

Abandoning Care? A Critical Perspective on Personalisation from an Ethic of Care

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The adoption of personalisation as the principle on which policy and practices for social care in England should be developed has been hailed as marking a fundamental transformation in the nature of social care and the experiences of service users. This article examines both the discourse of personalisation and the practices that are being adopted to implement this from an ethic of care perspective. It adopts an approach based on Sevenhuijsen's 'Trace' analysis to trace the normative frameworks in key policy documents (in particular Putting People First), noting that critics of care have largely succeeded in relegating care to a marginal position within policy discourse and that a relational sensibility is largely absent within this. The article considers the practices associated with personalisation in relation to the moral principles of an ethic of care and conceptions of the 'individual' within these. It addresses the implications of this approach for broader political and policy issues: the universality of provision, collective responsibility for welfare and well-being, and broader issues of social justice in conditions of vulnerability.

Keywords Social Care; Transformation; Care Ethics; Gender; Disability; Carers; Ageing

Introduction

In this article I examine the personalisation agenda in social care in England from an ethic of care perspective. Following Gilligan's (1982) early articulation of the debate between care and justice as a basis for moral decision making, feminist political philosophers have questioned the notion that care and justice are mutually exclusive modes of thinking. In doing so they have proposed an ethic of care that can be applied to interpersonal relationships, to political decision making and to specific social policies. In this article I apply an analytical framework (Trace) developed by Selma Sevenhuijsen (2003) specifically to

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interrogate policy documents from this perspective and to evaluate the normative frameworks of care contained within them.

This is of particular interest in view of the devaluing of care in favour of principles of rights and choice within the contemporary social care context. An early claim by the disability movement was that ‘The concept of care seems to many disabled people a tool through which others are able to dominate and manage our lives’ (Wood 1991, p. 199). Strategies to recognise disabled people’s capacity to make their own decisions about how to live their lives and what support they need in order to do so have often been couched as claims for rights rather than care. Whilst some disabled activists have sought to embrace an ethic of care together with a human rights-based approach (Morris 2001), others have recognised the tension between the collectivism of the disability movement and the individualism of proposed solutions to the ‘problem’ of care (Shakespeare 2000). Another position dismisses care as a value on which support might be based: ‘The term “care” . . . has exceeded its sell-by date. It is undermined by its association with inequality and discrimination’ (Beresford 2008, p. 1). Such positions reinforce the moral boundaries between care and justice that Tronto (1993) sought to dismantle. This article considers the consequences of retaining such boundaries for the way in which the policy of personalisation has been conceived.

What is ‘Personalisation’?

Campaigning by service users directed at ensuring greater involvement in decision making about service delivery led to ‘personalisation’ being adopted as the big new idea for public service reform across a number of areas of human service delivery in England, including education, children’s services, health and social care. It is considered to mark a radical shift in the relationship between citizens and government, mediated through the way in which people are able not only to use but also to choose and purchase the services they wish to receive. This is hailed as marking a fundamental transformation in the nature of social care and in the experiences of service users:

Across Government, the shared ambition is to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity. (http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/DH_079373)

Personalisation is hailed not only as the final solution to the problem of over-professionalised, bureaucratic and paternalistic welfare services, and the best way of resolving service provision challenges associated with a growing number of and increasingly assertive older people, but also as evidence of the success of campaigns waged by disabled people’s movements to gain control over their

lives. Decisions about the types of support services people receive, when, how and by whom they are delivered, are central to this. The organisation ‘In Control’—a social enterprise committed to creating ‘a new welfare system in which everyone is in control of their own lives as full citizens’ (<http://www.in-control.org.uk>)—has become a key player in and sponsor of government action to secure the transformative change heralded by what has come to be called the personalisation agenda. The implementation of this approach has also led to formal recognition of what are now being referred to as User Led Organisations (ULOs) within official discourse as key players in the process for delivery (Prime Minister’s Strategy Unit 2005, recommendation 4.3).

