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The dialectics of health and social care: toward a conceptual framework

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Abstract The difficulty in conceptualizing health and social care resides in its complex and dialectical character: its constitutive social relations are not reducible to a single logic or type of actor; it is both a descriptive and a normative idea, a tool of classification and evaluation, a means of analysis and a weapon of critique. It is both theoretical and practical, a scientific construct and an ethical stance, rooted both in academic disciplines and the manifold practices of health and social care. This article draws out the radical core of the concept of care as a dialogical form of labor that transcends mere instrumental or strategic action; it then explores the contradictions of this praxis in the context of the social division of care in late capitalism.

Keywords Health care · Carework · Dialectic · Gift · Reification

The concept of care

Health and social care have become a massive set of service, financial, and manufacturing industries shared between the public, private, not-for-profit, and informal sectors. The manufacturing side of health and social care (construction, pharmaceutical products, surgical, diagnostic, and other equipment) is dominated by flourishing capitalist firms selling to the huge, welcoming markets constituted, regulated, or subsidized by states. The financial landscape of health and social care is peopled by a mix of public bodies, private, cooperative, and mutual assurers, as well as individuals paying out of pocket. Health and social care "services" are parceled out in various ways, depending on the country, between public agencies, private firms, cooperatives, charitable and non-profit associations, families, neighbors, and friends.

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What is *care* in the universe of health and social care? Is all of it care or only a part? What do we mean when we speak of health and social care? Is there a unifying concept of care in a health care literature that spans many academic disciplines and theoretical traditions (England 2005)? Recent years have, for example, seen outstanding treatments of community care from an anthropological perspective (Twigg 2000), analyses of emotional labor in the fields of nursing and social work (Bolton 2005), institutional-ethnographic studies of the impact on care of new forms of management in hospitals and social-service agencies (e.g., Baines 2004), discussions of the ethics of care from the vantage point of political philosophy and critical social policy (Williams 1999), as well as psychoanalytical writing on care (Hollway 2006). A rich overlapping literature deals, for example, with aspects of giving, such as volunteering (Mellow 2007), and the role of the social economy in health and social care (Jetté 2008).

Many studies explore the construction of meaning in care relations; a voluminous corpus of publications discusses the political economy of health and social care in terms of legislation, policy, financing, patterns of ownership, organizational design and dynamics, and so on. Sometimes, care is treated as synonymous with certain types of activity, such as the work of feeding, bathing, and dressing the bodies of the young, the sick, the elderly, and others in need of assistance with activities of daily living; at other times, care designates a way of living and performing such practices, a particular relationship to them.

The very plurality and heterogeneity of this literature casts doubt on the possibility of developing a single, *undifferentiated* concept to which all forms of care could be reduced. In a classic article, Carol Thomas argued that the literature on care had failed to conceptualize it, offering instead only representations, pseudo-concepts constructed on the basis of some of its empirical manifestations. In her view, it would not be possible to develop "a concept [of care] that can have an independent theoretical validity," because "a case would have to be made that 'care' constitutes a distinct form of social production by virtue of its social relations, whether capitalistic, patriarchal, or in terms of some other social-scientific category"—and "it is not possible to make such a case" (Thomas 1993: 665).

In spite of Carol Thomas's arguments, I believe that it is. To be sure, one cannot reduce the constitutive social relations of care to a single logic (e.g., capitalism) or type of actor (e.g., women). Gender occupies a key role in any account of care (Armstrong and Armstrong 2004). Yet the latter cannot, for example, simply be collapsed back into "the unpaid domestic and personal services provided through the social relations of marriage and kinship" (Daly and Lewis 2000: 283), any more than it can be reduced to capitalist relations of production, in spite of the fact that much health and social care moves within their orbit throughout the world today.

Care's gendered character is historical, not natural: "Caring can be understood as women's work only within the unequal relationships, structures and processes that help create women as carers and undervalue this caring work" (Armstrong 2004: 10). Mothers care and so do daughters, but then so do fathers and sons, although differently and asymmetrically. Psychoanalytical theory tells us that we are profoundly shaped and differentiated by our earliest relationships, which produce us as gendered subjects (Hollway 2006). Yet, our relationships throughout life do not simply replicate those original ones again and again.

Care is both theoretical and practical, descriptive, and normative, a scientific construct and an ethical stance, a tool of classification and evaluation, a means of analysis and a weapon of critique. It is rooted both in academic disciplines and the manifold practices of health and social care. Care is complex, but can be conceptualized if it is grasped dialectically. A valuable basis for this can be found in the growing literature on care as a *specific* form of work. As *complex, collective labor* (Browne 2009a), care can be *thought through* (Armstrong 2004) in terms of the relations of production that organize it.

