REAL Centre
A radical new vision for social care

How to reimagine and redesign support systems for this century

Hilary Cottam

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The Health Foundation

About the author

Dr Hilary Cottam OBE is an internationally acclaimed author and social innovator. Hilary's work combines a commitment to connecting radical participatory practice with new ideas. Hilary was named UK Designer of the Year in 2005 for her pioneering work in the creation of social design. Her recent book *Radical Help: How We Can Remake the Relationships Between Us and Revolutionise the Welfare State* was published by Virago Little Brown in 2018.

Hilary's work focuses on welfare systems. In her practice with communities in the UK and across the world she challenges us to stop trying to reform out of date systems and instead to look again at how modern solutions might start with people, communities and their capabilities. Hilary is an Honorary Professor at the UCL Institute of Innovation and Public Purpose (IIPP) and her current work focuses on technology revolutions and their possibilities for social change.

About the REAL Centre

The Health Foundation's REAL Centre (research and economic analysis for the long term) provides independent analysis and research to support better long-term decision making in health and social care.

Its aim is to help health and social care leaders and policymakers look beyond the short term to understand the implications of their funding and resourcing decisions over the next 10–15 years. The Centre will work in partnership with leading experts and academics to research and model the future demand for care, and the workforce and other resources needed to respond.

The Centre supports the Health Foundation's aim to create a more sustainable health and care system that better meets people's needs now and in the future.

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October 2021

Introduction

Who made the vaccine? When journalist Sirin Kale went to meet the vaccine scientists last year,[1] she found collaborative teams working long hours in a race against time. Vaccine research is hard and not particularly well paid. What was the secret of success? she asked. Our husbands, our families, our networks, her interviewees responded: you can't make a vaccine without someone cooking your dinner, doing your laundry and looking after your children.[2] As these dedicated modern scientists saw it, care made the vaccine.

Stories of care have been the steady baseline beat of the COVID-19 pandemic. In the beginning our spirits were raised by acts of spontaneous community care – the WhatsApp groups that enabled neighbours to support one another: collecting medicines, providing company, preparing Iftar suppers. Those of us who participated found that we felt just that bit better from connecting with and helping others.

More alarming was the thrum of crisis that came from our care homes: the realisation that too many were dying – that care homes had been abandoned, required to tend vulnerable older people without the requisite resources and protection. Tragically, care workers themselves became vectors of contagion as many were forced to

continue working even when unwell – on low pay, without benefits, they had no other options if their families were to eat.

As schools closed, millions more families found their lives hanging from increasingly precarious threads. The 'she-cession', the dent to women's work as nurseries closed and home-schooling increasingly fell to mothers, has made headlines.[3] Schools are a form of care that allow us to work. They are also the places where vulnerable children are cared for – through the provision of school meals, the presence of trusted adults and much needed friendship.

This pandemic has exposed a deep crisis in care.[4] Despite decades of brilliant work: the research, the policy papers, the advocacy and the data, we are stuck. So, today we want to ask how could things be different? Can we tell a new story about the ways in which care would enable all of us to flourish? A story that ignites imaginations and moves us towards new action? Can we care about care?

Reimagining: becoming an ‘I’ through a ‘you’

1

In 2017, in a surprise TED talk watched by 3.5 million people, Pope Francis addressed the ways in which our futures are deeply connected and dependent on one another. 'I become an I, through a you,' the Pope declared.[5] His words echoed the writings of the German philosopher Martin Buber, whose 1920s treatise *I and Thou* describes the way that we become human through our relationships with and care for each other and the natural world around us.[6] Just as trees stand tall in their individual beauty by entwining their roots with one another, so we as individuals, communities and nations only fully reach our potential within ecosystems of care and support.

This idea that the work of caring for one another is core to our humanity and human wellbeing was well understood by our ancestors. In my own work and practice, I draw on Aristotle's concept of *eudaimonia*. Often translated as 'happiness', Aristotle's concept is closer to that of 'flourishing'. Aristotle argued that we need support to grow and develop and we need a sense of *meaning*; of our place in the world. For Aristotle, this meaning comes through collective participation in the home, the market place and societies' wider institutions.[7] In other words, tending to one another and the wider infrastructure that shapes our world is what enables us to flourish.

In the West this understanding of human flourishing has gradually unravelled. Our implicit understanding of human thriving as a collective endeavour in which caring (and our need to draw on support) plays a central role, was replaced by a utilitarian model perhaps best characterised by that rapscallion *homo economicus* – the individual who

realises himself through a ruthless quest to maximise individual material gain.[8] Caring in this utilitarian model would be outsourced, placed elsewhere, out of sight. If we could find a way for others to take on this messy business, so this logic runs, then that is the route to wellbeing.

There were good reasons for this shift, not least the realisation that the work of care – *everything we do to maintain, continue and repair our world, our bodies, our selves and our environment*[9]– was increasingly not shared, but was racialised and feminised. Falling on women within the household and again on women, and in particular women of colour, within institutionalised welfare systems.[10] Care work, these women remind us, can be joyful and fulfilling. But it is often repetitive, tedious, oppressive and rarely valued either in monetary or any other form. A world in which caring is neither shared nor valued oppresses: it does not enable the carer or the cared for to flourish.

