

The Commodification of Care

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This paper discusses the question whether care work for dependent persons (children, the elderly, and disabled persons) may be entrusted to the market; that is, whether and to what extent there is a normative justification for the “commodification of care.” It first proposes a capability theory for care that raises two relevant demands: a basic capability for receiving care and a capability for giving care. Next it discusses and rejects two objections that aim to show that market-based care undermines the caring motives essential to care, one of them because of its reliance on contracts and the other because of the corrupting influence of payment on motivation. If market care is in principle legitimate, the commodification question transforms into one about the appropriate combinations of market and non-market care. This question can be answered only by adding an additional complication: care is to be balanced against other activities, most notably work for the labor market. This brings in the problem of gender inequality, since paid work has been traditionally distributed to men and caring activities to women. I show how the capability theory of caring presented in this paper can help resolve the dispute between competing models for balancing work and caring.

Giving and receiving care is one of the primary functions of any society. In caring for those who are vulnerable and dependent, societies express responsibility for their members when they are unable to sustain themselves without help. At the same time, since giving care usually involves the expenditure of considerable time and energy, care is an economic practice. Choices have to be made about the ways in which care should be provided. Sometimes these choices are met with resistance and criticism, where prevailing patterns of the organization of care work are contested. In many Western societies, this is currently the case. Ingrained patterns of care provision are contested from the perspective of women who have been responsible for the bulk of care to children, the elderly, and sick people. Their entry into the labor market has

stimulated the outsourcing of care to the market. Simultaneously, attitudes to the value of care provision outside of the household are changing. These developments necessitate new ways of thinking about the responsibility for care work and the division of labor among households, markets, and the state. In this paper I will concentrate on one aspect of these questions, that is, what this means for the choices between market and non-market forms of care. The main question of this paper will be whether care may be entrusted to the market, and if so, to what extent and under which conditions. Thus, it discusses whether there is a normative justification for the (partial or complete) “commodification of care,” or whether care should rather be a “moral limit to the market” (Walzer 1983, 100–03; Anderson 1993).

Care will refer to a restricted set of activities: caring activities on a structural basis for people who are in a position of dependency or vulnerability. These caring activities include both a kind of action (“caring for”) and a motive (“caring about”). To care for a person is to deliver care to that person, that is, to fulfill the needs of the person (physical as well as emotional) through a myriad of caring activities. To care about a person is to have a caring disposition toward that person: the “caring motive” (Himmelweit 1999, 29; similarly Folbre and Weisskopf 1998, 172–73). Successful action and the right motive do not necessarily coincide. It is possible to care for a person without caring about that person or vice versa. Wherever one side of care’s dual nature is lacking we may be tempted to judge that what is provided “is not really care.” But that would have the unwelcome consequence that these activities disappear from our purview. Therefore I will say that care takes place wherever someone responds to a reasonable demand or expectation for care without that person necessarily succeeding (completely) in fulfilling the demand (care may differ in quality). Thus, a tension between action and motive may emerge where people are predisposed to perform caring activities without the requisite motive (this will be important in our discussion of objections to market-based care; see section II).

Furthermore, care here refers to caring activities provided to people whose *dependency* or vulnerability is of a certain degree of severity and permanence, necessitating the deliverance of care on a structural basis, that is, regularly recurring for a more or less extensive period of time. Allowing every type of dependency as an object for the practice of care would make our definition overly broad. Following Eva Kittay, I will restrict my attention to care for the person who “cannot survive or function within a given environment—or possibly within any environment—without assistance” and consequently “needs to be *in the charge* of another for her care and protection” (Kittay 1999, 31).¹ The main examples of the dependencies that are included are care for children (especially in their earliest years) and care for the elderly and the sick, insofar as old age or poor health makes them dependent on care.

With respect to the wide variety of institutional forms that care provision may take, I will simplify greatly and organize my discussion around two ideal types of care provision: informal provision and market provision. They are distinguished from each other on the basis of the different origin of the relation between caregiver and care recipient. Informal provision is characterized by the fact that the origin of caring relations lies in a previous personal relationship between a caregiver and a care recipient. Some social context has brought them together: the family, the neighborhood, a network of friends, and so on. When dependency of one of them arises, both feel that engaging in care activities is appropriate or even (morally) obligatory (the care for babies by their parents is a limit case here, since it immediately arises upon the coming into existence of the child—although one might of course argue that at birth the parents have had a personal relationship of some sort with their unborn child for nine months).

When informally provided, care is usually (but not always) unpaid, as in standard examples of gift exchange. By contrast, market provision is characterized by the fact that the origin of the relationship between caregiver and care recipient lies in a contractual agreement, not in a preexisting personal relationship. Here the caregiver is a professional who is paid a wage by the care recipient or by a care institution for which she works.² The commodification of care occurs when caring activities that were previously provided for on an informal basis are now being redirected toward the market.

The paper will be developed in three stages. First, I will formulate a capability theory for care that raises two relevant demands: a basic capability for receiving care and a capability for giving care (section 1). Next, I will discuss two objections that aim to show that market-based care undermines the caring motives essential to care, one of them because of its reliance on contracts and the other because of the corrupting influence of payment on motivation. I reject both objections, but I do show that important practical conditions for market contracts and payments have to be fulfilled in order to make the market compatible with good care (section 2). If both market care and informal care are legitimate, the commodification question transforms into one about the appropriate relations or combinations between market and non-market care. This question can be answered only by adding an additional complication: that care is to be balanced against other activities, most notably work for the labor market. Nancy Fraser has developed a model in which all workers are also caregivers. In criticism of this model, Angelika Krebs proposed another model, which gives people the financial means to choose between themselves caring in person or buying care on the market. I show how the capability theory of caring presented in this paper can help resolve the dispute between these competing models (section III).