The perspective of total social labor (Glucksmann 1995) highlights the plurality of the relations of production in society, encompassing both wage labor and that which is often not recognized as work, such as much carework. Daly and Lewis define the total social labor of care as the "[d]ivision of care (labor, responsibility and cost) for children and elderly or ill adults between the state, market, family and community" (2000: 287).

Care under conditions of alienation (e.g., capitalist or patriarchal relations of production) has received considerable attention. But what are care's intrinsic features as a form of work? What would it be like if there were no exploitation or oppression? In the first part of the article, drawing in part on my own experience, I propose an ideal-type of care as *co-production* that affirms the unity of "caregiver" and "care recipient" in the production of what I call here the "care effect." I then present the two faces of the "care effect" and outline an as-yet abstract typology of the plural relations of production in care, emphasizing their dialectical character: each is contradictory and opens the way for the emergence of its other, but each also interacts with its other in a higher, albeit asymmetrical unity. The third part of the article leaves behind the abstract typology of care relations and highlights two aspects of reification: the occlusion of the unity of the total social labor of care by the social division of care; and the organizational and discursive reification of care impelled by the drive for managerial control of the labor process. I conclude the article with some points about the right to care in a world of asymmetrical relationships.

Care as co-production

A developing tradition of scholarship has discerned a unifying theme in the heterogeneity of care, defining the latter as a blend of physical, emotional, and intellectual labor, the material and instrument of which is the human body (James 1992). "Carework is bodywork" (Twigg 2000: 17, 137ff.), in which the product—what I call the *care effect* (of which more presently)—is appropriated and enjoyed in the very act of its production. This act is mediated by, and only possible within, the development of a specific relationship: "the process is itself the development of a relationship. The care a carer provides is basically inseparable from the relationship that is being developed with the person she is caring for" (Himmelweit 1999: 29). As Abel and Nelson (1990: 7) put it: "This activity involves the texture of human connectedness, not simply tasks and burdens." Indeed, care is properly understood, not as something one (active) person does to another (passive) one, but as an act jointly performed by both together: "It is in the dynamics of the care encounter that the nature of what is produced is defined; production and consumption collapse into one another. [...] users and workers are co-producers of care" (Twigg 2000: 1, 121).

A personal experience may serve to illustrate this dynamic. Some years ago, my mother, who was suffering from Parkinson’s, began to need help with most aspects of everyday life. For a time, she was able to remain at home thanks to formal home care assistance and the help of kin and friends. Later, it became necessary for her to move, first into a retirement home in which she continued to receive home care, then into a chronic care hospital.

Helping her on a daily basis compelled me to face the limits of what I could and could not do for her, as well as the extent and limits of the assistance she could expect from other quarters. The realities of bounded care on the part of her caregivers were thrown into relief by her continued power to care for them, even as she gradually lost all mobility, until even her ability to speak was diminished. I could shop for her, do her banking, pay her bills, clean her house, prepare food, deal with the home care agencies, retirement home, hospital, physiotherapists, occupational therapists, nurses, home care workers, and physicians. I could drive over to her house in the middle of night to help her back to bed when she got stuck in the hallway or the kitchen, because her legs suddenly would not cooperate. As her son, I did not feel comfortable helping her with bathing, toileting, or dressing.

She, too, faced limits to her capacity to care. She could no longer do many of the things she had done for me or for others. However, she could still, with her strength and serenity, with her refusal ever to complain, with her words of encouragement, deflect all guilt from me and make the time spent with her always pleasurable. Clearly, she was still caring for me, although in a changed form, just as the way I cared for her had evolved—indeed, our respective manners of caring had transformed together in mutual interaction. The same may be said of her relationships with the other people entering her life, the personal support workers, therapists, nurses, social workers.

If care were no more than servicing or repairing the body like a machine, little would distinguish it from any other service. More than tending to an object, though, care means attending to a person. The kind word and smile, attentiveness and listening—in short, the *time*, however brief, spent beyond what the physical task in itself requires—these can transform the perfunctory act into the graceful, comforting gesture, on the part both of the “user” and the “worker” (Simmel 1950, 391).

Care is thus not something that is only performed by the “caregiver” and that happens only to the “care recipient,” if it is true that there is co-production. Care is thus not only reflexive work; it is a dialogical process of awakening recognition and trust (Baldock 1997; Maheu and Bien-Aimé 1996). In this view, the “caregiver” also receives; the “care recipient” also gives. Although care is a form of material labor, human beings acting upon nature in the form of the human body, it is also communicative action, differing radically from the Weberian notion of work as instrumental, strategic action (as proposed by Habermas 1984).

