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ABSTRACT
This paper considers developments in long-term care that are increasingly focused around the individual. Recent decades have seen massive changes in the way that care is understood and provided. Yet in Australia, as in Europe, North America and Asia, we are still a long way from a stable state of agreed services and provisions. Emphasising the social theory behind the shift, it is argued that understanding the individualisation of care cannot be reduced to a simple dichotomy of good or bad. Individualised care promises much, but the concept is applied to a wide range of phenomena, often in ways that conceal rather than reveal the character of the transactions involved. For individualisation to become meaningful it must be developed as a condition of recognition that is equally applicable to those who provide and those who depend on care. It is also important to distinguish individualised care finance arrangements from real attainments in the practice of providing care. These distinctions are necessary if we are to distinguish its use as an ideological justification for welfare cutbacks and the restructuring of care provisions as markets from the liberating potential that the approach can present when care practices are more truly based around the recognition of the individuals concerned: those who receive and depend on assistance as well as those who provide it.

KEY WORDS – aged care, care, carers, care-givers, care payments, individualised care, individualisation.

Introduction

Recent decades have seen massive changes in the way that care is understood and provided. Yet in Europe, as in North America, Asia and Australasia, we are still a long way from achieving a stable set of agreed services and provisions. Formal services in which care is paid and systemically organised, as well as informal care, in which unpaid support is provided by family or intimate others, are seen as under pressure, if not in crisis. Yet the rapid pace

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of restructuring and reform that we have grown used to in recent decades does not appear about to end. Rather, in the face of demographic pressures, continuing economic uncertainty and environmental and technological challenges, the pace and extent of change has become a process of ongoing transformation that is reconstructing care, and our normative expectations about what care is, in all its forms.

Now, in the early 21st century, global social and economic forces are reshaping the lives of social groups and individuals, transforming care along with other elements of social life. A key dimension of this process is the individualisation of care (Fine 2005; Yeatman et al. 2009), a process that is incomplete and ongoing, fiercely contested and still open-ended. Drawing on both sociological theory and surveys of recent international developments in aged and long-term care, I discuss here what is meant by the term and identify a number of the most crucial of recent and impending developments in care that are increasingly focused around the individual. My aim is to show that, like the wider processes of individualisation, the individualisation of care cannot be reduced to a simple dichotomy of good or bad. Individualised care promises much, but the concept is applied to a wide range of phenomena, often in ways that conceal rather than reveal the character of the transactions involved. In particular, I argue, it is important to distinguish individualised care finance arrangements from real attainments in the practice of care. For individualisation to become meaningful it must be developed as a condition of recognition that is equally applicable to those who provide and those who depend on care. These distinctions are necessary if we are to distinguish its use as an ideological justification for welfare cutbacks and the restructuring of care provisions as markets from the liberating potential that the approach can present when care practices are more truly based around the recognition of the individuals concerned: those who receive and depend on assistance as well as those who provide it. For those who, at different levels, are responsible for managing, planning and ensuring care is available, individualisation is likely to have a different significance – although here too, there have been important developments, especially in the field of case management.

The article begins by briefly outlining the elements of social theory that concern both individualisation and care, and proceed by considering some examples that show how these concepts have been translated into practice. This includes a brief overview of a number of the key developments – from changes in institutional provisions to the promotion of community care and beyond that to approaches based on the movement from patients, citizens and clients to consumers. Each of these draws on the concept of individualisation, although the meaning of the concept varies considerably with changes in context. To understand the often selective process used,
however, we need to go beyond the moral and cultural theories of care to consider the political and economic forces that have accompanied population ageing and the restructuring of care, especially aged care, over recent decades. The article concludes, therefore, with some comments on the value of an agenda that advances, rather than retreats from, the ideals of care for and by individuals.

Theories of individualisation and care

Despite their current embrace, individualisation and the rise of contemporary interest in care are often regarded as independent, even antagonistic phenomena. Care is concerned with the wellbeing of others and is typically seen as relational, even altruistic in its essence. Individualisation, in contrast, is commonly portrayed as the opposite—the withering of social bonds leading to the emergence of a preoccupation with the self, or as the narcissistic withdrawal from social connections. Individualisation is also commonly understood as inherently manifesting a form of intensified competition between those seeking to make their own mark and take charge of their own identity (Tronto 1993). From this dichotomous perspective, the concepts are not surprisingly often seen as gendered: care as a female value and concern, individualisation as male. Indeed, this gendering of the concept of care as female, in opposition to a competitive, self-centred masculine individualism attributed to males, is at the heart of the emergence of what has become known as the ‘ethics of care’ debate (Gilligan 1982; Noddings 1984).