It is now official policy to support ULO development through financial help and capacity-building initiatives. A key role for ULOs is to support disabled people to take advantage of Direct Payments and Individual or Personal Budgets in order to ‘self-direct’ services: ‘Professionals help an individual assess their need and once this is done, the person is given an indicative budget they can use to design the service solutions that make sense to them’ (Leadbeater *et al.* 2008, p. 10). Thus workers employed by statutory social care agencies should no longer determine what services people use. Personal budgets are the key mechanism through which personalisation is to be delivered. They are the financial resource assessed as entitlement in order to meet identified need (within the context of overall criteria determining eligibility to publicly funded social care—the Fair Access to Care (FACS) criteria). The argument is that individuals decide where this money should be spent and make their own plans for how their needs should be met: individuals become their own service commissioners. ULOs can support people who may be uncertain about their ability to make these choices and decide where to seek support services and they can also keep registers of people who work as personal assistants to assist in the process of recruitment. The underlying intention of this approach is that support services are focused on and built around the individual, who is ‘in control’ of what help they receive, when and how.

Personalisation in social care has been the subject of critiques relating both to principles and practical implementation (Ferguson 2007; Lymbery 2010). Early research evidence also suggested that a number of policy, funding, charging and practice issues needed to be resolved, and was cautious about the extent to which significant change in outcomes was evident in the pilot projects that preceded full-scale implementation (Glendinning *et al.* 2008). My focus here is not on how the policy is being implemented and with what effect, but on what it reveals about the way in which ‘care’ is being addressed in ‘social care’ policy.

Trace

The goal of Trace analysis is to

trace the normative framework(s) in policy reports in order to evaluate and renew these from the perspective of an ethic of care. The background motivation

to this approach is the wish to further develop care into a political concept and to position care as a social and moral practice in notions of citizenship. (Sevenhuijsen 2003, p. 1)

It is thus not a neutral endeavour. It derives from feminist scholarship that has sought to 'de-privatise' and 'de-gender' care, but also to expand our concept of citizenship through including care within this. This is evident not only in Sevenhuijsen's own work (Sevenhuijsen 1998, 2000) but also, in particular, in the work of Tronto (1993) and Kittay (1999) and I will draw primarily on these sources in developing this analysis.

The Trace framework is an articulation of the process adopted to interrogate Dutch policy documents: 'Choices in Health Care', equal opportunities policies and reports on ageing societies and family politics (Sevenhuijsen 1998). Sevenhuijsen (2000; Sevenhuijsen *et al.* 2003) has also applied it to an analysis of South African welfare policy and UK parenting policy. It calls attention to claims by policy analysts that policy is or should be based on facts rather than values; the way in which moral concepts and arguments are concealed—sometimes within empirical statements, rather than made explicit; and the way in which values and moral arguments are often taken as self-evident. Sevenhuijsen notes that policy is often the result of complex compromises and one consequence is that there are likely to be contradictions and inconsistencies in the normative frameworks of policy documents.

Policy formulation does not follow an orderly process, adopting precisely defined, uncontested and consistent ideas about positions on social problems that determine an unambiguous strategy intended to address these. Rather, policy embodies different and sometimes competing discourses that may enable co-operation or alliances in service delivery between those who adopt different ideological positions, but which may also contain the seeds of unsustainable differences. Hence an analysis based solely on official texts has limitations. Worker agency and increasingly the agency of service users and citizens can result in 'policy failure' as they resist or subvert official policy, often by taking advantages of such contradictions and inconsistencies (Barnes & Prior 2009). Thus we cannot fully understand how 'care' is being employed within personalisation without looking at how both workers and service users negotiate personalisation in practice.

However, we can establish how normative frameworks are at work within policy texts in order to construct the possibilities within which front-line negotiations take place. In order to do this the Trace analysis considers:

- How the text was produced.
- How it defines the problem to be addressed.
- What are the leading values at work within it.
- What suppositions about human nature are contained within the text.
- How care is defined and elaborated.

- Whether the role of gender in caring arrangements is acknowledged.
- How the role of the state vis-à-vis responsibilities of individuals and private institutions is defined.
- And finally, how a focus on the rhetorical characteristics of the text can support this analysis.

