consequences, noted earlier, for the provision of care at home and through what is generally referred to as the 'work-life' balance. At the core of the new economy are the information managers and professionals, the 'symbolic analysts' and knowledge workers who enjoy relatively high pay and secure employment prospects, although not necessarily secure employment conditions. Alongside this core works what Castells calls the 'disposable labour force' (2000: 295). Disposable workers experience relatively poor working conditions and are easily laid off when labour market conditions are unfavourable. This group, which includes most so-called 'unskilled' workers, has a disproportionate number of overseas-born workers and women, a great many of whom typically work in part-time or casual positions, often with little or no control over their work lives. For Castells, the global dimension to this means that there are now always others, somewhere on the globe, willing to work harder, for less pay and for longer hours. In a global economy, work and life for those reliant on disposable employment is insecure, with choice constrained by limited local opportunity. The disproportionate amount of low-paid, insecure care work undertaken by female migrants in aged and child care in developed nations across the globe, for example, is a significant manifestation of this process (Bettio and Plantenga, 2004; Ehrenreich and Hochschild, 2002).

The labour market for care clearly exemplifies the dual structure of core and disposable workers that Castells identifies. The professional/managerial core of experts – doctors, social workers, registered nurses, para-medical professionals and, perhaps most important now, managers, accountants, planners and book-keepers of various kinds – enjoy a relatively privileged position in this system. Direct care staff, the majority of staff in most systems, are typically assigned work conditions that involve low rates of pay, insecure and often casual employment with limited or no promotional prospects, little or no recognition of knowledge and experience, and few opportunities for advanced training (Franzway, 2001; Neysmith and Reitsma-Street, 2000; Wallace, 1990). The parallels here with Ritzer's analysis of 'McDonaldization' (Ritzer, 1993, 1999) are strong, especially the economic organization of the workforce that underpins it, whereby a small number of very highly paid corporate managers deal with a series of franchisees, who each manage a workforce consisting largely of well organized but low-paid casual staff, each assigned a standardized task for which they require some, but not very much, training. Women, especially those from ethnic minorities, including a disproportionate number of immigrants and workers with temporary or no citizenship rights, rely on such employment as a growing alternative to the declining employment in manufacturing (Hondagneu-Sotelo, 2000). By supplementing the supply of locally born women seeking work in the field of care, the global care chains that result from international patterns of migration and labour exchange that underlie globalization, have underpinned the recent growth of care services, based on the economics of low-paid frontline work (Ehrenreich and Hochschild, 2002). Volunteer programmes, in which work is undertaken entirely without pay (Baldock, 1990; Bittman and Thomson, 2000; Neysmith and Reitsma-Street, 2000) extend this, typically placing unpaid workers alongside paid staff in these positions, as if to emphasize the risk associated with this segment of the labour market.

## Conclusion

Care, it has been argued, is a necessary social response to bodily vulnerability and a foundation for the patterns of social solidarity that underlie human societies. This should mean that it is a topic of central interest to sociology, but to date this has not been the case. Despite its relative silence on the topic, contemporary sociological theory can provide some guidance to elucidating its significance and for understanding the dilemmas that need to be faced, as this article has tried to show. Recognition of the bodily nature of care and the positive potentials of individualization offer ways to help reconstruct how care is conceptualized and enacted. The concepts of risk and of the new organizational logics also open up lines for the deeper investigation of how care is understood as well as for expanding our



understanding of changes in the social arrangements for the provision of care in the 21st century.

The division between core and marginal segments of the care labour force can be seen as representing alternative futures for care and human services. On the one hand, professional experts enjoy respect and relatively high rates of pay. Their command of expert knowledge and capacity to provide a quality service, possibly even life-saving in character, provides legitimacy for formal interventions on the basis that what they provide is simply not available in the ordinary household. On the other hand, a potential workforce of low-paid care staff suggests a future of McDonaldized care, workers who might be thought of as providing cheap and affordable labour at short-term notice, ready to be laid off if and when it is convenient. The legitimacy of such care has been based largely on the idea that, through its provision, an opportunity is created to enable household members, particularly women, to undertake other employment. But without commitment to the conditions experienced by the care workers, there can be little reason to expect them to have a commitment to those who rely upon the care they provide. Nor can we expect that the recent changes in women's employment will be sustained over the next century if this means handing over responsibility for care to workers who have little commitment or expertise.

As care has become an increasingly a public issue, it has inevitably been reflected in academic research and debate. To date, much of this has remained in relatively specialized and segmented fields – in feminist research and social policy writings, and in the research and professional practice literatures of applied fields such as ageing, child development, disability and mental health, health services and social work. Some of this attention has been reflected in the field of sociology, but care, to date, remains a topic that has commanded little mainstream interest at the level of theory. If the arguments and analysis advanced in this paper are correct, this lack of interest should not be allowed to continue to characterize the discipline.