However, the coming together of these concepts is neither coincidence nor evidence of the convergence of two previously antagonistic or independent phenomena. It is apparent that each is a manifestation of the same underlying social dynamic—that of the incomplete and unfolding logic of modernity and globalisation (Castells 2000). Both the process of individualisation and the emergence of care as a public concern can be best understood as processes of insecure and incomplete liberation, arising from a loosening of the traditional bonds of rigid normative role expectations and the development of a potentially benevolent shared public concern. This process, referred to by such terms as detraditionalisation, modernisation and globalisation (Giddens 1996), entails an opening and loosening up of the previously closed and private domestic realm of the family and the breaking down of the rigid rules of marriage, accompanied by the increasing public availability of various forms of support and intervention. As Beck (1992; Beck and Beck-Gernsheim 2002) and others have pointed out, the individual, rather than the family or local community, suburb, ethnic
group or social class cohort, is increasingly becoming the social unit of greatest salience. The possibilities for personal realisation is strengthened with the increasing recognition of the individual, but with the loosening, even in some cases breakdown of existing social roles, so too is the potential for insecurity, exploitation and inequality.

The coalescence of the two phenomena is well expressed in Elizabeth Beck-Gernsheim’s (2002) writing on women and the family, in which, she argues, the drive towards individualisation has accompanied the movement of women from living ‘a life for others’, bound by duty to care within the domestic sphere, to claiming ‘a life of their own’ and demanding recognition as individuals in their own right. Care theory developed from this impetus (Fine 2007). Although public responsibility for providing health and limited social care services has a long history, there was a marked upturn following the development of the welfare state in the post-war period. For most of this period, aged care was considered to be the support provided in institutional settings, from workhouses and hospitals to long-stay residential institutions (Thomson 1983; Townsend 1962). Support at home remained a private matter, an unpaid domestic duty assigned to women. Care, in turn, was a largely untheorised domain. It was only following the rise of feminism in the 1960s and 1970s as feminist scholars sought to make visible the domestic duties of women that care began to receive attention (Waerness 2005). As a simple illustration of this, consider the recent adoption of the term ‘carer’.

The first recorded use in the English language of this term, in the modern sense, was in 1978, as the carers movement in the United Kingdom (UK), and later around the world, first took root in the emerging feminism and growing engagement of women in paid employment, growing stronger with the confidence imparted by the expanding recognition of individuals that had earlier taken hold in the 1960s and 1970s.

Individualisation is a complex phenomenon that can only be briefly outlined here. 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, has long been recognised as a central dynamic of modernisation (Durkheim 1984; Elias 1991; Lukes 1973). But it intensified over the 20th century, with the consequence, as Yeatman succinctly puts it, that in liberal democracies at least, each human being has now come to be considered as a subject of right, that is, as a person in their own right (Yeatman et al. 2009).

The long-term shift away from solidaristic social formations such as family, community and social class, towards a more ego-focused individual identity in high modernity has been particularly important for Norbert Elias and Ulrich Beck, sociologists from different generations. Elias identified individualisation as a process that is not unique to modern industrial or
post-industrial society, but one that occurs at historical moments which represent points in the process of social integration as smaller, relatively tightly knit social units are absorbed into a larger social unit causing a shift in the relative position of people in relation to the social group to which they belong (Elias 1994: 63, 234ff). Such a shift was designated by Elias as a change in the ‘We–I balance’, as people become detached from traditional groupings, placing greater emphasis on the I-identity of the individual person (Elias 1991: 165ff). In theory at least, citizens of modern states are not treated differently according to their affiliation to a particular community or even social class, but as individuals.