I. A CAPABILITY THEORY FOR CARE

In deciding about the appropriateness of the commodification of care, we first have to make explicit which normative theory we will use to evaluate market and non-market forms of care provision. In this section I will propose a capability theory to formulate the relevant normative demands.

The main feature of this capability theory is that it recognizes as “basic” only those capabilities that are necessary to develop the capacity for agency, or autonomous choice. Only these autonomy-developing capabilities are therefore “morally required” and potentially worthy of political protection. This contrasts with familiar conceptions of capability theory such as Martha Nussbaum’s, in which all capabilities that make life “fully human” are recognized as basic. Thus, the capability theory used here is both more liberal (restricted to personal autonomy) and more modest in its assumptions. On its list of morally required capabilities it will include those capabilities that are a prerequisite to an autonomous life (such as Nussbaum’s capabilities for “life” and “bodily health”) as well as those capabilities that develop the capacity for autonomous choice more directly (for example, Nussbaum’s capability for “practical reasoning”), but it will exclude those capabilities in which autonomy is merely exercised, not developed (for example, Nussbaum’s capability for “contact with other species”). Furthermore, apart from a list of basic capabilities, this theory will acknowledge that there are non-basic capabilities, which do not help to develop the capacity for autonomous choice. These capabilities are merely “morally permissible.” If several capabilities conflict, this has important consequences: morally required capabilities will take priority over morally permissible capabilities.

This all sounds fairly abstract. Unfortunately, I cannot present here a complete list of autonomy-developing capabilities, nor expand upon their philosophical justification and implications, which I do elsewhere (Claassen 2009). Rather, I will show their fruitfulness in the present context, by showing the consequences they have for caring activities. I will discuss the care recipient’s capabilities and the caregiver’s capabilities in turn.³

For the care recipient, care clearly is a prerequisite of developing and exercising his capacity for agency. As heavily dependent persons, care recipients depend on care for their physical survival, their emotional stability, and their mental development. Being able to receive care therefore is a morally required capability or basic need (Nussbaum 2003, 54). This moral claim normally goes uncontested.⁴ More problems arise in determining the appropriate level of care. It is not possible for all dependent persons to become agents in the full sense, even with extensive levels of care. Care for young babies or severely disabled individuals cannot make them speak, deliberate, and choose like full agents. The basic need for care must therefore refer to a level of care that brings the

person the capacities for agency that the person in question can reasonably be expected to attain. Moreover, this level varies with the demands that are placed on the agency of members of a society in different sociohistorical contexts. In modern societies persons are required to make life choices that often require complex cognitive and emotional skills: orienting oneself in dynamic fields of opportunities, relationships, and expectations. This increases the burdens. Child care, for example, will have to be adapted in order for children to start developing the required skills from a very young age. Finally, medical possibilities and economic resources change over time, transforming our beliefs about the level of care that counts as fulfilling the basic need for care.

The caregiver's normative claim is of a different kind.⁵ One who has the capability for caring both has the skills (personal powers) to care for others and lives in a social environment in which there are opportunities to use these skills in actually caring for others.⁶ Such a capability to care is not a constituent part of being an agent; one can be a person without practicing intensive and long-lasting care activities. Indeed, in many societies a life without these care activities has long been proclaimed to be the normal kind of life for one of the main social roles, that of a male breadwinner. This ascription was complemented with the ascription of the caring activities to the other main role, that of the housewife, who was supposed to have a "natural" proclivity for caring. These ascriptions taken together have had the effect of translating supposed "innate needs to care" into social obligations hard to escape. This should make us think twice about ascribing a need for caregiving to any group of persons. Persons (of whatever gender) do not *need* to care in order to be persons. Rather, they have a morally permissible—but not required—*capability to care*: they may or may not exercise their agency in caring for others.

To take this specification of the capability as our starting point frees us from postulating dubious biological essences of men and women. Moreover, it frees both caregiver and care recipient from being "condemned to each other." Not only is the caregiver released from fixed obligations to care, the care recipient is liberated from persons who may want to take care of him against his wishes. The latter cannot justifiably claim a "right to care" for the dependent, who should always be able to refuse to receive care from anyone he judges unfit (he may do so because the caregiver is violent, aggressive, and unpleasing, but also, for example, because he prefers care from an institution rather than being dependent on his family). Potential caregivers for their part have the legitimate opportunity to refuse to convert their capability to care into actual functioning.⁷

The moral asymmetry between the care recipient's needs and the caregiver's capabilities to care means that it is an open question whether the dependent's care needs will be fulfilled and if so, by whom. If no person has an obligation to take upon herself care responsibilities, but if nonetheless dependents have a

basic need for care, then the obligation falls upon society at large to create an institutional setting in which enough people will voluntarily choose to care for those in need of it (convert their capability to care into actual functioning)—either informally or as care professionals. Put differently, although there is little doubt that informal provision is a legitimate mode of care provision, we have to reject the stronger claim sometimes made, that informal provision is the most preferred way to provide care.⁸ The argument underlying this stronger claim is that the origin of informal care in preexisting personal relations guarantees or at least makes more likely the presence of the caring motive characteristic of good care (compared to formal care). This argument seems to me to be contentious. Much will depend on the contingent circumstances that influence the quality of informal or formal care.