## References

- Abrams, P. (1989) *Neighbourhood Care and Social Policy*. London: HMSO.
- ABS (Australian Bureau of Statistics) (1999) *Caring in the Community, Australia, 1998*, ABS Cat. No. 4436.0. Canberra: Australian Bureau of Statistics.
- AIHW (Australian Institute of Health and Welfare) (2003) 'Informal Care', pp. 65–120 in *Australia's Welfare 2003*. Canberra: Australian Institute of Health and Welfare, AusInfo.
- Arber, S. and N. Gilbert (1989) 'Men: The Forgotten Carers', *Sociology* 23(1): 111–18.
- Arber, S. and J. Ginn (1990) 'The Meaning of Informal Care: Gender and the Contribution of Elderly People', *Ageing & Society* 10(4): 429–454.

- Baines, C.T. (1998) 'Women's Professions and an Ethic of Care', pp. 23–46 in C.T. Baines, P.M. Evans and S.M. Neysmith (eds) *Women's Caring: Feminist Perspectives on Social Welfare*. Toronto: Oxford University Press.
- Baldock, C.V. (1990) *Volunteers in Welfare*. Sydney: Allen and Unwin.
- Beck, U. (1992) *Risk Society: Towards a New Modernity*. London: Sage. (First published 1986.)
- Beck, U. and E. Beck-Gernsheim (2002) *Individualization*. London: Sage.
- Beck-Gernsheim, E. (2002) 'From "Living for Others" to "A Life of One's Own": Individualization and Women' (first published in 1983), pp. 54–84 in U. Beck and E. Beck-Gernsheim (ed.) *Individualization*. London: Sage.
- Bettio, F. and J. Plantenga (2004) 'Comparing Care Regimes in Europe', *Feminist Economics* 10(1): 85–113.
- Bittman, M. and J. Pixley (1997) *The Double Life of the Family: Myth, Hope and Experience*. St Leonards: Allen and Unwin.
- Bittman, M. and C. Thomson (2000) 'Invisible Support: The Determinants of Time Spent in Informal Care', pp. 98–112 in J. Warburton and M. Oppenheimer (eds) *Volunteers and Volunteering*. Sydney: Federation Press.
- Blattel-Mink, B. and E. Kuhlmann (2003) 'Health Professions, Gender and Society: Introduction and Outlook', *International Journal of Sociology and Social Policy* 23(4): 1–21.
- Castells, M. (2000) *The Rise of Network Society. The Information Age: Economy, Society and Culture*, 2nd edn. Oxford: Blackwell.
- Chamberlayne, P. and A. King (2000) *Cultures of Care: Biographies of Carers in Britain and the Two Germanies*. Bristol: Policy Press.
- Chappell, N.L. (1992) *Social Support and Aging*. Toronto: Butterworths.
- Clark, C. (1998) 'Self-determination and Paternalism in Community Care: Practice and Prospects', *British Journal of Social Work* 28: 387–402.
- Connell, R.W. (2002) *Gender*. Cambridge: Polity.
- Daly, M. (2002) 'Care as a Good for Social Policy', *Journal of Social Policy* 31(2): 251–70.
- Daly, M. and J. Lewis (2000) 'The Concept of Social Care and the Analysis of Contemporary Welfare States', *British Journal of Sociology* 51(2): 281–98.
- Douglas, M. (1966) *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*. London: Routledge and Kegan Paul.
- Douglas, M. (1992) *Risk and Blame: Essays in Cultural Theory*. London: Routledge.
- Durkheim, E. (1984) *The Division of Labor in Society*, trans. W.D. Halls. New York: Free Press.
- Ehrenreich, B. and A. Hochschild (ed.) (2002) *Global Women: Nannies, Maids and Sex Workers in the New Economy*. New York: Metropolitan Books.
- Elias, N. (1991) *The Society of Individuals*, ed. M. Schroter, trans. E. Jephcott. Oxford: Blackwell.
- Elias, N. (1994) *The Civilizing Process*, trans. E. Jephcott, rev. edn. Oxford: Blackwell.
- England, P., M. Budig and N. Folbre (2002) 'Wages of Virtue: The Relative Pay of Care Work', *Social Problems* 49(4): 455–73.
- Feder, E.K. and E.F. Kittay (2002) 'Introduction', pp. 1–13 in E.F. Kittay and E.K. Feder (eds) *The Subject of Care: Feminist Perspectives on Dependency*. Lanham, MD: Rowman and Littlefield.
- Feinberg, L.F. and C. Ellano (2000) 'Promoting Consumer Direction for Family Caregiver Support: An Agency-driven Model', *Generations* 24(3): 47–53.