The two faces of the care effect

In her classic work, *The Managed Heart*, Arlie Hochschild points to the salience of giving in emotion work: “We bow to each other not only from the waist but from the heart. Feeling rules set out what is owed in gestures of exchange between people”

(Hochschild 2003, 76). She speaks of the "payment of latent dues," but regards this basically as an essential part of the gift relationship in everyday life: "The deeper the bond, the more central and latent the gifts exchanged, and the more often a person compensates in one arena for what is lacking in another. One way that such compensations are achieved is through the medium of emotional gift exchange" (Hochschild 2003, 83–84).

Drawing on theories of drama (notably Stanislavski), Hochschild portrays emotion work in everyday life as a performative activity that generates a specific effect, just as the dramatic event in the theatre does. A play or concert only has an effect because the audience opens itself and responds to it. In the case of care, care givers and recipients are typically the authors and actors of the event. Through their various interactions, they produce mutual feelings, attitudes and relationships. This is *a fortiori* the case in health and social care, which bring together individuals in order to treat or cope with poverty, addiction, disability, disease, or impending death. It confronts them with difficult, even frightening and horrible realities, but in such a way as to offer comfort and a way forward.

The conjunction of physical, emotional, and intellectual contact in the context of a collective performance constitutes an aesthetic moment at the heart of care, the "care effect." The performative, aesthetic, dimension gives care a holistic character (Lukács 1963) and marks it as distinct from the continuum of everyday life (Browne 2003: 1–3). It is a bracketing out of everyday life that (in Caudwell's words) "adapts the heart to a new purpose" (Caudwell 1973: 37). The extent of the break with everyday life varies considerably. Moments of birth, death, catastrophic illness, or surgery mark sharp ruptures, while routine visits to the doctor or other health care provider may scarcely do so.

Especially at moments of marked rupture, "ordinary time" is suspended and replaced by a different experience of temporality, a "time outside of time." This is analogous to an aesthetic experience, such as a solemn high mass or other religious gathering, a mass political demonstration, a memorial ceremony, a dramatic presentation or concert, or any other immersion in a work of art. Of course, the experience of time will be very different in moments of high dramatic intensity (such as may arise in acute care, e.g., surgery) than in the ongoing work of maintenance and rehabilitation (such as may occur in chronic care—e.g., home care).

For its participants, carework, like the aesthetic experience, both conceals and reveals. The care "giver" reveals herself by the way in which she goes beyond her abstract work mandate (insofar as the latter allows her to, as we shall see). A home care worker, for example, is assigned a given number of clients to bathe and dress each day—but how she interacts with them, in order to accomplish this, conditions the care effect. The care "recipient" through her work reveals herself to be something more than just a "patient," a body, an illness or disability, a mindless victim (which is too often exactly how people, especially elderly women, are treated in the health care system). Confined to her bed because of Parkinson's, my mother regularly had to listen as nurses and other staff spoke about her in the third person, as though she were not there. An ironic comment on her part would jolt them into awareness that she was not only present, but an interlocutor to be respected. Dialogue thus set in motion led to interaction and mutual respect.

The care effect is often only noticed when it is absent or inadequate (James 1989: 28) or some extreme situation arises. Like a dance, which must appear to involve much grace and little effort, but in which grace is the result of much hard work, care may have a natural, effortless character. In other words, it may appear as a self-contained harmony that seems simply given—or may come across as a display of heroic self-sacrifice or stoical forebearance in the face of a terrible fate. My mother, lying on a stretcher in emergency suffering from a bowel obstruction, betrayed none of her pain, instead expressing her concern for me: “Poor you, having to sit up with me in the middle of the night! Please go home and get some sleep!”

The care effect reveals, but also conceals: the caregiver may strive to make the gift of time, attention, speech, and physical work seem as ‘natural’ and effortless as possible, de-emphasizing its difficult and stressful character—deprecation being in certain cultures a typical aspect of the gift (Visser 2008). The care recipient, meanwhile, downplays pain and discomfort with a view to making the caregiver’s task easier. The care effect in this case seems to embody Gouldner’s *norm of beneficence*: something seems to have been given for nothing, as a response to the other’s need, irrespective of his or her past behavior (Gouldner 1973b: 266). That contemporary North Americans often experience care in this way is confirmed by Wuthnow. Calling into question the reciprocity model, he suggests that people do not so much give of themselves in order to receive from others, as derive fulfillment from within themselves and give out of a sense of what is right (Wuthnow 1991: 96ff.).

According to Gouldner, the world of work is characterized by reciprocity. The guiding principle of reciprocity is: “tit for tat”—I do x for you in exchange for your performance of y for me (Gouldner 1973a). By contrast, “something for nothing” is an aesthetic construct: “Reciprocity is the norm of the ‘realistic’ world of work. Something for nothing is the ideal of the world beyond work, the world of fantasy and imagination. Something for nothing is the surrealism of the world of *art*. For aesthetic gratification keeps no books and does not measure out returns against investments” (Gouldner 1973b: 268–269).