Nonetheless, we have to modify our framework in one respect to account for instances in which a caregiver does not have a right to refuse caring. Although the caregiver normally has the legitimate opportunity not to act upon her capability to care, her refusal has to be disallowed for those cases where the care receiver's capability to be taken care of has to be interpreted as the capability to be taken care of *by some specific person* (since the latter is a morally required capability, the application of the priority rule in these cases overrides the caregiver's capability). The paramount example of such a "personalized care obligation" is with respect to children, who have a claim on their parents to take care of them.

Society expects—and needs—parents to provide their children with continuity of care, meaning the intensive, intimate care that human beings need to develop their intellectual, emotional, and moral capabilities. And society expects—and needs—parents to persist in their role for eighteen years, or longer if needed. A variety of social and legal institutions convey a common message: Do what it takes to give your children the continuing care that they need. Put simply: "Do not exit."
(Alstott 2004, 1942)

It is important to be clear about the basis and scope of this obligation. Its basis is the child's interest in developing her capacity for agency, not the parents' interest in having a relationship with the child. This interest is best protected if at least one adult provides her with what Anne Alstott calls "continuity of care." This position does not require defending the claim that the mother is better placed than the father to be this person. There is no commitment to naturalized gender roles. Nor does this position require defending the claim that no additional caretakers can be involved, as they are in day-care centers. The obligation is that parents have the main responsibility, not exclusive responsibility. Nor does this position require that parents be biological parents. For

example, they may have been put in that role as foster parents. Finally, this position does not require a denial of the fact that in exceptional cases it may be in the best interest of the child to be removed from her parents' care-giving efforts (or lack of them). All that is required is a parental obligation that ensures continuing care for the child. The case does not rely on the child's interest in continuity of care as such (for other dependents also have such a need for continuous care), but in that interest combined with the fact that the parent is best placed to provide such care.⁹

As far as I can see, there is no knockdown argument why such personalized obligations could not be extended to other care relations, for example to care for elderly relatives (or even to care for those with whom one doesn't have a biologically determined connection, like friends or neighbors). Nonetheless, the child's case, with its interest in having parental care, is arguably the easiest one to make. In the end this differential judgment about child care and other forms of care may betray a culturally variable, Western judgment on care relations; but that only proves once again the inescapable context-sensitiveness of the application of capability theory.¹⁰ However, we would do well to place the burden of proof on those arguing in favor of such a personalized obligation, given the considerations presented above about the moral status of the capability to care: as much as possible we want to give people a choice whether to sacrifice themselves and spend large parts of their lives caring for others, such as women have traditionally often been forced to do. We would also do well to set the standard for such a proof sufficiently high—for once a certain type of relationship is qualified as giving rise to a personalized care obligation (such as is the case for the parent toward her child), this has important repercussions for the way society is organized (see section III). In this respect, we should keep in mind that we are not talking about a personal *feeling* of “being obliged” to care in person (such as many children may feel toward their elderly parents), but about an impersonal norm that we may rightfully *expect* persons not to shrink from giving such care, backed up by social sanctions (disapproval) as well as legal sanctions (such as we have for child neglect by parents). For the sake of exposition, in the remainder of this paper I will restrict the circle of personalized obligations to the case of parental care, but the arguments would apply *mutatis mutandis* if a wider circle of care relations were judged to be in this category.

Let us now see the implications of the attribution of care claims and obligations defended in this section for the role of the market in care provision.

II. TWO OBJECTIONS TO THE COMMODIFICATION OF CARE

In academic work as well as in popular opinion one often encounters suspicions that the market is inappropriate for care work. These suspicions often try to

express the idea that the market is in some way *a priori* unsuitable or incompatible with the activity of caring. In this section I will discuss two objections that—each in a different way—try to establish such a principled incompatibility. If one of them succeeds, then the commodification of care should be rejected.

The first objection to market-based care is the most radical one. It holds that the explicit nature of the exchanges based on these contracts corrupts what care should be about. “Real care” is motivated by genuine concern for the other, and such concern by definition cannot be bought and sold. The required caring motive is incompatible with explicit “commensuration” of the performances of the caregiver (care) and the care recipient (payment for care). Let us call this the incommensurability objection. It holds that caring activities are corrupted when performances are commensurated on a common scale, that of money, that is, when a monetary value is attached to their performance. Commensuration is a social process: societies may grant or refuse commensurating certain goods with money.¹¹ In cases where commensuration of goods is refused, goods are treated as *constitutively* incommensurable. The standard example is that of friendship and money: it is said to be constitutive of friendship that it is not to be commensurated with money. One cannot exchange a friend for money (Raz 1986, 345ff.).¹² Similarly, some hold that care cannot be commensurated, for it is delivered out of a caring motive, and this motive cannot be transferred from one person to another. Just as one cannot buy a friendship, one cannot buy care. When we do, the product is not what it seems to be: what actually happens is that a non-caring service is being transacted.¹³

This set-up of an insurmountable dichotomy between care and market provision is unhelpful. For friendship, a distinction can be made between a direct exchange of friendship for money on the one hand (“Here you are. My friendship with Anthony. That’ll be 30 dollars”), and the fact that people make indirect trade-offs between friendships and money, as when they accept a job offer that will allow them less time to spend with friends. The inappropriateness of direct exchange does not entail that options are incomparable and choices impossible to make. Rather, it means that we make those comparisons and choices in a different way: by refining our interpretation of the demands that we face in the context of different relationships (Anderson 1993, 62–63). Similarly, for care there is no direct exchange of the caring motive for cash. A nurse is not supposed to say to an elderly patient: “pay me an extra 50 dollars and I’ll care for you more.” Nonetheless, caring institutions will have to choose between hiring cheap and badly trained personnel or more expensive and well-qualified personnel, or between prescribing brief or extended periods of time for a nurse to spend per patient. Indirect trade-offs between care and money, wherever necessary, will and can be made.