But today I think we see a hunger to reimagine these tensions and to think again. Growing numbers of us want to put care for each other and the environment before money.[11] Attachment Economics, Restoration Economics, the Foundational Economy, the work of the Women's Budget Group – all this thinking and more represents an enquiry into how we might reorder our economies.[12] The intention is to heal the current split in consciousness whereby we are asked in myriad ways, explicit and implicit, to contribute to the economies of extraction in the hope that invisible others will do the work of repair and care, on which we all depend.

Today we face a binary world that falsely assumes work and care are mutually exclusive spheres. Millions of us live lives of acute stress as we try to manage this border war: the competing demands of caring for small children; friends who perhaps need some extra support; young adults whose minds and bodies are deemed not to 'fit', or for our beloved parents. Before the pandemic struck I was conducting workshops across Britain with people from all walks of life: nurses, carers, grave diggers, university professors, nuclear weapon makers and more. All cited this 'juggle, juggle' as the single biggest challenge in living good lives. Everyone wanted to rethink the linear working life in new ways that would allow work to be rewoven with time for connecting, learning and caring.

These demands are not new. We stand on the shoulders of decades of feminist scholarship, the activism of disability and carer movements and more recently environmentalists, who understand the ethical connections between care for ourselves and wider living webs. But might this moment – in which the forces of a technology revolution (which is disrupting our work); a looming environmental catastrophe (which must reorder what work counts); and the cruel effects of the pandemic (which have so brutally exposed the fault lines in our existing care systems) – offer us a real chance to reimagine and reorganise?

Work and care: a new relationship

I originally studied history and I have a deep interest in the relationship between technology revolutions and social change.[13] The relationship is not linear: the social gains that have previously accompanied shifts in technology – better health, longer lives, better working conditions – have been hard won and are not irreversible.[14] But the longer run trends are clear: new technology disrupts and creates opportunities for radical social change.

If you had told those who crowded into our cities in the last technology revolution – that of mass production – that they would gain guaranteed decent incomes, paid holiday and a 2-day weekend, you would have been roundly mocked. And yet it happened. I want to suggest that the weekend – that totemic gain of the early 20th century[15] – should be echoed in this century, in a rethinking of the relationship between work and care. Care time should become as normal as the weekend.

Some perhaps – like their early 20th century counterparts – believe such a change sounds utopian. But the lessons from history and from modern-day experiments prove otherwise. Weaving care and work together enables higher productivity and greater life satisfaction. It might also enable us to repair the fragile ecosystems on which our human life ultimately depends.

Let me give you just two examples. The first, from the 1930s when Kellogg's, the largest manufacturer of breakfast cereals in the world, started a radical experiment: 6-hour working days. Workers at Kellogg's embraced the change – in the 1930s people assumed that technology would deliver such liberation as the norm, the economist John Maynard Keynes after all had recently written a treatise predicting the 15-hour week.[16] What detailed economic and household studies of the Kellogg's experience show are two things. Firstly, workers used their time in many different ways, but all recorded their increased health and happiness from having the time for 'maintenance'; taking care of children, making things from culture to good meals, joining clubs and just passing time together. Secondly, Kellogg's productivity and profitability rose even though workers were earning the same wages for less hours. Cared for and happy workers were better workers: output rose and industrial accidents fell dramatically.[17]

Such evidence would not surprise modern-day experimenters such as Karen Mattison and Emma Stewart, the founders of TimeWise.[18] Their consultancy is built on a simple premise: if you offer good, part-time, flexible work you will attract a talented, loyal and highly motivated workforce. It is not surprising that, particularly in the beginning, many TimeWise clients were new mothers seeking ways to balance the care of small children with the continuing love of their professions. TimeWise grew in the early years because employers realised they were attracting higher calibre candidates through offering

predictable but flexible work: time to care. More recently the gender balance has evened out – after all, fathers also want to care as do older workers and many more. TimeWise are pioneers because they have shown over almost two decades that work and care can be reintegrated so that life and business is better.

The common thread running through the reorganisation of Kellogg's, the innovations at TimeWise, the words of the Pope and the interventions of activists, is a recovery and reconceptualisation of what it is to be human and to flourish.

Our systems – social and economic – are designed around who we imagine humans to be. Today that imagined human is the solitary, calculating and insatiable *homo economicus,* already referred to. To create change we need to explicitly recognise that scholarship across the widest range of disciplines tells us that humans are not in fact wired in this rational, individualistic way.[19] This human template no longer fits and must be consciously replaced. It is time to give *homo economicus* a good death and to replace him with *sapiens integra*.[20] *Sapiens integra* works, cares, loves, plays and learns for pleasure. They become who they are in relationship to others, assuming, valuing and making visible whole, connected human beings with our unique aspects, blemishes, affects and defects. We grow, we compete and sometimes we suffer. *Sapiens integra* is the template around which we can design our new systems.

I am arguing that at a profound level improving wellbeing is not about the design of a great social care system that patches up the gaps where real life should be. It is about turning this thinking on its head. We must think first how to create the conditions for good lives: which means the ability to support and care for one another, across the life span. We can acknowledge that this work is messy, sometimes painful and that its pleasures and pains need to be shared. We must recognise that care is a continuum: we need every-day time that allows us each to contribute, and we need the expertise of professionals working within redesigned support systems. This redesign then does not start within the current system. It starts with this very different understanding of the role care plays within human and natural world systems. This in turn provides the very different principles that can guide and govern the creation of those new systems.