Beck’s concern with the process is with what he claims is best translated as the growth in institutionalised individualism (Beck and Beck-Gernsheim 2002: xxi). Individualisation, in this sense, is not to be confused with the notion of market individualism based on competition between self-interested individuals. Nor should it be confused with the exercise of choice by consumers, as advocated by neo-liberal economic theory. Rather, the term refers to the structural transformation of social institutions and of the relationship of individuals to society. It represents the process whereby ‘modernity has freed people from historically inscribed roles [and] . . . simultaneously created new forms of social commitment’ (Beck 2002: 202). Individualisation, in Beck’s sense, is a process that involves liberation through the disembedding of people from traditional roles and social constraints as a first step, and which holds open the promise of the recognition of new forms of re-embedding through social recognition of individualised identity and personal commitments as a second.

In contrast to the longer-term interest in individualisation, attention to issues of care have been noticeably absent not just from sociology but from economics and other social sciences until at least the 1970s (Folbre 2001; Thomas 1993). Despite the vital importance of care, this lack of interest applied to theoretical discussions as well as to empirical research on the private domain. It was only with the large-scale move of women from the private to the public spheres in the 1970s that care and caring began to receive from the social sciences even the limited recognition it currently receives. In the process, different schools of thought proposed a range of contending perspectives. Perhaps the best known in Europe is strongly identified with feminists linked to the UK and European social policy tradition. Their initial interest in care arose as a concern with the unpaid work of women within the family (Finch and Groves 1980; Land 1978). In these analyses, closely linked to the establishment of the carers movement, care came to be portrayed as a burden for those responsible, the unpaid and largely unrecognised domestic duties of women which kept them back from successful careers and other achievements outside the home. Attention to
the issue of care was essentially a call for recognition of the plight of carers (Barnes 1997), but in its most radical forms there was a call for collective interventions that would relieve women, by relieving the family of the task of care and replacing it with communal institutions and services (Dalley 1988). Later developments, a number of which explicitly acknowledge the distinctions made by Kari Waerness (1984, 1987) between care-giving work and care, went further by recognising the often exploitative character of much paid care. Research and theory ceased to privilege unpaid or informal care and increasingly came to provide quite sophisticated accounts of the links and overlaps between paid and unpaid care work (Fine 2007; Ungerson 1990).

Criticism from the disability movement, informed by the ideals of the rights of individual personhood, helped reshape the assumption that care can be reduced to a one-way activity in which an active care-giver does something to and for a dependent (and seemingly inactive) care recipient (Keith 1992; Morris 1993). Rather than seeing care as the responsibility solely of the carer, the emergent consensus understood caring as a ‘widespread activity in which we are all implicated’, with a need to ‘balance the rights of both people in the caring relationship’ (Lloyd 2000: 148). From this perspective, care needs to be understood as a ‘relationship-based’ activity (Henderson and Forbat 2002) in which care recipients and care-givers are linked. Some versions of this approach sought to reconstruct care in an idealistic way as a form of mutual assistance or help, expressing the universality of interdependence (Shakespeare 2000). While this may be overly optimistic, the critique from disability activists has proven a necessary antidote to the tone of moral superiority that had crept into many of the accounts of care as a burden. This also helped lay the foundations for an acknowledgement of the potential for conflict in policy and care transactions.

An alternative vision developed in the late 1970s in the United States of America (USA) that came to be referred to as the ethics of care approach. From this perspective care was seen as inherently relational. An ethic of concern for others was contrasted with the abstract, individualistic and universal morality that underlies the impersonal principles of justice (Gilligan 1982). While subsequent feminist analyses emphasised that care is a precondition for justice and is therefore complimentary (Bubeck 2002; Moore 1999), the approach ‘provides a powerful critique of the moral framework of independence and autonomy as characterised in contemporary policies and practices’ (Lloyd 2004: 235). Where justice requires the recognition of the rights and duties of individuals, an ethic of care does not negate the recognition of individuals, but requires it. As Sevenhuijsen and others have argued, to be both ethical and just, care needs to be brought out of the
private realm and into the political arena (Morris 2001; Sevenhuijsen 1998; Williams 2001). It is only in the public sphere that the needs and rights of each party can be recognized and the conflicting interests that emerge in care relationships resolved. If this is accepted, it is clear there is no inherent antagonism at the heart of the concept of individualised care. Just as recognition of the individual is a concept grounded in legal convention, so too must achieving the ideals of care be enhanced through the public promotion of just principles for care.