- Fine, M. (1994) 'Supporting, Exploiting or Displacing the Family? Community Support for Disabled and Frail Older People', pp. 73–92 in J. Inglis and L. Rogan (eds) *Flexible Families: New Directions for Australian Communities*. Sydney: Pluto Press.
- Fine, M. (2005) 'Dependency Work: A Critical Exploration of Kittay's Perspective on Care as a Relationship of Power', *Health Sociology Review* 14(2).
- Fine, M. and J. Chalmers (2000) 'User Pays and Other Approaches to the Funding of Long-term Care for Older People in Australia', *Ageing & Society* 20(1): 5–32.
- Fine, M. and C. Glendinning (2005) 'Dependence, Independence or Interdependence: Revisiting the Concepts of "Care" and "Dependency"', *Ageing & Society* 25(4): 601–21.
- Fisher, K. and M. Fine (2002) 'Care Coordination, Case Management Theory and the Coordinated Care Trials: Reconsidering the Fundamentals', pp. 23–38 in *The Australian Coordinated Care Trials: Reflections on the Evaluation*. Canberra: Department of Health and Ageing.
- Franzway, S. (2001) *Sexual Politics and Greedy Institutions*. Annandale, NSW: Pluto Press Australia.
- Franzway, S. (2003) '“You Need to Care”: The Work of Care between Home and Market', in *Conference Proceedings, The Australian Sociological Association Annual Conference*, University of New England, December 2003. Armidale, NSW: TASA and the University of New England.
- Freidson, E. (1970) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. New York: Dodd Mead.
- Gerhardt, U. (1987) 'Parsons, Role Theory, and Health Interaction', in G. Scambler (ed.) *Sociological Theory and Medical Sociology*. London: Tavistock.
- Giddens, A. (1991) *Modernity and Self-identity: Self and Society in the Late Modern Age*. Cambridge: Polity.
- Giddens, A. (1993) *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*. Cambridge: Polity.
- Giddens, A. (1998) *The Third Way: The Renewal of Social Democracy*. Cambridge: Polity.
- Giddens, A., U. Beck and S. Lasch (1994) *Reflexive Modernisation*. Cambridge: Polity.
- Glendinning, C., S. Halliwell, S. Jacobs, K. Rummery and J. Tyrer (2000) 'New Kinds of Care, New Kinds of Relationships: How Purchasing Services Affects Relationships in Giving and Receiving Personal Assistance', *Health & Social Care in the Community* 8(3): 201–11.
- Goffman, E. (1968) *Asylums*. Harmondsworth: Pelican.
- Goyder, J. (2001) *We'll Be Married in Fremantle*. Fremantle: Fremantle Arts Centre Press.
- Graham, H. (1983) 'Caring, a Labour of Love', in J. Finch and D. Groves (eds) *A Labour of Love: Women, Work and Caring*. London: Routledge and Kegan Paul.
- Graham, H. (1991) 'The Concept of Caring in Feminist Research: The Case of Domestic Service', *Sociology* 25(1): 61–78.
- Hakim, C. (2000) *Work–Lifestyle Choices in the 21st Century: Preference Theory*. Oxford: Oxford University Press.
- Hakim, C. (2001) 'Taking Women Seriously', *People and Place* 9(4): 1–6.
- Hirst, M. (2001) 'Trends in Informal Care in Britain', *Health and Social Care in the Community* 9(6): 348–57.
- Hochschild, A.R. (1983) *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press.