Bourdieu’s theory of the gift suggests that caregiver and care recipient must lie to themselves about the self-interested nature of their relationship, that they must experience reciprocity as something more than it actually is in order for it to occur (Bourdieu 2003: 276ff., 1980: 178–180; Adloff and Mau 2006). When each is motivated by the norm of beneficence to give something for nothing *and to make that gift seem like nothing*, the resulting aura fills the parties involved with the energy and conviction to do ever more: “there is no gift that brings a higher return than the free gift, the gift given with no strings attached. For that which is truly given freely moves men deeply and makes them most indebted to their benefactors” (Gouldner 1973b: 277).

While the initial move may be motivated by the norm of beneficence, with no thought of a return, its “recipient may well interpret a beneficently motivated action in terms of the norm of reciprocity and he may feel himself obliged to repay. The same action can, in short, be posted to different accounts in the ledgers kept by different people; the donor can place it in his beneficence account, the recipient in his reciprocity account.” (Gouldner 1973b: 276) At the same time, as Gouldner points out: “To note that an exchange of reciprocities may be the *consequence* of a given action is, of course, no basis for interpreting that act as having been *motivated* by the norm of reciprocity. The ‘earthy’ consequences of mutual exchange may be activated by the ‘heavenly’ motive of an altruistic beneficence” (Gouldner 1973b: 277; Chanial 2008: 25ff.).

Does the “utopia” of altruism mean that the care effect is a form of false consciousness and that it masks relations of domination, as Bourdieu would have it? There is no doubt that by making themselves feel a certain way in order to foster emotions in the other, the parties to the relationship may no longer see each other for what they are. In the resulting situation of misunderstanding or misrecognition, the labor and suffering of the other are eclipsed behind a “beautiful” mask of serenity and competence, or aestheticized as the sublime face of sacrifice. In the eyes of third parties, in particular, this dramatic performance appears as the meeting of two “good,” strong individuals, who are “naturally” admirable. Behind this “natural” and “beautiful” veil, relations of domination may prevail.

Giving is subject to an internal dialectic: it may deviate into pure competition and power struggle, or into the dissolution of autonomy, the oppression of one or the other party (Graeber 2001). There is nothing intrinsically egalitarian in the gift relationship (Godelier 2007). Its aestheticization may contribute ideologically to the reproduction of patriarchy, as the glorification of giving provides a sublime aspect to the grim compulsion of the “caregiver” to labor in conditions of subordination. Alternatively, the “caregiver” may abuse her power, crushing the autonomy of the “care recipients,” in a sense “killing them with kindness”: “the impulse to care for the other, when taken to its extreme, leads to the annihilation of the autonomy of the other, to domination and oppression” (Zygmunt Bauman quoted by Hughes et al. 2005: 262).

The oppressive and exploitative imposition on women of the lion’s share of carework—not just in the family, but in society in general—has long been made legitimate either by the denial that it is really work, or that it involves any skill, on the basis that it stems from women’s nature (Cresson and Gadrey 2004). Just as the aestheticization of care has served to exploit women as caregivers, so it has also reinforced the oppression of people with disabilities, painted as the helpless charges of paternalistic and benevolent care (Williams 2001).

Molinier’s powerful article on childcare centres sheds light on the reification generated by repetitive, monotonous, and physically stressful work. Many workers complain of back problems in particular. But their burden is emotional, too: “elles en ont plein le dos”—they are fed up. The work is alienating, but, for fear of appearing “unnatural” and even losing their jobs, they dare not admit to others, or even overtly to themselves, that they often resent the babies and toddlers they look after. One could say that they frequently “mind” their charges both in the sense of caring for them and of being bothered by them. Molinier sees many such workers trapped in an imposed “womanly” consciousness (*la muliérité*), by virtue of which they can only profess their love of the children and proclaim how adorable the latter are (Molinier 2004).

Isabelle Marin strikingly describes the contrasting case of the domination of the caregiver over the care recipient. In the special context of the cancer clinic, the patient, like a sacrificial victim of old, is granted extraordinary attention and support, in exchange for consenting to undergo the agonies of treatment: “Within the sacred precinct, [the sacrificial victim] is prepped, dressed up, and, virtually consenting, partakes of the intimacy of those practicing the sacrifice" (Marin 2008: 408).

Both forms of domination (i.e., of care givers over care recipients and vice versa) have been the object of social critique and resistance from political movements. Feminist activists have exposed the exploitation of women as caregivers. Disability rights activists have attacked the oppression of people with disabilities under the guise of care (Beckett 2007).