Summarising these theoretical perspectives, it is clear that both care and individualisation must be understood as phenomena that are inherently social in character. Each concept suggests a set of values and a way of behaving, just as they also imply a set of social responsibilities and commitments. As a consequence of social and economic change, both the sense of personhood that we identify with individualisation and the character of the forms of interpersonal support we call care have developed significantly and are likely to continue to do so. They must be understood not as behaviours, duties and obligations associated only with small-scale personal interactions or as the attributes of fixed role patterns. Rather, the terms refer to aspects of relationships that each depend on larger-scale societal acknowledgement. Being an individual is not just a lifestyle whim or a personal identity. It is a legal responsibility, enforced and protected by the apparatus of the law. Similarly, the duty and conduct of care, and the division of care responsibilities, is also subject to legal regulation. Yet neither can be reduced solely to legalities, as each reflects far deeper and more profound levels of social constitution.

Importantly, it is therefore not possible to accept the application of the concepts of individual personhood and rights, or the dispositions, work and interpersonal relationships involved in providing care, as applying solely to one party in care relationships. Both care-givers and care recipients, insofar as it is appropriate to make that distinction, must be recognised as an individual. In other words, just as it is necessary to recognise the individual who needs care, it is as essential to recognise the unpaid carer and paid care worker as an individual with a right to give and receive care and to care for themselves.

Theories of care and individualisation emphasise moral and cultural dimensions of social life, generally without explicit reference to political and economic processes. But both care and individualisation are concepts that are context dependent, not social laws that are automatically translated into real-world practices. While it is possible to define such everyday terms in operational ways that make them suitable for sociological analysis, as I have attempted to do here, the terms continue to refer to social values that have a wider currency and contestation, and continual redefinition is inevitable.
Processes of individualisation, along with calls to recognise the significance of care and the contribution of carers and care workers, have taken place at a time characterised by the growth of globalised finance and by long-duration global economic restructuring, in which processes of both welfare cut-backs and innovation have been, and will continue to be, prominent. In the field of aged care, as in child care and disability support, demographic and economic pressures add urgency to the processes of policy development and service provision (Esping-Andersen 2002; Fine 2007). Further pressure is added by the rapidity of technological and bio-medical innovation, in which enhanced capacities for intervention in both acute and chronic illnesses continually test the system’s capacity to meet demand. Alongside genuine innovation and enhancement of service provision models, much of the restructuring undertaken through large-scale reforms has seen increased reliance on the market, the privatisation and contracting-out of public services, the replacement of more qualified and professional staff by low-cost casualised generic ones, and other changes often referred to collectively by the terms of neo-liberalism and the new public management (Dumenil and Levy 2004). In this context, the concept of individualised care has been consistently invoked by those who seek to reform national systems.

From theory to the transformation of care

From the introduction of specialised aged care services in the 1950s until the commencement of wide-scale reforms in the 1970s and 1980s, residential forms of aged care services dominated care provisions (Parker 1987; Sax 1985; Thomson 1983). As research undertaken by a range of scholarly and other critics from the 1960s made clear, one of the major failings of residential institutions to that time was that inmates were forced to conform with an institutional management regime that deprived them of individual identity (Jones and Fowles 1984). These concerns were given a particularly prominent voice in Goffman’s (1968) important critique of total institutions.

According to Goffman’s account, the processes of social regulation within total institutions denied inmates recognition as individuals. Those admitted to such a facility, he argued, were required to carry out their daily activity in the immediate company of others. These mass-management programmes required them to be ‘treated alike and required to do the same thing together’ according to a single plan imposed from above that denied opportunities for any inmate to express an individual identity. The result, he noted, was the ‘mortification of the self’ (Goffman 1968: 11). Each person
who entered was thus forced to abandon any sense of individual dignity and personhood. To survive, ‘inmates’ were forced to forgo their autonomous initiative and sense of self. Adaptation to institutional life required instead that they submit and conform to impersonal institutional rules and procedures.

The expansion of community care as an alternative to institutional or residential care was justified in part through its capacity to individualise care by enabling recipients of support to sustain a sense of self by remaining in their own homes, maintaining their possessions and setting their own daily routines. Beyond the ever-present scrutiny that life in a congregate facility entails, care at home offered the possibility of a degree of choice and control to those who can maintain the integrity of their own living environment. Yet it is an implicit assumption that someone beyond the paid staff of specialised community-based services would provide much of the ongoing care at home.