Redesigning: the death of the care home?

2

In nature, the new is frequently born through cataclysm: the flood, the forest fire, the ravages wreaked by a storm. Perhaps we can use the current conjuncture in a similar way. We could free our imaginations for just a moment by imagining the death of an institution that exemplifies the impossible boundaries we have placed between every day human care and the service that goes by the same name; an institution that in this pandemic has been the site of so much grief and death: the care home.[21]

The story of a friend of mine may be familiar to you. Shortly before the pandemic made such things impossible, she visited her mother who is frail, elderly and lives in a home where she must be bathed, dressed and fed by others. My friend no longer recognises the wisp of a figure her mother has become. Her mother in turn has long forgotten who her daughter is. This situation is a source of anguish for my friend – let's call her Mary – who, despite the fact she will not be recognised, makes the long trip from London to the North East on a regular basis, full of love for her mother.

On one particular visit Mary found her mother distressed and in considerable pain: it seemed her tooth had broken. Unable to get a proper look, she suggested to the doctor on duty that perhaps an anaesthetic could be arranged in order to examine the problem without causing her mother distress and address the pain. Oh no, the doctor demurred; the anaesthetic would need to be general and it might kill her.

The care home is a place fraught with complex emotions and contradictions. Few of us can bear to think about the frailty that is inherent in being human. And hardly anyone wants to live within an institution. Our apprehension that we may be moved from our home to 'a home' is not only a fear of death – the only exit. It is a fear of loss, of the disruption of life's natural rhythms. Being dressed in someone else's cardigan, eating things you dislike, next to people who do not interest you, losing your memory and your mind.[22]

Of course, care homes for older people are only one part of our industrial care system. It surprises many to learn how few of us will in fact reside in such places and surprises even more of us to learn of the substantial care need among younger adults and among the 15 million of us who suffer from chronic health conditions that require active care, as opposed to the medicine on offer.[23] In fact, of those receiving care paid for by their local authority, around a third are younger adults who account for around half of annual funding.[24]

But the care home perfectly symbolises the care system we know today. It is a node in a form of warehousing that is euphemistically called 'care' and is on offer for everyone, not just older people. Childcare – another point in this failing system – is also organised according to the same industrial logic. This logic seeks to lower the unit costs in order to increase the scale of production. The answer is low wages for carers and as many young children as possible allocated to each carer. Against the advice of childcare experts, up to eight pre-school children can be

left with one adult carer.[25] Policymakers assure us that the carers are increasingly well trained. But no adult, however well qualified, can take eight very small children on a walk or make something with so many tiny hands at once. The activities core to our human development are curtailed.[26]

For older people, and for adults who are cared for within their own homes, the 'care' on offer is not much different: you simply find yourself at a different point on the industrial conveyor belt. This is the system that will offer a young person 'a befriending service' rather than seek ways to make every day connections to existing friends. It is the system that confuses the practical support adults need to live their lives, with paternal ideas of care provision.[27] And it is the system that leaves notes by the door, reminding the visiting carer – who will rarely be the same person and will have a 15-minute visiting slot – that the white flannel is for the face and the blue flannel is for the bottom.

Care today is not defined by the warmth of human connection or the practicalities of support needed, but by an uneasy relationship between the market place and transactional state regulations. The care home is a place where fortunes are made. It is well documented that too many children's homes and older people's homes in the UK are centres of profit: physical assets are wrapped into complex financing structures where taxes can be avoided, and immense wealth is made from 'flipping' the assets when the time is right.[28]

Unsurprisingly, given the mismatch between human need and the state/market structures, few can bear to work long in these conditions. In her moving and magisterial study of the crisis of care *Labours of Love,* Madeleine Bunting writes of her visits to a care home that is well run, '…but the quiet routine seemed to amplify the sense of surplus, of unneeded human beings and of unwanted time.' In the end, Bunting can't bear to go back, 'I had retreated, overwhelmed by the sheer scale of human need bursting out of that neat building.'[29]

I have written before of the choice faced by many thousands of health workers, social workers and care workers, between burn out and numb out.[30] Working shadow shifts in different institutions (such as care homes for older people and residential care for at risk young people), I notice the gap between the 'personal care plans' routinely referred to by my colleagues and the reality of the person sitting waiting – to be moved, fed, medicated. Bunting describes the 'distant, bland competence used by the staff, with varying degrees of cheerfulness'. She describes a lack of humanity as a way of coping.