Evoking positions formulated within the disability rights movement, Fiona Williams writes: "for many, the very concept of 'care' embodies an oppressive history in which the practices and discourses of paid (particularly professional) and unpaid caregivers have maintained disabled and older people in a position of, at worst, unwanted dependency, abused and stripped of their dignity, and, at best, patronized and protected from exercising any agency over their lives" (Williams 2001, 478). In order to escape the paternalism and inequality that some forms of care relationships may harbor, movements of people with disabilities have affirmed the core value of independence and sought to replace "care" with "support," based on "choice" and "control." A key demand has been the right of people with disabilities to be the employers of the personal assistants (rather than caregivers) of their choice (Hughes et al. 2005).

Such movements show how broader social norms of liberty and equality, autonomy and fairness, provide an essential context for care. Gabrielle Meagher's discussion of contract as a normative resource for caregivers is relevant here. She defines contract as a "freely chosen interaction between autonomous equals," mediated by commodity exchange (the payment of money for service), and "underpinned by trust in the generalized other" (Meagher 2006: 38–39).

Because the appropriate response to a gift is not the repayment of the exact equivalent at a specified date (as in a contractual arrangement), but the return at an undetermined *later* date of something that is not determined *a priori*, the debt created by the initial gift may be more lasting. The goal of every actor in the market is to be free of debt, whereas the goal of actors in gift exchange (at least of the open-ended kind) is to maintain indebtedness. In the market, paying off debts leads to good relationships; in gift exchange, good relationships come from giving, receiving in return, and then giving back again (Godbout 2007).

Contract may, for example, often be viewed positively by a parent who does not wish to be beholden to a child for care, notwithstanding the child's willingness to give, notably in cases where such care might be of an intimate nature. Certain situations may more easily be negotiated and gotten through with a stranger than with kin. The contract may have a useful distancing effect, enabling both the person in need and the provider to hold certain emotions (shame, guilt, embarrassment) at bay. Those providing and receiving assistance may both value the flexibility and the "power to exit" in principle inherent in the employment relationship (Williams 2001: 482).

The down side is that contract can lead to pure instrumentality, the mere pursuit of self-interest. Giving is about forging ever stronger social bonds, while contract is about avoiding being entangled in such bonds (Godbout 2000). To suggest that the parties to a contract for care "specify a good caring relationship as a term of their contract, perhaps as an element of service quality" (Meagher 2006: 39), begs the question of how the care effect is to be produced in such a fashion.

If the contract were to enumerate, clause by clause, different requirements and aspects of such a "good caring relationship," this would never amount to more than a sum of parts that did not add up to a whole called care. It is a lot easier to specify the type and quantity of services (laundry, meal preparation, baths, assistance with routine personal activities of living, etc.) than to define the type of relationship that should be developed in the course of performing them. If the contract were very vague, the parties would have to draw upon other "resources"—i.e., their sense of professionalism, of religious or moral duty, their desire to give—in order to produce the care effect. In other words, they would have to fill the form of commodity exchange with content not readily specifiable in any contract.

Contract may indeed be "necessarily underpinned by trust in the generalized other," but, as Hobbes long ago pointed out: "Covenants, without the Sword, are but Words, and of no strength to secure a man at all" (1968: 223). In fact, contracts exist because one often does not trust the other not to misunderstand, misinterpret, forget, or neglect, the agreed-upon tasks. They exist as a means of channeling self-interest into the realization of an exchange that is mutually beneficial, instead of a competition in which one's interest can only be fulfilled at the expense of the other's.

One of the notoriously difficult aspects of care is ensuring the security of vulnerable individuals, such as children, the frail elderly, and the sick, at the hands of those given the task of caring for them. One does not hire just anybody to look after one's elderly mother who lives on her own. The high transaction costs in this area are often invoked as a sign of market failure and as a reason for entrusting such tasks to the non-profit sector, to professionals, or to others who are worthy of trust (for an excellent brief discussion of this and related issues, see Laville and Nyssens 2001).

It is interesting to note in this context that the advocacy of the contract form among people with disabilities takes place in the context of collective movements and struggles that are "part of a collective response to the social relations of welfare and have, as such, more in common with socialist and communitarian traditions" (Williams 2001: 482). Really existing market relations are *asymmetrical* (Livant 1998): movements of people with disabilities, like labor unions, are attempts by those who occupy weaker positions in the market to achieve greater balance. The formal mechanisms of the market and the invocation of equal rights are important as levellers, but they are incomplete: the market is only fine if one has money and the ability to rule one's own affairs; rights are fundamentally important, but only if they can be enforced (prevention of discrimination) and implemented (empowerment).