The defender of care incommensurability could now raise the claim that indirect trade-offs in the case of care are themselves inappropriate. In the friendship example the person finds himself in a situation in which a job offer and time for friendship have to be weighed. Both being in the job market and having friendships are normal and justified courses of action; consequently, a conflict may arise. We might say: this is the structure of the world. In contrast, the example of the personnel policy of the care institution could be portrayed as an example in which such a trade-off should not arise in the first place. The world should have been structured in such a way that care institutions do not exist at all—and all care would be done informally, outside of the corrupting influence of markets and monetary rewards. This argument tries to show that if the constitutive incommensurability of direct exchanges is socially constructed, so is the (non-)permissibility of indirect trade-offs. But this idea rests on the naïve view that there is a world available in which care is not traded off against other goods. Note that even if care is provided informally, it has to be traded off against all kinds of other goods, not least against money, for the simple reason that care work consumes time and energy and requires that the caregiver give up other activities. If the provision of care out of caring motives is to imply the impermissibility of any trade-off with other goods, then care would be an unrealizable good.

This establishes that there is no principled objection to payments for care. They do not necessarily corrupt the personal relationships and concomitant caring motives associated with good care.¹⁴ Of course, it may be the case that certain practical conditions have to be in place to guard against corruption. Empirical study of home health care delivered by professionals confirms this. Payment as such does not seem to be the problem, but caregivers need to devise strategies to pretend that money does not play a role in the relationship with their clients (Stone 2005). The real problem for many caregivers, according to this study, is not the introduction of money in caring relations but the bureaucratization of care that comes with its political and managerial control. Most forms of formal care are paid for by third parties, who are not a party to the primary care relationship (either investors in market-based care companies or government agencies controlling public funds). These third parties press for minimization of costs, either to increase profits and please shareholders or to minimize public spending and please taxpayers. This puts constant pressure on primary care relations; these need to be made “more efficient” by adhering to standardized procedures and minimizing expenditure of time and energy per patient (Stone 2005, 282–86). This suggests that the real issue is not so much on the supply side (caregivers’ motives and payment) but on the demand side. Care may suffer from under-demand as a consequence of a lack of real power over budgets on the part of care recipients (Nelson 1999, 56). If the issue of payment presents a limit to formalized, marketized care, then, this is due to the

practical inability or unwillingness of these third parties to give care recipients effective control and adequate budgets for care.

Let us now turn to the second objection. Market-based care relies on personal relations formed after care is contracted for between a consumer and a provider. The contractual origin of market care, so the objection goes, prevents the creation of the kinds of personal relationships necessary to sustain good caring activities. Marketized care is based on contracts that specify the amount and kind of care that is to be delivered and—by implication—the amount and kind of care that the dependent can *not* be expected to receive. Contracts purport to make care into a good with transparent and well-specified boundaries. Contracts therefore fail to accommodate caring obligations, which by their very nature are unspecified and without clear boundaries:

Family work allows no eight-hour day; it offers no free weekends, no five-day week, no fixed holidays a year, no paid sick leave. What can be called a different rationality owes at least *prima facie* to the fact that family work is not really operationalizable, cannot be stipulated in a contract, for those who work in their own families. Living with one's own child can at times be extremely anarchic and can easily take up twenty-four hours in a day. In other words, no beginning or end can be structured into the working day. An infant, for instance, needs and expects care all day long. It is hard to imagine a contract stipulating working hours here—at least not for the caretaking parents, and we are only concerned here with them. (Rössler 2007, 141)

The problem with this objection based on the open-ended nature of care responsibilities is that its skepticism about the possibility of molding such responsibilities in contractual terms is based on an over-demanding view of contractual specification. Contracts require a specification of the time during which the contracted person or institution is responsible and of the kind of care to be provided. Of course, not every separate action can be foreseen and described in such a contract; in that sense the contract necessarily remains global. However, these kinds of global contracts are quite usual in many parts of economic life, especially for services (cf. economists' concept of "incomplete contracts"). There is no reason why care would be different. Furthermore, the fact that care is also needed outside of the contracted hours does not argue against these kinds of contracts; in these hours somebody else takes over responsibility for the dependent person. Moreover, nothing prevents one from concluding a more extensive contract for these hours. In principle, a child or elderly person can even be cared for in an institution twenty-four hours a day (as in orphanages or nursing homes), where professional caregivers—even if in shifts—make sure that care is provided around the clock.