This is the process I applied to *Putting People First* (HM Government 2007), the policy document that sets out the ‘vision’ for transformation of social care through personalisation. *Putting People First* (PPF) needs to be read in conjunction with other policy and guidance, e.g. the most recent carers’ strategy (HM Government 2008). I consider what these documents reveal in relation to an ethic of care under a number of headings and reflect on what this suggests about broader issues relating to the delivery of welfare and the achievement of social justice for disabled people, older people and others who need more than usual support in order to live their lives.

What Sort of People?

A focus on the way in which policy documents conceive of ‘human nature’ alerts us to the importance of considering how PPF understands the ‘people’ it seeks to address. What concept of the ‘individual’ is assumed by personalisation and to what extent does this reflect the lives and circumstances of social care service users and those who care for them? In many places the document is explicit about this—but it is important to make clear and evaluate the assumptions that underpin these explicit statements.

The people addressed include the increasing numbers of those living to old age whose health problems mean they need social care as well as health care; people living with dementia or chronic illness. Whilst they may ‘depend on social care for their quality of life and capacity to have full and purposeful lives’ (PPF, p. 1), they have high expectations not only that the services they depend on will treat them with dignity and respect but also that they will be treated as equal citizens within services and beyond. As well as needing the support of social care services there is an assumption that people are not socially isolated, and that many are in paid work: ‘interdependent on family members, work colleagues, friends and social networks’ (PPF, p. 3). However ‘the alleviation of loneliness and isolation’ is seen as a major priority (PPF, p. 3). This is one of a number of indications that the policy fails to fully engage with the diversity of circumstances in which older and disabled people live their lives. The position of isolated older people experiencing chronic mental or physical ill health is not distinguished from that of a disabled adult who is in paid employment and has a significant social network.

Whilst there is recognition of the significance of interdependence there is also an assertion that people want to live independently. Family members who

identify as carers may in some cases 'deny a family member the chance to experience maximum choice and control over their own life.' (PPF, p. 4) Although the carers' strategy (HM Government 2008) recognises and seeks to promote actions to support carers in their own right, the recognition of carers as 'partners in care' is conditional on their not being seen to deny the wishes of the person they care for. Indeed, a key role for carers is to enable 'the person they support to be a full and equal citizen' (PPF, p. 16) (see Barnes 2011). In these formulations caring relationships receive little attention. The focus is on individuals whose needs and interests may be opposed to each other, rather than on the relationships through which support (often reciprocal) is given and received and in the course of which complex moral decision making is necessary to enable both care givers and care receivers to live a good quality of life (Barnes 2006).

That those who use social care services want to exercise choice and control over those services is central to personalisation. For those unable to exercise control it may be necessary to prioritise 'care and protection'. Consultations in relation to a parallel policy of 'safeguarding adults' highlights the importance of establishing an 'appropriate balance between safeguarding and personalisation' (Department of Health 2009a, p. 6). But PPF is clear that there is an expectation that people both want to and are capable of managing budgets, and planning and directing their own support. In the case of those who are already used to other ways of receiving services, there is an expectation that they can and will change their behaviour so that more people will be prepared and able to shape and commission their own services.

Elsewhere I have summarised the image of the 'people' summoned by PPF as implying: '...a high level of self knowledge and reflexivity; substantial predictability in relation to needs and the circumstances in which they may be met, and a willingness to take on responsibility of constantly reviewing whether the support and help being given is enabling the achievement of objectives' (Barnes 2008, pp. 156–57). 'People' are addressed in gender-neutral terms. The only specific reference to gender is obliquely via cited examples in which women are more often identified as care givers than men. There is no explicit recognition of the gendered nature of 'caring responsibilities', nor any discussion of the way in which gender, class and culture impact on and give meaning to the experience of both care giving and receiving. The image of the independent choice maker summoned by PPF embodies masculinised 'virtues' in contrast with the feminised, dependent welfare subject (Fraser & Gordon 2002). It reflects Tronto's observations concerning the ability of those in powerful positions not only to ignore the needs of others for care but also to ignore the importance of receiving care to enhance people's own capacity to live their lives as they wish. This position is both gendered and raced (Tronto 1993, p. 174).