Relationships between "caregiver" and "care recipient" are therefore dialectical (in the sense that they harbor contradictions and may give rise to their opposite): the dimensions of kinship and giving are conducive to the establishment of a lasting bond, in which need may be recognized, negotiated, and addressed in conditions of co-production. However, the continuity of care thus achieved may be undermined by the emergence or perpetuation of competition, inequality, inequity, and subordination. (These may be occasioned by forms of systemic oppression, such as gender, class, or "race." However, the potential for domination is intrinsic to the gift relationship.)

In reaction to this, individuals may seek out the autonomy and equality promised by contractual relations. The latter, in turn, may undermine the production of the care effect by lapsing into mere instrumentality, thus calling forth their opposite, a return to the gift, to primary sociality. The realization of care thus requires going beyond the either/or of autonomy and dependency, emotional bonding and instrumentality, gift, and contract. Broader social norms of liberty, equality, and fairness provide an essential framework, as may standards and knowledge related to professional practice, as well as responsibility to a third party (agency, hospital, etc.).

Care in a world of asymmetry and reification

Kinship and gift relations are an insufficient basis for ensuring health and social care. Many people in need may be without kin, at least of the kind willing and able to give care. Gift relations are too unstable and unpredictable to offer a guarantee of adequate care. Direct contractual relationships are not a practical proposition for those who are too young or too ill to manage them on their own, for those suffering from dementia, or for those who lack the organizational and other resources to do so. Supervising such relationships may prove difficult for those acting on behalf of individuals who cannot manage their own affairs. Negotiating their own care contracts may expose individuals to the risk of exploitation by unscrupulous operators. Given the complexity of health and social services, it is difficult for any individual without much time and assistance to find the appropriate caregivers. Finally, health and social services must be financially accessible to those who need them.

All this makes it desirable to provide those in need of care with legislative and regulatory protection, with financial assistance (such as free, universally accessible health care), and with the support of managers, brokers, or other agents. These are present throughout a large part of the global North in the form of public systems embodying a collective, social response to need. This takes the form of legally established standards of care, mechanisms of enforcement and implementation, as well as the gratuity of (or at least subsidized access to) care. This is achieved through the mobilization of trained, supervised, and competent workers organized in territorially based services.

In many countries, these institutional and organizational frameworks form the basis of accessible, affordable, and equitable services, but harbor contradictions of their own. One needs to ask whether they paradoxically imperil the care effect by the relations of production they put in place.

In the global North, health and social care arose out of and on the basis of the patriarchal division of labor between men and women (with its own dialectic—see Fisher and Tronto 1990), and were developed by religious and community organizations, capitalist firms, or the state. Health and social care are not only divided between state, capitalist, and other sectors, and therefore riven by relations of gender and class. They are also characterized by a highly developed division of labor between givers and recipients, providers and patients, waged and unwaged workers, professionals and non-professionals, and regulated and unregulated employees. Furthermore, there is the division of labor between different professions, e.g., physicians, nurses, and social workers. “Race” and ethnicity also play a significant part in segmenting the workforce, while cultural barriers complicate the establishment of trust between caregivers and care recipients.

Hierarchies exist between the different actors, places, and times of care—hierarchies guided and legitimized by values and perceptions, and materialized in flows of capital (money, equipment, labor power, bodies as raw material). Thus, hospitals came in the twentieth century to be the privileged spaces of care; pharmaceutical corporations came to be immensely powerful actors, while personal support workers did not.

The segmentation and stratification of the actors by profession, function (provider vs. patient), status (waged/unwaged, professional/non-professional, regulated/unregulated), and sector (state, market, community, and family) raises questions as to the potential for co-production of care. The development of modern medicine as a set of specialized fields of knowledge and practices monopolized by guild-like professions had already institutionalized the separation of health practitioners (those who do) from patients (those who suffer and submit). The process of commodification tends to transform care recipients into consumers instead of co-producers, reifying care as a bundle of "deliverables" (as in the expression "delivering health care") (Leys 2001).

One can construct a typology of positions in the care labor process in function of the degree of presence of the workers to the care recipients. Physicians, nurses, home support workers, and social workers, for example, are at times immediately present to the care recipient and for a certain duration. They not only encounter the care recipient in the public spaces of reception areas, hallways, or doorways, but in the private spaces of homes or examination rooms, where care recipients regularly must disrobe and submit to intimate inspection. Other workers encounter care recipients, but fleetingly and without access to their private spaces and selves—one thinks of clerical workers or of those who deliver meals at home. Their tasks do not differ notably from other service jobs. Finally, there are all those workers who are never in the physical presence of the care recipients and whose work is not performed in the same time as it is consumed: lab technicians who analyze blood samples, for example (Browne 2009b).