The objection might be slightly reformulated: any contract, because of its global nature, will be insufficiently attentive to the specific needs of care recipients. The impersonal rules governing contracts prevent caregivers from catering to the special demands of patients in the way that caregivers in an informal setting can (Young 2007, 208). However, the conclusions of a recent study on care institutions for disabled persons point in the opposite direction. Markets make it possible for clients to differentiate in the care that they buy with the personalized budgets allocated to them. As a consequence, institutions do indeed differentiate among patients, depending on the care obligations contracted with each of them. Markets—at least in theory—are very well able to ensure that care is matched to specific needs of dependents. I add that markets can ensure this “in theory,” because there are practical difficulties in meeting these conditions. The trick for market provision of care is to make sure that medical need and market demand coincide sufficiently well, that is, that patients get a personal budget that is adequate for buying the care that fits their needs, that patients are sufficiently capable or assisted to purchase the care they need and to claim their contractual rights in cases of conflict. If the contractual nature of market provision points to the limited appropriateness of market-based care, this inappropriateness lies in the difficulty of organizing these practical conditions. Wherever it turns out to be impossible to create markets that fulfill these conditions, markets run the danger of failing to meet vital care needs of dependents.

In conclusion, neither of the two objections to market-based care succeeds. The contractual nature of market-based care provides no principled problem to the open-ended structure of care, nor do payments necessarily prevent the required caring motives from arising. With respect to both objections, we would do better to focus on the practical conditions under which market care is delivered than pronounce a categorical verdict on the market’s inappropriateness for caring.

III. CARE AND THE CAPABILITY TO WORK

The outcome of our discussion so far implies that both market provision and informal provision can be viable ways of providing care. Moreover, each is valuable in its own way. When care is provided informally, care is sustained by an intrinsic interest of persons in each other (as in friendships), a biological bond (family), a “community of fate” (as in neighborhoods), and so on. These care activities express and reinforce the different kinds of previously existing relationships. The market, because of its contractual basis, cannot perform a similar function. In the market, new care relations are forged only at the moment of and for the sake of care activities themselves. However, this does not make care relations in the market of lesser quality. Market care is both a welcome form of

care on its own, and it helpfully provides an alternative for care on the basis of previously existing relations (when these are absent) or even an escape from them (when these are unwanted). Thus, informal and market-based care should be allowed to exist side by side; caring will be provided in what I will call an “institutionally pluralist” setting. This acknowledgment transforms the commodification question. Instead of asking whether care can be subject to the market, we now have to ask what the appropriate relation between (or combination of) market provision and non-market—that is, informal—provision should be. The remainder of this paper will be devoted to this question.

To answer it, we need to give up the tacit assumption used until this point that the only important normative demands are internal to caring activities (that is, the capabilities to receive and give care: section I). Numerous other activities compete for time and resources. The appropriate organization of care will also be determined by a need to reconcile these competing claims. To keep the discussion manageable, I will focus on one important factor influencing the opportunities to engage in caring activities, that is, the extent to which people participate in formal employment through the labor market. For the sake of convenience, I will refer to this as “work” (even if caring is also “work” in a broader sense of the term). As an addition to our normative care theory, we should recognize a morally required “capability to work.” This claim should be understood in a contextual manner. In present-day modern societies many kinds of human activities can be realized to a meaningful extent only in work. For many activities the corresponding hobby simply is not an alternative comparable in worth—it lacks the degree of organization, the level of skill, opportunities for social esteem, and so on. This role of work is not a universal and timeless truth, but its current predominance requires giving each person the capability to engage in work. In addition, the financial independence that may be gained through work also counts in favor of making this capability a moral requirement. It is hard if not impossible to have equal standing as a person in a society if one belongs to a group that is systematically excluded from labor-market participation and the financial independence that it brings. This kind of equal standing has proven to be especially problematic for women. Women’s emancipation involves giving women the capacity to act upon their choices, and given the centrality of work, they cannot have this capacity without having the capability to work. Therefore this capability should be available to everyone, not just to the male half of the population. The normative claim is *not*, of course, that actual functioning is required. Men and women alike may choose not to work if they want to (and can afford to). There is no legitimate dictate that people should be forced to cooperate to ensure maximum labor-market participation.

As a consequence, we now have to take into account *two* capabilities for potential caregivers that play a role in organizing care: the capability to work

and the capability to care. Our question now becomes what the relation between these two should be. The fact that those who have done and still do the bulk of caring—women—engage in work to an increasing extent has given rise to the problem of the “work—care balance.”¹⁵ To explore this problem, it is useful to start with Nancy Fraser’s thorough normative investigation of this issue. Fraser outlines three models to restructure the relations between work and care in the face of the decline of the male-breadwinner model, in which families divided work and care responsibilities along gender lines. The first model she calls the “universal breadwinner model.” Its aim is “to enable women to support themselves and their families through their own wage earning,” by creating “full-time, high paying, permanent jobs” for them. Under this model, care would be “shifted from the family to the market and the state, where it would be performed by employees for pay” (Fraser 1994, 601–02).¹⁶ The universal breadwinner model requires that care be commodified to a large extent. The second model is the “caregiver parity model,” which aims “to enable women with significant domestic responsibilities to support themselves and their families, either through care work alone or through care work plus part-time employment” (Fraser 1994, 606). The main institutional innovations for implementing this model, according to Fraser, are a system of caregiver allowances to compensate women for care activities plus workplace reform that guarantees opportunities for part-time work, flexible working hours, parental leave, and so on. As a consequence, the bulk of care work will remain in the household, instead of being outsourced to the market or the state.