What Sorts of Values?

Putting People First is suffused with explicit statements of the values that shape the policy. These relate to:

- (1) The nature of the society to which it is intended to contribute: one which is socially just, which enables equality of citizenship and promotes active citizenship.
- (2) The service system to be put in place. This is one that should be 'fair and sustainable'; which enables universal access to high-quality support; is accessible and responsive; is characterised by partnership and encourages innovation from outside the statutory sector; and which has citizens at its heart.
- (3) The nature of available services. These should have 'dignity and respect at their heart'; emphasise 'prevention, early intervention, enablement and high quality personally tailored services' (PPF, p. 2), and be subject to maximum choice, control and power exercised by those who use them.
- (4) How people should live their lives: independently, empowered, self-determining, in control, within sustained family units.

Reference to care in the section on *Values* reflects an association between care, paternalism and reaction:

The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention, enablement and high quality personally tailored services. (PPF, p. 2)

Care, in this formulation, is not 'mainstream' but rather something to be evoked only in exceptional circumstances:

to provide care and protection for those who through their illness or disability are genuinely unable to express needs and wants or exercise control. (PPF, p. 2)

Hence PPF constructs two distinct groups of 'people': the first, the mainstream majority, who are capable of and willing to embody the values of independence and self-determination, who have no need of 'care' and indeed would find this restrictive and possibly oppressive. The others are a marginal group, namely people who are unable to live up to the autonomous expectations on which the policy is built and thus for whom paternalism is acceptable. Care elides with protection and little attention is given to how the needs and wants of such people might be understood and responded to in a care-full manner. Beresford's (2008) assertion that care is undermined by its association with inequality and discrimination is reinforced by this discursive construction of care as incompatible

with choice, and inevitably linked to protection. Tronto (1993) specifically addresses the difference between care and protection, and warns against conflating the two in precisely the way in which PPF appears to do. 'Care and protection' is the booby prize if people can't exercise 'choice and control'.

This construction of care as something that is exceptional and only to be invoked in situations where people are unable to articulate their needs and wants is fundamentally at odds with insights offered by a feminist ethic of care. Rather than recognising care as a practice deeply embedded in everyday life, and a political idea necessary to the creation of circumstances in which we can live well together, it reflects an antipathy that Tronto claims reinforces subordination and inequality:

In contemporary American society, where a great emphasis is placed on autonomous individual life, we perceive neediness as being a burden on those who must help us meet our needs. We often resent needing the help of others, and translate that need into a resentment towards those who are in a position to help. (Tronto 1993, p. 141)

If care is deemed relevant only to the most needy, then both they and care become devalued. If, however, we understand care as something that we all need and receive at some stages of our lives, and we recognise that 'individuals can only exist because they are members of various networks of care and responsibility, for good and bad' (Sevenhuijsen 2000, p. 9) then the challenge is not how we can *replace* care but how we can create the conditions in which good care can flourish.

This relates to the moral choices that are associated with care giving and receiving. Choice, as understood in the context of personalisation, relates to choice over what services are to be bought, from whom and how support should be given. It is undoubtedly the case that the opportunity to exercise such choices is something that many users of social care services value. However, limiting understanding of choice to decisions about what support services to buy is to offer an impoverished view of what is necessary for a good quality of life. It ignores the significance of moral and ethical choices associated with care at both the personal and collective level.

The next section of this article considers the mechanisms through which personalisation in social care is being delivered and the broader implications of this approach for welfare provision and social justice.

Planning and Buying Support

The 1990 NHS and Community Care Act introduced the practice of social care assessments that were intended to be needs led and involve the person being assessed in the process (Barnes 1997). PPF describes this as having been 'well-

intentioned' but leading to a complex system that 'too often fails to respond to people's needs and expectations' (p. 1). One objective of personalisation is to shift the emphasis from professionally driven assessment to self-assessment, leading in turn to individual commissioning of services.