- Hoggett, P. (1990) *Modernisation, Political Strategy and the Welfare State: An Organisational Perspective*, Studies in Decentralisation and Quasi-Markets No. 2. Bristol: School for Advanced Urban Studies, University of Bristol.
- Hoggett, P. (2001) 'Hatred of Dependency', pp. 159–80 in P. Hoggett (ed.) *Emotional Life and the Politics of Welfare*. Houndmills: Macmillan.
- Hondagneu-Sotelo, P. (2000) 'The International Division of Caring and Cleaning Work: Transnational Connections or Apartheid Exclusions?', pp. 149–62 in M. Harrington-Meyer (ed.) *Care Work: Gender, Labor and the Welfare State*. New York: Routledge.
- James, N. (1992) 'Care Organisation and Physical Labour and Emotional Labour', *Sociology of Health and Illness* 14(4): 488–509.
- Kemshall, H. (2002) *Risk, Social Policy and Welfare*. Buckingham: Open University Press.
- Kittay, E.F. (1999) *Love's Labor: Essays on Women, Equality, and Dependency*. New York: Routledge.
- Lawler, J. (1991) *Behind the Scenes: Nursing, Somology and the Problem of the Body*. Melbourne: Churchill Livingstone.
- Layzell, S. and M. McCarthy (1992) 'Community-based Health Services for People with HIV/AIDS: A Review from a Health Service Perspective', *AIDS Care: Psychological & Socio-Medical Aspects of AIDS/HIV* 4(2): 203–15.
- Lukes, S. (1973) *Individualism*. Oxford: Basil Blackwell.
- Mackenzie, C. and N. Stoljar (eds) (2000) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self*. Oxford: Oxford University Press.
- Mills, C.W. (1959) *The Sociological Imagination*. London: Oxford University Press.
- Newton, T. (2003) 'Truly Embodied Sociology: Marrying the Social and the Biological?', *Sociological Review* 51(1): 21–42.
- Neysmith, S. and M. Reitsma-Street (2000) 'Valuing Unpaid Work in the Third Sector: The Case of Community Resource Centres', *Canadian Public Policy* 26(3): 331–46.
- Parsons, T. (1951) *The Social System*. London: Routledge and Kegan Paul.
- Pocock, B. (2003) *The Work/Life Collision: What Work is Doing to Australians and What to Do About It*. Annandale, NSW: Federation Press.
- Reich, W.T. (1995) 'History of the Notion of Care', pp. 319–31 in W.T. Reich (ed.) *Encyclopedia of Bioethics*, rev. edn. New York: Simon and Schuster/Macmillan.
- Ritzer, G. (1993) *The McDonaldization of Society*. Thousand Oaks, CA: Pine Forge Press.
- Ritzer, G. (1999) *Enchanting a Disenchanted World*. Thousand Oaks, CA: Pine Forge Press.
- Sevenhuijsen, S. (2000) 'Caring in the Third Way: The Relation between Obligation, Responsibility and Care in Third Way Discourse', *Critical Social Policy* 20(1): 5–37.
- Shaddock, A.J. and P. Bramston (1991) 'Individual Service Plans: The Policy–Practice Gap', *Australia & New Zealand Journal of Developmental Disabilities* 17(1): 73–80.
- Shilling, C. (1995) *The Body and Social Theory*. Newbury Park, CA: Sage.
- Thomas, C. (1993) 'De-constructing Concepts of Care', *Sociology* 27(4): 649–70.
- Thomas, J.E. (2000) 'Incorporating Empowerment into Models of Care: Strategies from Feminist Women's Health Centers', *Research in the Sociology of Health Care* 17: 139–52.
- Tronto, J. (1993) *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.

- Turner, B. and C. Rojek (2001) *Society and Culture: Principles of Scarcity and Solidarity*. London: Sage.
- Twigg, J. (2000) *Bathing – the Body and Community Care*. London: Routledge.
- Twigg, J. (2004) 'The Body, Gender, and Age: Feminist Insights in Social Gerontology', *Journal of Aging Studies* 18: 59–73.
- Ungerson, C. (ed.) (1990) *Gender and Caring: Work and Welfare in Britain and Scandinavia*. Hemel Hempstead: Harvester Wheatsheaf.
- Ungerson, C. (2000) 'Thinking about the Production and Consumption of Long-term Care in Britain: Does Gender Still Matter?', *Journal of Social Policy* 29(4): 623–43.
- Waerness, K. (1987) 'On the Rationality of Caring', pp. 207–34 in A.S. Sassoon (ed.) *Women and the State*. London: Hutchinson.
- Wallace, S.P. (1990) 'The No-care Zone: Availability, Accessibility, and Acceptability in Community-based Long-term Care', *The Gerontologist* 30(2): 254–61.
- Waters, K.R. and N. Easton (1999) 'Individualized Care: Is It Possible to Plan and Carry Out?', *Journal of Advanced Nursing* 29(1): 79–87.
- Watson, I. (2003) *Fragmented Futures: New Challenges in Working Life*. Annandale, NSW: Federation Press.
- Williams, F. (2004) *Rethinking Families*. London: Calouste Gulbenkian Foundation.
- Wilson, G. (1994) 'Co-production and Self-care: New Approaches to Managing Community Care Services for Older People', *Social Policy and Administration* 28(3): 236–50.
- Yeatman, A. (2001) 'Who is the Subject of Human Rights?', pp. 104–19 in D. Meredyth and J. Minson (eds) *Citizenship and Cultural Policy*. London: Sage.

## Biographical note

Michael Fine is Senior Lecturer in Sociology, and Deputy-Director of the Centre for Research on Social Inclusion, at Macquarie University, Sydney. He teaches at undergraduate and postgraduate levels in the field of sociology, social research, ageing, care and human services, and social policy, and is known for his research in these fields. *Address*: Department of Sociology, Macquarie University, Sydney, NSW 2109, Australia. [email: michael.fine@mq.edu.au]