Fraser argues that neither of these models satisfies gender equity. The universal breadwinner model is faulted for universalizing the male norm of paid work, while valuing care work only instrumentally: “it is what must be sloughed off to become a breadwinner. It is not itself accorded social value” (Fraser 1994, 605). Also, the imposition of this norm will still work out unfairly for women insofar as the commodification of care work can never be complete. It gives rise to new coordination tasks, which will fall mainly on women: their “second shift.” The caregiver parity model values care by financially supporting it. However, it will institute a labor market segregated into full-time careers and part-time, flexible jobs (the “mommy track”). As a consequence, caregiving “remains associated with femininity. Breadwinning likewise remains associated with masculinity. Given those traditional gender associations, plus the economic differential between the two life styles, care giving is unlikely to attain true parity with breadwinning” (Fraser 1994, 609). In two different ways, then, the two models fail to achieve gender equity *and* equal status for care work compared to paid work:

Although both are good at preventing women’s poverty and exploitation, both are only fair at redressing inequality of

respect: Universal breadwinner holds women to the same standard as men while constructing arrangements that prevent them from meeting it fully; caregiver parity, in contrast, sets up a double standard to accommodate gender difference while institutionalizing policies that fail to assure equivalent respect for feminine activities and life patterns. . . . Neither model, however, promotes women's full participation on a par with men in politics and civil society. And neither values female-associated practices enough to ask men to do them, too; neither asks men to change. (Fraser 1994, 610)¹⁷

The solution, then, according to Fraser, would be to develop a third model in which gender itself is deconstructed, so that both work and care activities would be associated with masculinity and femininity to an equal extent. She admits this is utopian under current circumstances, but nonetheless provides a rough outline of what this model of deconstructed gender would mean for the practice of the welfare state:

Unlike caregiver parity, its employment sector would not be divided into two different tracks; all jobs would assume workers who are caregivers, too; all would have a shorter work week than full-time jobs have now; and all would have employment-enabling services. Unlike universal breadwinner, however, employees would not be assumed to shift all care work to social services. Some informal care work would be publicly supported and integrated on a par with paid work in a single social-insurance system. Some would be performed in households by relatives and friends, but such households would not necessarily be heterosexual nuclear families. Other supported care work would be located outside of households altogether—in civil society. In state-funded but locally organized institutions, childless adults, older people, and others without kin-based responsibilities would join parents and others in democratic, self-managed care work activities. (Fraser 1994, 613)

Fraser does not give her preferred model a name; I will refer to it as the “universal caregiver model.” Before assessing the choice situation that her three models provide, we have to make one important modification.

This modification concerns the caregiver parity model. Fraser suggests that taking the route of paying for care means women will keep on providing it, albeit with better remuneration. However, there are at least three possible payment schemes, with very different results (Krebs 2002, 75–77). The first kind of payment is where the caregiver is compensated for buying care services in the

market (cf. a quasi-market mode of provision). This fits the universal breadwinner model. A second kind of payment scheme is where the caregiver is compensated for providing care herself (cf. paid informal provision). This is what Fraser has in mind; it supports the caregiver parity model. In a third kind of payment scheme a budget is allocated to the caregiver who herself can choose between these two options. This leads to an unknown outcome, depending on how people choose to use the budget. If people were to use their budget to buy care services to replace their personal care activities, it would lead to universal breadwinner. If they were to use it to compensate women for care work, it would lead to caregiver parity. If they were to use it to realize equal care and work combinations for both men and women, it would lead to the universal caregiver model. This kind of payment scheme could therefore lead to a heterogeneous situation where different parts of the population would go in different directions, not realizing one particular model at all but rather a combination of all of them.

These finer distinctions in the caregiver parity model are important. Angelika Krebs has explicitly proposed the third option just mentioned (let us call it the “caregiver choice model”) as superior to Fraser’s model. She appeals to the fundamental value of choice: people should decide for themselves whether they want to assume care responsibilities.¹⁸ Krebs argues against those feminists who object to payments for care on the grounds that such payments support current gender roles. She complains that these feminists act paternalistically and probably also counterproductively by enforcing their preferred choice upon the whole of society. Just as attaching a right to payment only to informal care would be paternalistic, so would attaching it only to the purchase of commercial care. Giving women a real choice between caring and working is just what is due, she maintains (Krebs 2002, 89–90). What should we think of this argument?

In my view, a defender of the universal caregiver model can reply to Krebs that any choice under current circumstances is not completely free, either because social norms may prevail that favor using personal budgets for female care work rather than market-based care (leading to the caregiver parity model) or vice versa (leading to the universal breadwinner model). The pressure to conform to such norms may be hard to resist. Nevertheless, I think that this response is insufficient to establish a preference for the universal caregiver model. For Krebs might reply that a formal choice is better than no choice. If the universal caregiver model is to be defended, we need a separate argument to establish that the substantial outcome this model prescribes (both sexes engaging in care and work) really is a normative requirement.

It is at this point that I think the capability analysis I have given earlier can help to resolve the dispute. When a care relation is at stake for which an obligation exists to act upon the preexisting personal relation between care

receiver and caregiver, we can argue that Fraser's model has to be preferred. For to the extent that such personalized care obligations exist, at least part of the care activities in question should not be handed over to market-based care institutions. To stick with the example of the parent—child relationship: it is impossible to take upon oneself the primary responsibility to care for the well-being of children (to stick with them) without actually doing the care-taking oneself, at least part of the time—otherwise no meaningful personal relation between parent and child will be established in the first place. Of course, it is conceivable that parents remain primarily obliged to care for their children while practically delegating the task to others. Nonetheless, at some point, delegation prevents the caregiver from exercising her primary responsibility. Where exactly that point lies remains a source of debate. This parental obligation requires an institutional setting that makes it possible to fulfill it, while at the same time giving opportunities for the conversion of that other morally required capability into functioning—the capability to work. The conflict between these two capabilities (the child's capability to receive parental care and the parents' capability to work) cannot be resolved by discharging either one of them, since they are both morally required. Therefore a solution must be found that reconciles them as much as possible.