To support service users becoming commissioners, local councils are expected to develop markets to ensure a range of providers that users can buy services from. Specific reference is made in the circular to a 'community equipment service, consistent with the retail model' (PPF, p. 6). But it is also expected that voluntary organisations will be encouraged to provide services that demonstrate the values of personalisation and thus are likely to be attractive to and chosen by these new individual commissioners. Social care staff need to be trained and 'empowered' 'to be able to work with people to enable them to manage risks and resources and achieve high quality outcomes' (PPF, p. 6). Family members and other carers need to be trained to be 'expert care partners' (PPF, p. 5). In making these and other changes councils will also be expected not only to demonstrate effective use of resources but also to deliver 3 per cent efficiency targets.

That these changes reflect the dominance of a neo-liberal market-based approach to welfare is self-evident. Applying an ethic of care perspective suggests rather different questions need to be asked of such developments than is typically the case in analyses that focus on the political economy of care. The process of 'renewing' that the Trace analysis encompasses requires application of the moral principles of an ethic of care to this. These principles—attentiveness, responsibility, competence and responsiveness—were developed by Tronto (1993) to give ethical content to the four phases of care: caring about; taking care of; care giving and care receiving.

Whilst such principles are constructed around what are typically understood to constitute personal caring relationships, they have been developed in a way that also demonstrates their significance in addressing political questions about ways in which we determine needs and how they will be met. As Tronto (1993) notes, virtually all needs can potentially be met through the market, but does this mean that we do not need to depend on others in an ongoing relationship? More broadly—if 'support' is something that can be bought and sold, what does this mean for our moral sensibilities and our sensitivities concerning the needs of others? And if the provision of support follows a series of individual commissioning decisions, how does this affect collective understandings of responsibilities to ensure justice, well-being and citizenship for those who are vulnerable to discrimination and marginalisation?

Thus in the final section of this article I consider the implications of the personalisation approach to the personal circumstances of individual disabled people, people who live with mental health problems, long-term illness and their family, friends and lovers, and also to broader political and policy issues about the nature of welfare and social justice.

The Personal

Whilst the precise needs and circumstances of disabled people, those who live with chronic ill health or with enduring mental health problems are as varied and individual as the people themselves, qualitative research and personal accounts reveal the shared dimensions of such experience. These encompass not only practical support and financial needs but also those associated with the personal and interpersonal emotional impacts of illness or impairment, with the building or re-building of identities in response to changed or unanticipated circumstances; and needs associated with negotiating social relationships in the face of discrimination or exclusion. In this context, the strength of the personalisation agenda is its promise of ensuring person-centred responses to diverse needs. But it does so by relegating care to a marginal position, and by giving little attention to the relationships through which help and support is given.

Two examples offer a useful perspective on this issue. I have selected these because both involve a situation in which individuals (in each case a family member) has commissioned care and support. They demonstrate a form of 'personalisation' in times and places before it became official policy. My argument is that they demonstrate the significance and indeed the centrality of care within this context, rather than offering evidence that it has 'exceeded its sell-by date' (Beresford 2008, p. 1).

The first example comes from *Love's Labor* (Kittay 1999). Here, American philosopher Eva Kittay tells the story of her own disabled daughter. Sesha was born with severe brain injury and has no speech. She is very affectionate and can communicate her love and joy, but needs constant stimulation and attention. She is frequently ill, has frightening seizures and cannot communicate what hurts her or where she is in pain. Kittay realised early on that she and her partner would not be able to provide the full-time level of care that Sesha needed and thus they employed workers to assist them. She describes the model that they evolved as a system of 'distributed mothering' involving herself, her partner, various temporary care givers and Peggy, a woman who came as an agency worker, but who stayed to provide long-term care for Sesha. In contemporary English terminology Peggy and the other temporary workers could be considered personal assistants, in this instance paid for not from direct payments or an individual budget but directly from the professional salaries of Sesha's parents. But the work that they do is clearly 'care work' embodying the moral principles that Tronto (1993) has outlined: it involves attentiveness to Sesha's needs, but also awareness of her responses to the care she is given and the capacity to learn from her how best to help her. It involves preparedness to take on the responsibility for ensuring her needs are met and to do so in competent ways that reflect awareness of the impact of the care that is given. For Eva and Peggy the practice of caring for Sesha in this way involves choices and dilemmas, not only in how to care for Sesha but also how to negotiate their own relationship and how to ensure space and opportunity for their own leisure and fulfilment.