The alternative is to leave. Care is a sector with high turnover rates and an estimated 100,000 plus vacancies.[31] Kelly is one of thousands of carers who cannot bare to stay. 'My shift was 7am to 3pm, but I would work sometimes until 8pm because I was always behind. Later I discovered that my insurance stopped at 3pm, and after that it was at my own risk.' Kelly recounts the worry – that she had not done a good job, the pain at leaving people who plead with her to stay just 5 more minutes. She lost

weight, took the worries home, stopped sleeping. After 18 months she has to resign. She explains to her manager that this is not care. He explains to her that this is what social services can afford.[32]

In his 2019 film *Sorry We Missed You,* the filmmaker Ken Loach shows the impact of this form of industrial care work on the care worker's home and family life: the costly social spill overs that undermine us. Abbie loves her care work and we see her kind and mindful care for those in her charge. We live her long shifts (impossible to fulfil on public transport once she loses her car) and we see how the combined low pay and long hours of her and her husband's work (Ricky is a delivery van driver) make it impossible to juggle caring for their own children. Supervising homework, noticing when her teenage son runs into trouble, doing the laundry, saving enough money for the electric meter and the myriad more things that are required to maintain family life are out of reach for the care worker. We watch as, in debt and exhausted, Abbie's once loving home life comes apart in the face of impossible odds.

The low wages that Abbie must endure may contribute to the profits of the private care provider but they create costs elsewhere: the untold personal cost of an unravelling marriage; the significant financial costs to the state through the need for police intervention; the court appearances of her son; the need for school intervention, a truancy service and mental health support.

Too often when we talk about redesigning care, the conversation is about redesigning pathways into and out of these systems. We also talk about how these systems might be better funded. But the reality is that we need to talk about the stuff of care itself and we need to start to unpick and reweave our systems in new ways. This is hard. It requires new stories, new ways of seeing and working, and new forms of data and accounting.

The work and methods of the French philosopher and historian Michel Foucault provide us with one such shift in perspective. In the middle of the last century Foucault embarked on a unique study of institutions. In invoking the death of the care home, I am echoing and inverting one of the most famous of these studies: *The Birth of the Clinic*.[33]

The Birth of the Clinic is a study of the transformation of a system: a moment in history when disease – which up until the end of the 18th century had been located in the family and the family home (with family members responsible for care) – moves into the medical space of the clinic. Once established, the clinic becomes associated with certain rules and practices. Power becomes vested in the new medical profession whose systems of observation and classification create an almost abstract science that is no longer about the individual human or the wider social context. The contemporary development of statistics played a particular and important role in this new culture and practice.

It's hard not to see the parallels between the clinic and the care home: a focus on the body, rather than the whole social being; a binary shift from family to institution; a sanctity of the professionals – the ones who know – and the reliance on data and indicators, which officially tell us what is happening – whether the home is clean and the residents are 'cared' for, but in fact occlude most of what we want to know: how people are feeling, the quality of human interactions, the balance of power between those in need of support and those paid to offer support.

Foucault likened his historical analysis to archaeology. In seeking to uncover how institutions come into being he was trying to understand and make visible the way certain institutions come to order society in ways that are so deep rooted they are perceived as immutable and beyond question. The procedures and ways of operating of these institutions – the clinic, the prison and I would add the care home – are tightly regulated but seldom questioned. Indeed, Foucault's studies show that such institutions are rarely reformed even when they have clearly failed.[34] Instead the impulse is to reinvoke or redesign the original, such is the strength of the wider systems of data, regulation and professionalism that these institutions hold in place.

Again we can see the parallels here with the care system and the ways in which plans for deep reform are regularly stalled, ignored or watered down.[35] We can also see the abstraction to which Foucault refers in the striking way in which care debates today are largely conducted without reference to the wider social context: the increasing

poverty and widening social inequalities that impact on children's care in particular. Children in Britain's 10 poorest neighbourhoods are 10 times more likely to be taken into care compared with their affluent peers. And yet this correlation between poverty and care is not central to current plans for system reform, which continue to emphasise the regulation and practice of the system as if it operates in a social vacuum.[36]

I'm using this comparison because I want to illuminate the way things within the care system that we currently see as disparate: research, data, working conditions, our understanding of risk, of cost, of regulation, even the language of care, are part of a connected way of thinking and operating that can no longer serve us.[37] By invoking the death of the care home, I am not necessarily suggesting we do not need homes, rather I am asking a bigger question about how we might free ourselves from the concepts that no longer serve us in order to think again and to flourish. I'm also situating our need to redesign and reimagine within a particular historical context. We have inherited an industrial system of care. In this century – a new technological era in which we face new challenges and have new possibilities – we can create something new.

Making it happen

3

The Health Foundation's REAL Centre is a unique space for the careful and meticulous work required to birth new systems. This is work of the imagination – making a leap into the future, while drawing on the best of the past. And it is work of practical experimentation, drawing on the new ways of caring that are growing all around us. These new models are often fragile, struggling to survive within the apparatus of the old system: regulations, metrics and markets that are antithetical to caring. I can't cover every aspect of the apparatus that needs to be reimagined and redesigned, but in closing I would like to talk about five aspects we could work on now. Each is largely a silence in current debates but a necessary foundation stone of any new system.

1. The imagineers

It is those with experience of caring and being cared for who have the ideas, the stories, the imagination to help us think again. This work is not about consultation or simply about ensuring a (critical) representation of lived experience. It is not about those with power deciding too late in the process to let others in. It is about shifting the frame, starting from the perspective of those who are knee high, or who at a particular moment in time need extra support, or who like Kelly have suffered from working in the current system and have ideas about alternatives. This is where we must start: with the invisible wiring of the system and the everyday stories that we shouldn't

try to flatten but rather hear on their own terms. This way of working takes time, something I will return to, but it is where we start.