It is to this end that Fraser's universal caregiver model is superior to the caregiver choice model. Redistributing care for children and work responsibilities over both men and women accommodates the fulfillment of obligations for informal child care and the opportunity to work on a gender-neutral basis. Insofar as a system of payments to caregivers would be able to reach the same substantial outcome, it would be an alternative. However, the fact that it requires people who voluntarily choose to fulfill care obligations to put themselves at a job disadvantage compared to others who choose to formalize their care obligations, or who have none, makes for an important argument against it. In assuming that all workers are also caregivers, Fraser's model does make a choice that puts workers without care responsibilities at a disadvantage (because they have to restrain their work efforts; see below). However, I think she is right that this is the price to be paid for supporting those who do have care obligations. There is no middle ground—a policy that does not support caregivers implicitly supports those without caregiving obligations.

The flip side of this argument is that there are clear limits to the obligation of primary caregivers as well. For the care recipient (child) the reception of care exclusively by the primary caregiver (parent) is detrimental to her basic need of care. At some point receiving care from her parents prevents her from becoming acquainted with the wider society (other children, other adults). Children also have an interest in learning from people other than their parents and experiencing a wider range of views on all kinds of matters. These limits suggest the appropriateness of a division of labor between primary caregivers obligated

to deliver care informally, and formal forms of care to fill up the remaining need for care and to give children a wider range of encounters while simultaneously giving parents opportunities to work.¹⁹ It is this substantive division of labor between informal and formal care that should inform the institutionally pluralist setting that we are looking for in the context of child care.

All these considerations do not apply to our other category of care activities, where no personalized care obligation is established. Here institutional pluralism should take the form of leaving a choice between informal and formal care, and to that end one Krebs's caregiver choice model is more appropriate. Translating this model into workable institutions will require making some tricky decisions. Let's take the case of an elderly parent as an example.

First, in this situation it seems more appropriate to allocate the caregiver allowance that Krebs's model provides to the care recipient himself, not to the person wanting to discharge a care responsibility (as we would for parental care, because the child cannot make choices yet). The elderly person can then decide for himself to spend this on care by his child(ren) or on market-based care services. This granting of freedom of choice to the care recipient corresponds to the fact that there is no person with a personalized obligation (as there was in the case of the parent's care for her child). Krebs's model could therefore better be called a "care recipient choice model" instead of a "caregiver choice model."

Second, it is up for discussion whether these allowances would be given to anyone who offers herself as a caregiver or only to a restricted circle, for example, to close family only. Is the elderly parent allowed to "hire" his children only, or also a friend, the neighbors, or some stranger? Making a wider range of people eligible may enhance the quality of care (since the care recipient arguably will choose someone he trusts to give good care), but it might also have large financial consequences (to the extent that this will make the system much more expensive for those who pay the allowances, that is, normally the taxpayers).

Third, we will need to decide on a solution for situations where nobody offers herself as caregiver for the dependent. In that case it seems most appropriate—as is most often the case in developed countries—that a professional will be assigned (whether or not in a care institution). A fourth and final problem would arise where the opposite is the case, that is, that several persons offer to care for the dependent (imagine they each separately would be eligible under the criteria established by the system), but the care allowances cover the expenses of only one of them. Even if such an abundant supply of care may not be very frequent (given the high time-intensity of care commitments), the system will need to arbitrate among these offers. Here the most natural option would be to leave the choice with the prospective care recipient (unless he or she is mentally unable to make these choices).

CONCLUSION

This paper has analyzed the problem of commodifying care, using a capability theory of caring. I have argued that two of the most important principled arguments against commodifying care fail. Markets are compatible with caring. This acknowledgment has led us to shift the focus to the question how market-based care and informal care should relate to each other. Here I have argued that this depends on the type of dependency at stake. Personalized dependencies require a certain amount of informal caring. To accommodate this need and the need to guarantee opportunities for labor-market participation, and to do so in a gender neutral way, requires the realization of a universal caregiver model, which assumes that both men and women work and care. However, where no such personalized dependencies exist, a different model, the caregiver choice model, is required. If these conclusions are accepted, then our next question will be what this requires in practice and what political strategies are required to get there.

NOTES

This article is a reworked version of a chapter of my dissertation “The Market’s Place in the Provision of Goods” (Utrecht University, 2008). I would like to thank my thesis supervisors, Marcus Düwell and Elizabeth Anderson, for their extremely dedicated and valuable supervision of this chapter as well as of all the others.

1. This excludes care work in a more extended sense, where a person either cares for someone who could take care of himself, or where caring activities are an integral but not a central part of a professional engagement (the care of a waitress for her clients).

2. Thus, market provision is here taken as a *pars pro toto* for what is sometimes called “formal provision.” To keep the discussion manageable I abstract from other forms of formal provision, such as public provision or quasi-market provision.

3. My discussion doesn’t claim that there are no other autonomy-developing capabilities than the ones that will be identified in this paper. Rather, those identified here are central for dealing with the desirability of the commodification of caring.