The second example is a story told in my book *Caring and Social Justice* (Barnes 2006). Alan had worked as a mental health nurse, social worker and manager within social care services. When his mother developed a form of early-onset dementia he respected her wishes not to be admitted to a nursing home, moved her into his house and used his professional contacts to put together a team of care workers, becoming the ‘team manager’ himself. He gave up his job in order to do this and took on occasional independent work. Once again we can understand this as a form of ‘personalised support’ commissioned by a family carer who also provided ‘hands-on’ care and offered significant emotional support. In Alan’s case this focused around his mother’s need in her final years to reconstruct an image of herself as a ‘good mother’ after an unhappy marriage, a history of heavy drinking and a conflict that had left Alan as the only one of her five children who was still prepared to have contact with her. He reflected on the importance of ‘caring values’ defining both professional and lay care: ‘I never believed from being an 18 year old student nurse about the crap about controlled emotional involvement and professional distance...’ (Barnes 2006, p. 112). But he also noted that he had surprised his brother by saying that his motive to care did not come from his love for his mother: ‘I didn’t like her and there were times when I hated her’ (Barnes 2006, p. 66). Alan’s story indicates that care ethics are not inevitably linked to love.

Both these stories are told from the perspective of family carers, not from the perspective of a disabled child and a mother with dementia. We do not know whether either Sesha or Alan’s mother Catherine would reject the construction of the support they were given as ‘care’, although there is little evidence in either story that they resented being recipients of care. But my point here is that it would be wrong to assume that the relationships created via the mechanisms of personalisation cannot or should not be characterised by ‘care’. Purchasing support does not necessarily mean that the workers who provide support do not care—just as there is evidence that those employed by local authorities as home helps, providing domestic and personal support, often ‘cared’ for their elderly clients (Warren 1990). But stories such as these reveal the perversity of attempts to ‘remove’ care from the characterisation of the type of relationships necessary to support those for whom social care services are designed. The danger in such a situation is that workers are not trained or supported to care, and that the skills that are valued are those of brokerage rather than the moral, practical and relational sensibilities of care (Barnes 2006, chap. 9).

The Social

Kittay notes that the model of ‘distributed mothering’ she adopted to care for Sesha was a privatised model, characterised by ‘discomforts and difficulties... attributable to lack of social services, services provided in other nations more attuned to dependency concerns’ (1999, p. 160). In England one origin of

personalisation lies in the perception not of a lack of service but of publicly provided services insufficiently attuned to individual needs and wishes. Those critiques were first articulated in relation to collective provision within residential care and have more recently spread to a range of services provided directly by public authorities, including day-care and personal support services. Hence one aspect of the problem that PPF seeks to address is that of poor-quality services apparently unable to demonstrate respect and dignity. The solution, as we have seen, is to create individual commissioners who will purchase only those services that they think can offer this. This, in turn, requires 'market building'—encouraging innovation in the voluntary sector as well as in private-sector services. It also involves prioritising access to 'mainstream' activities rather than promoting services such as day-care services designed specifically for older or disabled people.

Another aspect of personalisation is thus to undermine the actual and potential value of collective provision. I have noted that Shakespeare expressed some disquiet about the individualising implications of strategies adopted by the disability movement, and awareness of the potential for this was also evident in earlier research I undertook with disabled people's organisations (Barnes 1999). More recently, colleagues and I were surprised when women living with mental health problems used a consultation event to seek support for their campaign to save a day centre they attended (Barnes *et al.* 2006). Much received wisdom was that day centres were a poor substitute for 'mainstream' activities. But for these women 'their' centre was a space where they could get away from the tensions in their personal lives and receive support from others who shared similar experiences. Such experiences are also evident within mental health and other service-user groups (Barnes 2007) and the contribution of such collective, if segregated, spaces to the evolution of the disability movement has been demonstrated (Groch 2001).