In this context, the dialogical process of co-production is the final moment in a collective process involving many others, who are not all directly or immediately present. There would be no health care without the work of many such people; they must therefore be regarded as part of the overall work of care. As a result of the social division of care, it could and does *appear*, however, as though there were specific relationships in which care takes place and others that are merely "ancillary," and that do not differ from those to be found in other administrative, service, or manufacturing industries.

While recognizing that much of health and social care in the "real world" *seems* to have little to do with care as co-production, a more dialectical view grasps care as a complex and contradictory collective process that consists in the unity of these different aspects beyond the immediate appearances. In other words, rather than view health and social care analytically as the sum of discrete caring and ancillary activities, one ought to conceive them dialectically as a totality of carework, fragmented and distorted by the concatenation of oppressive relations of production. In other words, care today is obscured by reification (Lukács 1971).

The fragmentary thinking about care noted by Carol Thomas is thus scarcely surprising. On the one hand, a world of service industries, of public and private expenditures, of fiscal policies and legislation, of a plethora of professions, regulatory bodies, labor unions, community organizations, and private corporations; on the other, an intimate world of one-on-one caring relationships. What and where is care, then? Is it a product, a service, a practice, an emotion? Is it something people do in function of their gender (e.g., being a woman), class, or professional status? The thrust of my argument is that it is a process, the unity of which is occluded by the reification resulting from the social division of care.

The social construction of need in health and social care is not only shaped by perceptions, conceptions, and experiences that arise in the immediate relation of co-construction. It is also molded by powerful and hegemonic interests, identities, and ideologies that arise in various parts of the system (e.g., the corporate interests of pharmaceutical corporations, insurance companies, hospitals, and health-care professions). The principles of care are in many cases increasingly subordinated to commercial, political, and organizational imperatives in what are today largely understood as "service industries" (Rankin and Campbell 2006). Even at the "front line," where the care effect ought, if anywhere, to be produced in the immediacy of the care relationship, care is trumped by the imperatives of an exogenous and extraneous time economy, of maximizing profit or of "fighting government debt" by cutting back on public-sector expenditures (Browne 2000).

Standardization, the construction of measurable indices of quality, and the dissemination of "best practices" have become the order of the day as employers in the fields of health and social service strive to control the labor process more. The visibility and accountability these are meant to introduce are supposed to safeguard care from substandard practices and ensure equitable access to care for all.

Timothy Diamond's remarkable study of nursing homes (1992) shows how the real lives of workers and residents are relegated to the shadows by the *documentary reality* constituted by the structure of the reporting process. Along the same lines, Gustafson (2000) shows how changes in the tools of reporting and documenting in Ontario restricted the autonomy of professionals in home care. Rankin and Campbell (2006) have arrived at similar conclusions with respect to hospitals and Baines (2006) with regard to social services.

The definition of the goals, as well as the nature and process of the work itself, have been significantly altered from above, shifting health and social care from the formal to the real subordination of labor to capital (Marx 1976; Harvey 1982: 107ff.) to a much greater degree. The result has been a decrease in the autonomy of professionals to co-produce care with care recipients. Because bureaucracy "separates conception from execution (...) staff are prevented from applying personal knowledge about the needs of their clients or drawing from their own experiences" (Abel and Nelson 1990: 13).

In the face of new forms of work organization that limit their autonomy, many workers are faced with moral dilemmas. Their personal and professional values call upon them to give time and attention to those in their care, but institutional rules, policies, and protocols say the contrary. This was brilliantly illustrated by Diamond:

> Under present organizational principles, medical tasks can dominate—even cancel—caring work. One expressive moment of this for me was when I stopped to sit with Mary Karney, a seventy-seven-year-old resident, who was

> crying on her bed. Before I could find out why she was crying, I was interrupted by my supervisor who scolded me for sitting down with Mary, reminding me that I had sixteen more vitals to do before bed-check (Diamond 1990: 176).

A recent survey of nurses and personal support workers in Canadian and Scandinavian nursing homes drew similar responses to a question about what workers would like to have more time to do: listening, talking, and helping residents overcome loneliness. Some fifty-eight percent of the Canadian workers complained of having too much to do all or most of the time (Armstrong et al. 2009: 63). In institutional settings, most complain of being rushed off their feet, of barely having the time to perform the basic tasks of bodily care; emotion work, which is not quantifiable or predictable, tends to fall by the wayside.

The particular spatial character of the home, as a separate and private place, creates different dynamics. On the one hand, care recipients may have greater power and authority to co-produce the care effect, because they are in their homes. On the other hand, their very isolation may in some cases make them very vulnerable (or feel they are). The care givers, for their part, are less directly subject to the scrutiny of managers than in an institutional context. This can afford them greater flexibility and autonomy in assessing needs, in deciding what to do and how to do it. The result may be greater empowerment of the care recipient or the opposite, depending on how much genuine co-production takes place.