Refinement of the philosophy of individualised care began to take place within a few years. In Britain and Australia, as in a number of comparable countries, this involved the articulation of principles for ‘tailoring care to fit the individual’, the introduction of individualised care plans and the use of case (or care) management (Challis 2004; Howe, Ozanne and Selby-Smith 1990). Packaged care, such as that provided through the Community Aged Care Packages (CACPs) in Australia, extended the concept in other ways, providing a low-cost programme that when well administered, could enable the development of close and supportive relations of care between care workers and individual clients (Fine and Yeatman 2009). Attempts to introduce a strategy for users’ rights to lift the quality of care in nursing homes also extended the logic of the individualisation of aged care, as the title of a major Australian report on the rights of residents in nursing homes and hostels, ‘I’m Still an Individual’ (Ronalds 1989), indicates.

Although there are undoubtedly many other examples of service provision that exemplify the ideals of individualised care (see, for example, Fine and Yeatman 2009; Yeatman et al. 2009), the attainment of these ideals is not simply a matter of attaching the label of individual to them. In many instances, so-called individualised support takes the form of sub-contracted services, where case managers contract assistance of various kinds from a range of service providers, including for-profit agencies. This approach typically uses the market purchasing model to create mixes of support intended to meet the needs of the individual client. Each mix is potentially different from the others, and each capable of changing to meet changing personal circumstances. Much case management literature, as well as case management practice, also emphasises the flexible capacity of this approach to enable the wishes of the individual client to be met. Rather than attending
a day care centre, for example, a client may wish to continue with a hobby at home, for which some assistance may be required for the purchase of equipment or for other forms of personal assistance. Yet in most instances strict budgetary limits preclude case management from becoming a means for the fulfilment of dreams. It is important to note how the approach often re-expresses individualisation as a form of ‘consumer choice’ (Clarke 2006; Scourfield 2007; Vabo 2006), rather than as a form of support intended primarily to enhance the rights, responsibilities and recognition of the care recipient as a full person.

Even more strongly based on the equation of consumer-choice with individualisation are the ‘cash-for-care’ or as it is termed in North America, ‘consumer-directed care’ schemes that have become so widespread in recent years (Feinberg and Ellano 2000; Keefe and Fancey 1998; Ungerson and Yeandle 2006). In these cases, dependent clients and/or their families are provided with a sum of money that can be spent on compensating family members or hiring-in domestic labour, including in some countries that of low-paid temporary migrants. In others, such as the UK and the Netherlands, strict regulations govern the way that the funds are to be spent (Pijl and Ramakers 2006; Stevens et al. 2011). These programmes have generally proven popular with families and consumers, often because they enable the payment of family members who would otherwise have provided unpaid care. Similar conceptually are the ‘personal care budgets’ currently found in the Netherlands (Kremer 2006), in the UK in the form of Individual Budgets (IBs) (Stevens et al. 2011) and under consideration elsewhere. Here again the justification is one of individualisation as a form of consumer choice. Hidden in the arrangements is the transfer of responsibility for budgetary control and for rationing resources from those responsible for funding services to the consumer or the consumer’s family. Research has shown that these payments change the character of interpersonal relationships (Glendinning et al. 2000). While financial control can ‘empower’ the consumer, budgetary limits can also be used by service providers, including paid family members, to limit the support provided, to discipline clients and to reinforce their own position (Stevens et al. 2011). As the clients of Health Maintenance Organisations (HMOs) in the USA have long recognised, assuming responsibility for financial decisions does not ensure that the care provided will enhance the recognition of the individual in need.

When need is transformed into the principle of economic demand, it is clear that ‘tailor-made finance’ is not the same as ‘tailor-made care’, as two Dutch medical ethicists who have evaluated one such programme have recently demonstrated (Grit and de-Bont 2010). Their compatriot, Annemarie Mol, similarly reminds us in her recent book on consumerism
and diabetic health care, that the logic of care cannot be reduced to that of consumer choice (Mol 2009), despite the attempt of marketing agencies to convince consumers that attaining the status of an individual depends on it.

A key feature of the individualised care innovations discussed here, and many closely related policies such as the UK’s broader personalisation initiatives for public services (Needham 2011), is that they lay emphasis on recognising the care recipient as an individual. Yet except in extreme cases (such as those involving unconscious accident victims) and then only for very limited periods of time, care should not be reduced to something that is done to a helpless dependent. Because care involves living relationships between real people, it is also essential to address the rights of carers and care workers as individuals. Shifting attention to the paid and unpaid care workforce, broadly defined, brings into focus the effects of so many of the attempts to reduce the costs of care through measures that extend, rather than reduce, the exploitation of those who provide the support.