From an ethic of care perspective we need to ask what might be the longer term implications of strategies that may undermine both the public provision of services and opportunities for people who live with mental health problems, older people and others to come together and share both social activity and support with each other. Will this be compensated by genuine acceptance and integration within mixed social spaces, or will it contribute to a weakening of a collective sense of responsibility for ensuring the well-being of those in need of more than usual support? And to what extent does this represent the dominance of particular white, middle-class (male?) values that prioritise the individual over more collective values and understandings of what constitutes quality of life?

The Political

The latter points hint at the necessity to assess the personalisation agenda beyond its impact on specific individuals who use social care services. The

political significance of an ethic of care embraces a number of important perspectives. First is Kittay's point that we do not all start from a position of equality:

...the conception of society as an association of equals masks the inevitable dependencies and asymmetries that form part of the human condition—those of children, the aging and the ailing—dependencies that often mark the closest human ties. Therefore the presumption effectively obscures the needs of dependents within society and women's traditional role in tending to those needs. (1999, p. 14)

Devaluing care risks devaluing those in need of care, and what the personalisation agenda appears to offer is a re-drawing of a boundary that could reinforce the marginalisation of those who are most vulnerable. Rather than asserting the importance of linking care and social justice through challenging what Tronto (1993) refers to as a 'false dichotomy' between the perceived particularistic and compassionate characteristic of care, and the universalistic and rational qualities of justice, personalisation is in danger of prioritising service models that relegate emotionality and messy moral dilemmas to a private sphere from which public decision making is excluded. Social justice will not be achieved by starting from an assumption that we are all equal—precisely because this ignores the real inequalities experienced by those who are dependent on others' support for their very survival. Citizenship cannot be enabled by ignoring the limitations of rights-based models in complex situations where both care givers' and receivers' needs are interwoven (Brannelly 2004).

Adoption of this approach also has implications for collective responsibilities for unknown others. What will be the consequences of the widespread adoption of a model of individual service commissioning for the preparedness of those able to assert 'privileged irresponsibility' to commit to ensure public funding of high-quality welfare provision? A positive analysis suggests that one impact of personalisation will be to expand the range of people who experience the consequence of impairment, mental health difficulties or chronic poor health in old age through contacts resulting from more dispersed access to support services. This may expand and enrich understanding of the significance of care in everyday life. However, at a system level O'Brien and Duffy (2009) have argued that one consequence of self-directed support *should* be that we abandon the search for more effective partnerships between services because this may limit individuals' choices. Does this mean we should abandon the principles of universality of provision, geographical equity and public responsibility to ensure good co-ordination and effective collaboration in services? Ethic of care principles applied to public decision making imply a responsibility to ensure not only the delivery of care but also that the consequences of this are beneficial. When responsibilities for assessing impact are delegated to individuals, collective learning and accountability become more difficult to achieve.

Conclusion

Substantial claims have been made for personalisation in social care on the basis of very limited evidence and experience in practice. Whilst acceptance of personalisation as the basis on which disabled people should receive help can be seen as marking the dominance of an individualised approach to support that is the antithesis of the relational character of care, we do not know enough about how these new procedures and practices will be negotiated to conclude that the *practice* of care has been abandoned. But the discursive construction of care as marginal, inevitably associated with paternalism and protection and subordinate to choice and control, reinforces precisely those moral boundaries that Tronto (1993) sought to dismantle to argue for the necessity of care to social justice.

The devaluing of care within 'social care' policy suggests that those committed to policies and practices that embody a relational sensitivity and that recognise care as a necessary component of social justice have failed to convince. One reason for this is that care continues to be relegated to policies that focus exclusively on those considered to be vulnerable and in need of particular support. The broad definition of care offered by Tronto and Fisher (quoted in Tronto 1993, p. 103) has not been sufficiently developed, either theoretically or in policy terms, to offer a way of understanding what is necessary to live well together and with the material world. This is a task for another paper!

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