However, in its control over time and in its reporting protocols, management retains powerful tools for ensuring that home-care workers do its bidding. Workers scarcely have time to carry out their mandated tasks, such as bathing and dressing the people they visit in their homes, and whom they assist in eating their meals. It is known that workers, motivated by the norm of beneficence, frequently give of their own time to make up for the lack of remunerated time in which to address the needs of those for whom they care (Twigg 2000).

Gouldner speaks of the principle of indulgency, which “contributes to the stability of factory social systems precisely insofar as it allows workers to receive *more* than they are legally owed under their union contract or is customarily due them in their worker-status” (Gouldner 1973b: 266). In the case just discussed, the principle of indulgency works in the opposite direction: the employer gets more out of the workers than stipulated in the employment contract. The gift element in carework becomes a means of extorting surplus labor (Browne 2009a).

Conclusion

This article began by defining care as though it entailed perfect reciprocity, interdependence, and symmetry, as though (as in Rousseau’s social contract) all were equal, each were free, and the good of all were achieved. I delineated the reciprocal dimension in care as though all were equally indebted to all, as though each enjoyed the full benefit of giving and receiving care as an equal.

As the previous section made clear, however, the world of really existing health and social care is rather one of reification. Many who participate in the collective work appear not to be involved in care, while others are reduced to the passive role of patients. Only some are seen as doing care, but then in many different ways circumscribed by professional standards, employment contracts, and institutional imperatives.

The world of health and social care is fragmented by the social division of care. The lived experience of care is too often submerged under a factitious documentary reality. Multiple, intersecting relations of inequality and oppression are produced and reproduced in the social relations of health and social care, e.g., gender, class, "race," age, and ability/disability.

A full discussion of the questions that arise in this context, notably those that pertain to the social construction of such differences, is beyond the scope of this article. (For example: how does the psycho-social production of gendered differences condition the social construction of caregivers? How does the socio-cultural production of illness, disability, or childhood condition the social construction of care recipients?) I shall simply make the following points by way of conclusion.

Health and social care always bring together people whose conditions of life, identities, needs, and contributions are *asymmetrical*. Does asymmetry inhibit genuine co-production? For example, ought we to expect a young child or a person with Alzheimer's to engage in genuine co-production, for all the respect they ought to be granted and all the recognition one may give their contribution to producing the care effect? On a normative level, these questions can be answered in a general way by invoking the maxim that each should not only receive according to his or her needs, but ought to contribute according to his or her abilities.

More specifically, justice and equality require that we refuse to envisage a hierarchy of abilities. The above discussion of giving and reciprocity also compels us to ask whether the contribution need be *identical*. Equal dignity and status need not entail an identical contribution, some arithmetical equivalence, as in an exchange of commodities, but rather an appropriate reciprocity. As Simmel (1950: 390) wrote: "There is, probably, not a single interaction in which the things that go back and forth, in the reciprocity of giving and taking, are exactly equal…"

This could be envisaged on the logic of giving or on the logic of duty, as defined for example by law, contract, morality, custom or tradition—logics shown here to harbor contradictions. This raises the question of how different norms and logics of production, allocation, and distribution (as well as interactions between such norms and logics) enable or hinder each from receiving according to need and contributing according to ability, and thus being full participants and beneficiaries of care. *What right is there to care, both as giver and recipient?*

These questions push to the fore the very political nature of the definitions of ability and disability, of dignity and equality, of autonomy and justice. How will they be defined and by whom—and who will bear the cost of the actions taken or not taken in response to them? What is the appropriate form of reciprocity? How can care become the dialogical form of co-production outlined here, rather than a beautiful appearance masking a reality of (self) deception and oppression? The answers to these questions will be shaped both by political struggles and institutional forms. Such struggles ought to be informed by a dialectical analysis of carework, of the care effect, and of the social division of care.

In this context, an “ethics of care,” such as formulated by Fiona Williams, appears as a powerful instrument of critique: the virtues of “attentiveness, responsibility, competence and responsiveness” associated with care (Tronto 1993; Williams 2003) ought to govern health and social care in all its manifestations, and not be seen as arising merely in situations in which “caregivers” and “care recipients” are immediately present to each other. By emphasizing the way in which each must give and receive care, such an approach can be the basis for a critique of reification. It is therefore necessary to move *analytically* from intersubjectivity conceived on a microsocial scale to the system of objective relationships on a macrosocial scale. But, one must also move *politically* from the system of objective (reified) relationships to the critique of practices, organizations, disciplines, and professions that are part of the totality of heath and community care.

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