4. Indeed, it is a commonplace in the literature on the subject. See Kittay 1999, 55, which locates the claim in the vulnerability of the dependent (following Robert Goodin). This way of grounding the claim is criticized by Engster: “We may all be said to have obligations to care for others not so much because others are vulnerable to us, but rather because we are dependent (and have been or will be) upon others” (Engster 2005, 59). This is compatible with my grounding of the care claim in the need for developing agency on the part of care recipients.

5. I will use “him” for the care recipient and “her” for the caregiver to confront the reader with the actually existing gendered nature of the division of care labor, not in any manner to endorse that division.

6. This definition shows that I use the term *capabilities* in the broader sense, not just referring to personal powers, but personal powers and social conditions to exercise them. Compare Nussbaum, who distinguishes among basic, internal, and combined capabilities (Nussbaum 2000, 84–85). For a discussion of the scope of the capability notion in Sen and Nussbaum, see Crocker 2008, 172–77.

7. The inclusion in the argument of an explicit capability to care to some extent counters the criticism by Lewis and Giullari that a capability approach conceptualizes care only from the care recipient's side. It is an open question whether they will be content with its lower moral status (compared to the capability to receive care) defended here. See Lewis and Giullari 2005, 93.

8. Unfortunately, much of the literature on care work makes this assumption, often implicitly by assuming that care work will be done informally, and by paying no attention to formal care (thus begging one of the most fundamental questions of the organization of care). For an explicit statement, see Engster: “We have a primary duty to care for our children, parents, spouses, partners, friends and other intimate relations because we usually are best suited to provide care for them and have a relational history with them that allows us to anticipate and understand their needs” (Engster 2005, 66).

9. My argument here relies on the fact that as a general rule we may assume that parents are the addressees for this obligation because they are best placed to take care of their children. Some are skeptical that this general rule best captures the child's interests. They are impressed by the force of the redistribution problem: if the well-being of children is crucial, why not redistribute them to those who can take care of them best, whomever that may be? If one takes this problem seriously, a switch from a child-centered argument to a parent-centered argument would be needed, showing the parent's interests in having a relation with their children. One such argument is offered in Brighouse and Swift 2006, 92–95. I think, however, that we can have more faith that as a rule parents will be the best caregivers for their children, and then allow exceptions and contemplate a removal from their parents when they have proven to harm or neglect their child's well-being.

10. An empirical study on care of the elderly put the matter as follows: “Taking account of the views of elderly people and their families, it is clear that the assumption of a general preference for informal care is too simple a view. Particular family members may be irreplaceable in some ways—a visit from a voluntary visitor does not have the same meaning as a visit from a daughter—but it is not easy to see why this argument about social contact necessarily extends to the performance of practical tasks” [that is, to caring activities (author)] (Qureshi 1990, 68). Even though there often is a responsibility generated on the basis of family ties to ensure that care is being taken by someone (most often, some institution), the conviction that such care can be formalized is strong. Qureshi even notes that many elderly themselves prefer not to burden their children with extensive care obligations (67). However, in other types of societies and cultures there has been and still is strong obligation to care for the elderly in person, grounded in the conviction that it is a constitutive part of the elderly person's basic need for care.

11. In treating commensurability as the social process of assigning a monetary value (price), it becomes clear that there is nothing in the goods themselves or in our

choice process that forces commensurability or incommensurability upon us. See Espeland and Stevens 1998. Rather, (in)commensurability is a construction of practical reason: we commensurate goods when it makes sense to do so, according to social norms that have to be justified and can be criticized. See Anderson 1997.

12. This position is criticized in Chang 2001.

13. See Kittay 1999, 111, on the “nonfungibility” of care work. Similarly, Lynch 2007 on the “constitutional impossibility” of commodifying primary care. Similarly in the context of medical care, see Kaveny 1999; Pellegrino 1999.

14. This is also recognized by Held 2002. However, Held seems to be more skeptical than I am here when care payments are made in a market setting. Although she recognizes that actual markets may include “personal exchanges” and important non-market values, she fears that “market values” will exercise pressure on the organization of actual markets.

15. For a well-balanced empirical study of the problems in combining work and family obligations in the United States, see Jacobs and Gerson 2004. For an analysis from the perspective of comparative welfare-state analysis, see León 2005.

16. For an outline of similar models with some small variations, see Lewis 2001, 157.

17. Of course, the choice between a feminist ideal of competing on male terms versus an equally feminist ideal of valuing difference is long known to be a headache for the feminist movement. See Kittay on the “dilemma of difference” (Kittay 1999, 9–11). For a clarifying discussion of the policy implications of these two stances, see Folbre 1995, 83–87.

18. “But we do have something to object against the *family service*-variant. It should be left to every person himself to decide whether he wants to engage in reproductive and care activities or not. As long as this leads to a meaningful social organization of child care and elderly care, these belong in the economic sphere . . .” (Krebs 2002, 70, my translation). Eva Kittay in the end also opts for this route, and hopes that care can be degendered by paying for it, in combination with side-policies such as “training young boys, as well as young girls, in caring skills” and “restructuring the work place” (Kittay 2001, 544–45).

19. Folbre and Nelson argue that the part of care that is commodified is the time that parents would only have been “on call” anyway, with their primary attention elsewhere. The part of care that is retained for informal provision is the more intensive time with their children (Folbre and Nelson 2000, 128–29).

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