The unpaid work of family carers lies behind the success of community care, especially for those with high care needs. When this is not available the success of community care is put at risk or becomes untenable without very significant increases in the cost of such care. Among unpaid carers women predominate of course, but there are also many men who care, especially older men (Hirst 2001). Taking responsibility for support in caring relationships can be beneficial. But there is also a wealth of research documenting the problems of those carers who take on more than they should. One of the key problems is seen amongst those who lose themselves in the process. Eva Kittay (1999) identifies this as a process of over-identification with the other, when the carer’s own wellbeing has no meaning for her anymore, all that matters is that of the person who depends on her. The problems do not stop there. Outcomes that include poverty, loss of friendships and the development of social isolation, problems of mood and stress, serious health problems, marital and relationship problems have all been repeatedly documented (Schofield et al. 1998). In turn, many authors stress the importance of care-givers being able to care for themselves (Sevenhuijsen 1997; Williams 1998). This can be put in another way. Those who care must also be recognised as, and learn to recognise themselves as, individuals. This entails rights and responsibilities, but also it requires the right sort of support services available outside the family.

In the process of restructuring and contracting-out of services care staff have often lost security and recognition, their conditions of work increasingly casualised and often de-professionalised. Competition
between providers, the reliance on part-time and casual staff, and the deprofessionalisation of much of the work that was previously the preserve of professional and semi-professional staff, threatens what, after Ritzer, might be called the ‘McDonaldisation’ of care (Ritzer 1993; Ritzer and Walczak 1988). The effort to ensure that affordable care deals are available is all too often reliant on using cheap, low-skilled staff with insecure casual jobs. Is this insecurity what those reliant on care really need? Although matching services to needs has long been a key question in evaluations of public services, it is not considered crucial in a consumer market where demand has replaced need and market logic dictates the stimulation of demand. Perhaps the most urgent question for care researchers today must be whether the low unit cost associated with a McDonaldised care workforce can ensure there will be a sustainable, skilled and reliable workforce in future years (Fine 2007)?

The dilemmas of individualising care

Although intimately intertwined in contemporary policy and practice, the ideals of individualisation and care set out apparently conflicting ideals. At the core of their intersection, therefore, lies a dilemma. Care requires a social relationship in which the actions of one or more persons become an essential means for the realisation of another. Is the realisation of an individual’s autonomous agency and identity only to be achieved at the cost of another? Drawing on contemporary theories of care and individualisation, I have argued here that the giving and receiving of care is better understood not as an impersonal product which is consumed by the recipient, but as a relational process in which the care-giver must also be acknowledged as an individual and accorded recognition as having an autonomous identity and agency. If this is true, it is necessary to go beyond the reduction of the ideals of individualisation to the care recipient to include also those who give care. Only then can the potential presented by the ideals of individualised care be realised.

The application of the concept of individualisation to that of care has underpinned a considerable number of innovations that have helped reshape the way that personal support is provided to older people and many others who rely on assistance due to disability or medical need. Yet the open-ended and at times ambiguous character of each of the concepts makes their linkage suspect as the context in which change has been implemented has been shaped by the extension of market principles into almost all corners of human existence and by the global economic restructuring and welfare state reform since the 1970s (Iversen and Wren 1998).
Service innovation, restructuring and policy reform are likely to continue to be a key feature of care provision in the 21st century. Within that system, individualised care has proven to be a remarkably robust ideal. Yet, despite its potential, the term is often abused in its reduction of the concept of individualisation to market-based consumer choice and in the hidden exploitative approach to care workers and unpaid care-givers. For those reliant on assistance and perhaps even more urgently, for those who provide care, the agenda of individualised care has considerably more potential to achieve meaningful individualisation that should not be abandoned. This means moving beyond the one-directional model of care as something provided to passive dependants, or seeing care as something that should be done as cheaply as possible.

References


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**Description**

Covers human ageing all over the world: theoretical and empirical research on such issues as life-styles in later life, work and retirement, mental illness, sexuality, demography, health care and the history of old age.

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