2. The carers

I write with my computer propped up on two large volumes of the Oxford Dictionary printed in 1959. These dictionaries define 'care' as *to tend*, syn. worry, concern, pressure, tension. Interestingly, there is no entry for 'carer', a word that Bunting describes as, 'A reductionist description of a relationship developed to suit the bureaucratic need, rather than lived experience.'

One in ten of us have some form of caring role and we want to see caring reimagined in ways that are at once bold and tender, extraordinary and every day.[38] Millions of us want to have the possibility of caring when we want to: we will be the barefoot carers in ways which can only be enabled by rethinking work.[39] But this will not be enough. Carers – although they might not be called that – must be to this technology revolution what engineers were to the last. The work of this century is work of repair: of ourselves and of our wider environments.

If we are to make a transition to the restorative green economy that will ensure humanity's future and is longed for by many, then the work of care and of maintenance – of each other and the wider webs of life of which we are part – will be a core and respected activity. We have to design this role in such a way that thousands can embrace

the work, not because they have to but because they *want* to: because it provides a good income and time for a good life, because it is honoured. This means moving from data that tell us about the costs of care to new forms of accounting that reveal the impact of the investment in care.[40] It means creating paths from 'dirty' jobs to 'clean' care and it requires redefining the nature of the work.

3. The craft

Care is an art, a craft, a relationship. It is about entanglement in the lives of others and in emotions that are not always comfortable. Care is not an activity that can happen by the clock: the slots that undo Kelly, Abbie and so many more brilliant professionals I have worked alongside. Care belongs in the world of *kairos* time (measured by flow and connection) as opposed to *chronos* time (the industrial time measured by minutes and deadlines). Care is not the same as cure – yet it so often seems we have confused these categories. This is why our care systems 'think' in terms of an activity that is costed, rationed and meted out in response to a specific need or life moment, as opposed to an ongoing human activity.

10 years ago, I led a participative design experiment, which created a new form of community-based care for those aged 60 and older. Circle was a local membership club seeded in a number of different communities. Membership did not distinguish between those offering and those receiving support. Over 10,000 older people joined or took part. They were clear that all activities – from help

in the home to social meet-ups – needed to be valued according to the quality of the relationship. We had to design a business model that valued the activity *and* the relationship forged, as opposed to a traditional model that would cost tasks based on the time taken. Evaluations of Circle showed how developmental metrics and new forms of accounting that take a wide range of values into account can work in practice.[41]

4. The new institutions

As the proverb rightly goes, new wine cannot be made in old bottles, both bottles and wine are damaged. We need to reimagine the institutions that together constitute the 21st century infrastructure of care. This infrastructure includes the spaces in which we play, generous housing that can allow different generations to be together, park benches, public toilets – all these make it possible to connect and live together: they take care of us.

This infrastructure also includes professional support: expert child care, personal assistants for adults with disabilities, support when our families are in trouble, as older adults, and later in life. But what we imagine here is not a sibling system to the NHS, a national standardised set of institutions. It is about a web of support: many different actors and possibilities that share a core set of values but operate differently according to what is required. In almost every case we have the templates of these new forms of care from Shared Lives (a growing national home share scheme providing support to young

adults and older people); to Buurtzorg (holistic, nurse-led community care); to Somerset Carers (a platform to enable micro providers to support individuals across Somerset); to the community Circles I started almost two decades ago.[42] These new forms of care share an ethos that emphasises care as a relationship – giving autonomy to the carers and to those of us who need support at a particular moment.

Creating this infrastructure requires new leadership. In the United States, the Holding Co. is a lab dedicated to designing how we care for each other. In 2020 it published the first ever Care 100 list.[43] The list is noteworthy because it honours influential people in care based on an understanding of the diversity of leaders (social investors, practitioners, activists, scholars) who are required to build a *system*.

And it requires new forms of policymaking.[44] The state must provide a framework setting out a new goal that describes national flourishing and the role of care. We require a design code – the values and parameters that enable small, human-scale solutions to grow within a national framework. This is a policymaking process that is about a clear vision, human networks and relationships. It is the opposite of the existing industrial command and control policymaking process.[45] The parameters will specify new forms of metric and regulation, within a culture in which our relationships to one another are what matter most.[46] This in turn requires a new economic framework: a care economy.

5. Within a care economy

What about the money? One answer to this question is: we just don't know. Our metrics are too limited. When we think about the care economy we sometimes include the expenditure of those who pay for their own care – but not always. We rarely include the contribution of unpaid carers. We are uncertain even about what 'care' is: strikingly, what people choose to spend their own money or personal budgets on – perhaps a taxi to see a friend or to get to the hairdresser – rarely tallies with formal categories of 'care'.

We pay care workers derisory sums and do not factor in the cost of churn, recruitment, agencies, the misery of those who are cared for and the wider system costs dealing with burn out and the mental stress of our carers and their families. We accept an inequitable distortion of resources with funding skewed away from communities and individuals, towards inspection and regulation. With younger people and with old, we do not calculate the later costs of refusing to provide early the smaller, personal things – things those with personal budgets always choose – when needed. And lastly, we accept the scandalous leakage in untaxed profits made by for profit private care providers.

But the more important answer is that this question is too narrow. 21st century care must be capitalised within a new economic framework. We need to start to think about a care economy and this requires two shifts.

First, care needs to be categorised not as a cost but as a core investment: as essential infrastructure, just as understood by the vaccine scientists. In the US we see important moves towards this understanding. The work of the Holding Co. – who have drawn attention to the size of the care economy, which they value at $648bn 'larger than the US pharmaceutical market and the US hotel, car manufacturing, and social networking industries combined', has been pivotal in the argument accepted by President Biden that care is critical infrastructure, a core investment category rather than a cost.[47] In the UK, we must recognise the centrality of care to local community and any concept of 'levelling up', while placing care and care work as central to a modern, green industrial strategy in the ways I have described.[48]

The second shift is closely related. The care economy will need a particular set of rules to flourish. Foundational principles would include a broad definition of resource in which time, skills and money can be blended in new ways; a regulatory framework that does not distinguish between public and private providers but privileges worker ownership models and makes illegal the extraction of profits (surplus in this economy must be reinvested in the care economy); a culture that privileges learning over audit to ensure continuous experimentation and growth in our still nascent thinking about what could be.

*

The COVID-19 pandemic has been a cataclysm, brutally exposing the crisis in the funding, culture and operation of our care systems. I have argued that we can honour this recent experience and the deeper legacies of injustice, by creating something new. There are many working examples of the forms of care and support I have outlined here. What we are missing and I am arguing for, is the new framework that would allow these models to grow and, in turn, allow us to thrive. This can only happen when we dare to imagine: when we recover what it really means to care, and when we rescue this most human activity from the industrial clutches of an outdated system, and together create the new.

Endnotes

1. 'Four years' work in one': vaccine researchers are the unassuming heroes of COVID-19. *The Guardian*; 30 December 2021 (https://www.theguardian.com/lifeandstyle/2020/dec/30/four-years-work-in-one-vaccine-researchers-unassuming-heroes-covid-19).
2. '*Who Cooked Adam Smith's dinner?*' the economist Katrine Marçal asked in her 2012 book of the same title. Adam Smith's work was dependent on his mother cooking his dinner. As recognised by the vaccine scientists, informal, unpaid, unmeasured care is the foundation of every-day life as well as the academic and scientific discoveries on which we all depend.
3. Research by the Resolution Foundation has questioned the extent to which women's jobs suffered. It appears in fact that women continued to shoulder their work hours and longer hours of family care with the result that their mental health 'significantly worsened'. See: *Labour Market Outlook Q2 2021*. Resolution Foundation; 2021 (https://www.resolutionfoundation.org/publications/labour-market-outlook-q2-2021/).
4. Research from the Health Foundation documents both the crisis in care and the inequalities of provision within current frameworks See: Suleman M, Sonthalia S, Webb C, Tinson A, Kane M, Bunbury S, Finch D, Bibby J. *Unequal pandemic, fairer recovery*. The Health Foundation; 2021 (https://doi.org/10.37829/HF-2021-HL12). See also: Incisive Health and Age UK. *Care deserts: the impact of a dysfunctional market in adult social care provision* (https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care–support/care-deserts—age-uk-report.pdf).
5. His Holiness Pope Francis. *Why the only future worth building includes everyone*. TED; 2017 (https://www.ted.com/talks/his_holiness_pope_francis_why_the_only_future_worth_building_includes_everyone?language=en).
6. Buber M. *I and Thou*. Touchstone Books; 1970 [1923].
7. Aristotle (trans. Sinclair T A). *The Politics*. Penguin Classics; 1984. As frequently noted, Aristotle did not in fact expect everyone to participate: women and slaves for example were excluded. Modern discussions of *eudaimonia* rightly assume participation of all members of a society.

8. Kate Raworth tells the story of rational economic man's beginnings as a nuanced portrait in the 18th century writings of Adam Smith and his later development into the crude cartoon of the Chicago school's modelling (1970s), which to this day determines policy and shapes wider thinking and behaviour (Raworth 2017: pp 94–102). *Homo economicus* has a biological twin, popularised through Richard Dawkins' 'selfish gene' (see Tsing 2015 p 28). While this idea of the selfish human is also now discredited, it has been significant in the design of systems that emphasise the risk of cheating, leading to the investment of up to 80% of welfare budgets on procedures for the policing/punishing of 'deviants' and so called 'free-riders' (Cottam 2018).

9. I use the definition of care proposed by Joan Tronto, cited in: Puig M. *Matters of care: speculative ethics in more than human worlds.* University Of Minnesota Press; 2017.

10. See for example: Fraser N. *Unruly practices: power, discourse and gender in contemporary social theory.* University Of Minnesota Press; 1989. Poo A-J. *The age of dignity; preparing for the elder boom in a changing America.* The New Press; 2015. Segal L. *What is to be done about the family?* Penguin; 1983. Wingfield A H. *Flatlining: Race, work and health care in the new economy.* University of California Press; 2019.

11. In a survey conducted by Sky News only 9% of Britons wanted life to return to 'normal' after COVID-19 (April 2020, based on a YouGov poll of 4,343 people who responded that community, access to nature and clean air were priorities). ONS data consistently report that health, relationships and a sense of contentment with work (rather than just having a job), are seen as contributing to life satisfaction (https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/personalandeconomicwellbeingintheuk/whatmattersmosttoourlifesatisfaction).

12. See for example: Prendergrast J. *Attachment economics: everyday pioneers for the new economy*. Civic Revival (https://www.civic-revival.org.uk/attachment-economics/). Foundational Economy (https://foundationaleconomy.com). Women's Budget Group. Creating a Caring Economy: A Call to Action; 2020 (https://wbg.org.uk/analysis/creating-a-caring-economy-a-call-to-action-2/). Raworth K. *Doughnut economics: seven ways to think like a 21st century economist*. Random House Business; 2017.

13. The work of Carlota Perez has been ground breaking in its analysis of the relationship between technology revolutions and economic change. In the schema developed by Perez we are currently in the fifth technology revolution, which is why I have previously called for a fifth social revolution in which care and revalued care work would be an integral part of a new economy. See for example: Perez C. *Technological revolutions and financial capital: the dynamics of bubbles and golden ages*. Elgar; 2002.

14. See: Cottam H. *Welfare 5.0: Why we need a social revolution and how to make it happen*. UCL Institute for Innovation and Public Purpose, Policy Report (IIPP WP 2020-10); 2020 (https://www.ucl.ac.uk/bartlett/public-purpose/wp2020-10). It is important to note, as I discuss in this paper, that gains are rarely evenly distributed. In the last revolution, gains for workers in the global North have too often been at the expense of exploitation of others in the global South. More recently, we have seen how gains everywhere can be eroded: the 'gig' economy has left thousands without stable hours, paid holidays or sick pay while in UK and the US life expectancy is stalling and in some cases reversing. See: Marmot M, et al. *Health Equity in England: The Marmot Review 10 Years On*. Institute of Health Equity; 2020 (https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on).

15. Boots was one of the first companies to institutionalise the weekend in 1934 in its Nottingham factory. Originally instituted to cope with a period of over-production, the normalisation of the weekend was a product of the pressure brought from within civil society, organised labour and the recognition of leading industrialists such as John Boot that new forms of capitalism depended on a new deal with the labour force. Such pressures of course were not uniquely British, nor are they necessarily stable with the concept of the weekend under pressure from the gig economy.

16. Keynes J M. *Economic Possibilities for our Grandchildren*; 1930.

17. Hunnicutt B K. *Kellogg's Six Hour Day.* Temple University Press; 1996.

18. TimeWise (https://timewise.co.uk).

19. Recent scholarship in disciplines from biology to philosophy has emphasised the interconnections and complex support ecologies that underpin all living systems. Donna Haraway for example, drawing on the work of Beth Dempster, has developed the concept of '*sympoiesis'* to describe the way that systems are collectively produced and evolved by humans, nature and other tissues. See: Haraway, D. *Staying with the trouble*. Duke University Press Book; 2016. More recently, the physicist Carlo Rovelli has described how quantum theory is leading to new interpretations of the world that see reality as made up of relations as opposed to particles in space (Helgoland 2020).

20. I have developed the concept of *sapiens integra* with Anne-Marie Slaughter. For a fuller explanation see: Cottam H. *Welfare 5.0: Why we need a social revolution and how to make it happen*. UCL Institute for Innovation and Public Purpose, Policy Report (IIPP WP 2020-10); 2020 (https://www.ucl.ac.uk/bartlett/public-purpose/wp2020-10).

21. COVID-19 exposed the brutal reality of the modern care home. During the first wave of the pandemic, 40% of all UK deaths were among care home residents. See the Health Foundation's *COVID-19 impact inquiry report* (ibid.).

22. For a discussion of the ways in which we infantilise older people, prioritising their safety over their enjoyment, see: Gawande A. *Being mortal: Illness, medicine and what matters in the end.* Profile Books Ltd; 2014.

23. Those currently in residential/nursing homes in England number approximately 63,000 younger adults and 393,000 older people. In total 0.7% of the population and 3.1% of the population aged 65 and older. See: *Care homes for older people UK market report (31st edition).* LaingBuisson; 2021. And: *Adult specialist care UK market report (4th edition).* LaingBuisson; 2020. Almost 19 million people report having a long-term condition which they expect to affect them for 12 months or more. See: People with long-term health conditions, UK: January to December 2019. *ONS*; 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/adhocs/11478peoplewithlongtermhealthconditionsukjanuarytodecember2019).

24. NHS Digital. *Adult Social Care Activity and Finance Report, England – 2019–20* (https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20/4.-long-term-care) (Figure 14).

25. In registered early years settings this ratio can be as high as 1 adult to 13 children. See: Department for Education. *Statutory framework for the early years foundation stage*; 2021 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974907/EYFS_framework_-_March_2021.pdf).

26. Cottam H. *Radical Help: How we can remake the relationships between us and revolutionise the welfare state*. Virago; 2018 (p 38).

27. Anna Severwright, convener at #SocialCareFuture, makes a similar point when she calls for support that is more like an extra pair of hands than the 'care' of a parent.

28. The private sector, who manage 95% of places available within care homes, extracted an estimated £1.5bn profit in 2019. See: Centre for Health and Public Impact. *Plugging the leaks in the UK care home industry*. CHPI; 2019 (https://chpi.org.uk/papers/reports/plugging-the-leaks-in-the-uk-care-home-industry/). Individuals who own care companies and are domiciled overseas for tax purposes have recycled some of this wealth through philanthropic organisations, claiming they are changing Britain and addressing poverty. It seems astonishing that there has been little public comment on this matter given that the need for such initiatives would be significantly reduced were these same individuals to pay their workers fairly and forego tax avoidance.

29. Bunting M. *Labours of love*. Granta; 2020 (pp 202–205).

30. *Radical Help*, ibid.

31. In 2019/20 there were 112,000 vacancies in the formal adult social care workforce, a vacancy rate of 7% in a 1.65 million workforce (https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx).

32. As recounted by Bunting (ibid., p 182).

33. In addition to his study of the clinic first published in 1963, Foucault made studies of incarceration and madness.

34. As described in: Foucault M. *Discipline and punish: the birth of the prison;* 1975.

35. It has been a decade since the widely admired Dilnot recommendations, and while the recent government announcements are welcome, significant gaps remain. For example, there is no mention of unmet need, the support required for unpaid carers or to address low pay and insecure work in the sector. This would require both fundamental reform to the adult social care system, wider reform to benefits and work, and significant changes in broader society. Discussion of this reform and changes remain largely absent from the mainstream political debate, which is often narrowly focused on older people not having to sell their homes to pay for care.

36. The research of Brid Featherstone and her colleagues reveals the correlation between child poverty and being taken into care. Children in the most deprived 10% of neighbourhoods in the UK are over 10 times more likely to be in foster or residential care, or on protection plans than children in the least deprived 10% (https://research.hud.ac.uk/media/assets/document/research/cacyfr/CWIP-Executive-Summary-Final-V3.pdf#:~:text=The%20Child%20Welfare%20Inequalities%20Project%20was%20designed%20to,how%20to%20keep%20children%20safe%20and%20strengthen%20families). Featherstone is one of a number of academics who have commented on the way the current enquiry into children's social care again replicates past models by failing to take the wider context into account (https://www.pfan.uk/evidence_scr/). Also of particular importance is the scholarship of Michael Marmot. In *The Health Gap* (2015) Marmot dissects the ways in which all aspects of health and care are governed by wider socioeconomic inequalities.

37. Social Care Future's collaborative work with movement members and the public uses the term 'support' and 'supporting' as opposed to 'care' in order to emphasise agency and that 'care' is not an end in itself. Support is to enable lives well lived. In this paper I have somewhat clumsily used the terms interchangeably, given the invitation to speak to an audience who define themselves as the 'care sector'. But it is important to note that in the US, those with lived experience are similarly arguing for a change in language to prefigure a change in understanding. As adults in particular, we don't always want to be 'cared for' – rather we need support to live our lives. #socialcarefuture; *Changing the story of social care*; 2021 (https://socialcarefuture.blog/2021/04/20/by-changing-the-story-of-social-care-we-can-build-public-support-to-transform-it-for-future-generations-heres-how/).

38. Britain has 5.4 million unpaid carers who are estimated by the National Audit Office to contribute £100bn annually to the national economy (2018). Paid carers include the 1.65 million jobs in adult care.

39. The idea of barefoot doctors originated in China, see this profile in the Lancet; 2018 (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61355-0/fulltext). Citizens were provided with basic medical training to support the health system. It is a concept that has been replicated in many developing countries where citizens are supported to contribute to formal health and care systems through various training and income schemes.

40. The Treasury Green Book has developed a framework for assessing what it terms 'social value', but in practice imposing these frameworks onto systems that make decisions based on narrow cost accounting makes little impact – hence the call in this paper for a more fundamental redesign (https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent).

41. See 'Experiment 5' in *Radical Help* (Cottam ibid.) for a more detailed study of Circle.

42. Research shows that alongside landscapes of rich experimentation, there are care deserts (https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care–support/care-deserts—age-uk-report.pdf). Understanding the conditions that enable experimentation to flourish and take root, and the types of support and investment required to build the new care infrastructure, will be a critical part of the research programme going forward.

43. See Care 100 (https://www.care100list.com).

44. The Health Foundation has been an important advocate for different time horizons in policy and planning. See for example: *How can policymakers plan better for the long term?*; 2021 (https://www.health.org.uk/publications/long-reads/how-can-policymakers-plan-better-for-the-long-term).

45. Anne-Marie Slaughter, former Director of Policy Planning at the US State Department, outlines the differences between industrial (chessboard) policymaking and relational (web) policymaking. See: Slaughter A. *The Chessboard and The Web*. Yale University Press; 2017. It would be valuable to compile a series of robust exemplars following the Harvard Business School case study model that could be used in the training of senior civil servants.

46. In *Radical Help* I show how the capability frameworks developed by Amartya Sen and Martha Nussbaum can be adapted to provide very different developmental metrics (Cottam, ibid.).

47. See (https://www.investin.care). Anne-Marie Slaughter also addresses the principles of a new care economy in her book: *Renewal.* Princeton University Press; 2021 (pp 126–128).

48. The Health Foundation has made a powerful argument for investing in social capital, just as we now understand that we must invest in green capital: the two are interconnected. See: *The government's levelling up agenda: An opportunity to improve health in England*; 2021 (https://www.health.org.uk/publications/reports/the-governments-levelling-up-agenda) (pp 3–4).

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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