SOCIAL PROTECTION FOR THE 21ST CENTURY: TOWARDS A NEW POLITICS OF CARE

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1. INTRODUCTION

Warnings that the UK is facing a 'crisis of care' are growing in volume. NHS wait times have reached a record high, and staff shortages across the social care workforce are predicted to rise to 500,000 by the end of 2030, as poor working conditions and the lowest wages of almost any sector in the UK make these careers increasingly unsustainable. The shortfall is being met by the most vulnerable, and over 350,000 people aged 16-25 in England and Wales now provide unpaid care to a loved one (BMA, 2022).

This IGP working paper unpicks the UK's care crisis, using London's tuberculosis (TB) rate as a case study. We argue that the crisis extends beyond health and social care: the UK is experiencing a breakdown of its social protection system, as the state fails to fulfil its duty of care. The latest figures linking austerity measures introduced between 2010 and 2017 to 335,000 excess deaths highlight the breadth of this crisis (Walsh et al, 2022).

Care, like illness, is profoundly political, and is here understood according to Tronto and Fisher's definition:

A working definition of care

'Everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.' (Tronto and Fisher, 1990)

The failure to invest both financial and social capital in care has critical implications for human lives; it is structural violence exerted through policy (Farmer, 1999; 2004). Synthesising existing scholarship, we contend that our current approach to care is flawed, and we locate its problems on three interrelated levels: power, value, and scale. This paper argues that to act on all three levels, care must be redefined as a relational, interdependent, and multi-scalar phenomenon, and enacted across all areas of public policy. This can be achieved by the introduction of Universal Basic Services: an updated social protection system, fit for the 21st century.

2. WHAT HAS BEEN PROPOSED SO FAR?

Across the UK, different organisations are proposing solutions to the ongoing care crisis.

HEALTH CARE

In April 2022, the UK Government passed the Health and Care Act, which introduced structural reforms to health and care systems in England. The Act capped personal care spending at £86,000 over an individual's lifetime, and formalised Integrated Care Systems (ICSs): alliances of regional NHS providers and commissioners, that act together on all facets of population health (UK Government, 2022). The British Medical Association (BMA) called for multiple critical amendments to the legislation, among them greater government accountability for staffing requirements, and for the NHS to be the default option for service delivery and procurement contracts (BMA, 2022).

The ICSs introduced by the Health and Care Act were a pillar of The King's Fund's vision for population health, published in 2018. The King's Fund highlighted that the wider determinants of health are among the most important drivers of health outcomes, and that there is growing recognition of the role that 'place and community' (local environment, social relationships, community networks) play in health outcomes. To address population health holistically, they called both for ICSs, and for better collaboration across different levels of government (The King's Fund, 2018).

SOCIAL CARE

The Women's Budget Group (WBG) published the final report on a UK Feminist Green New Deal in November 2022, outlining their vision for a green and caring economy. They identify four structural changes needed to realise this vision: reorienting the economy away from profit, and towards wellbeing; democratising ownership models; reforming systems of taxation; and directing public investment towards social infrastructure. Underpinning these changes is a system of Universal Social Care, developed in an earlier report published jointly with the New Economics Foundation (NEF). Together, the WBG and NEF argue that the key issues facing the UK's social care system are rooted in means-testing, underfunding, and failing markets. They propose a comprehensive system of universal social care, free at the point of need, at an annual cost of £19.6bn (WBG and NEF, 2020). The WBG contend that this system could generate an additional 928,000 jobs, both directly and indirectly. These jobs would help to decarbonise the economy: on average, health and care jobs produce 26x less greenhouse gases than manufacturing jobs, and 1500x less than oil and gas (WBG, 2022).

NEF has published widely on ownership in social care. In the 1970s, social care services were largely delivered by the state, yet today they are mostly outsourced (ex. 83% of residential care beds are provided by for-profit organisations). Rather than democratising decision-making, patterns of privatisation have given citizens less purchase over what support looks like, and care has lost its relational quality. NEF makes several policy recommendations: the creation of a 'right to own' scheme, giving employees the ability to buyout care providers; giving local authorities more power to buyout failing or underperforming providers; and the development of collaborative, rather than competitive, forms of commissioning (NEF, 2020).

CHILDCARE

In a 2021 briefing for Westminster, the WBG called for the provision of universal childcare, year-round and full-time. They estimated the total spend for England in 2021-2022 would be £15.5bn – an increase of

£10bn on current childcare spending. This policy could ultimately pay for itself: first, through the short-term, additional revenue that would come from increased employment in the childcare sector (WBG's calculations suggest this could recoup 75-79% of annual gross investment), or through higher tax revenue and reduced spending in means-tested benefits (WBG, 2021).

These proposals all provide strong alternatives to our current economy of care, but we contend that they must be integrated into a broader policy framework. This crisis extends beyond health and social care: it highlights a broader breakdown of the state's capacity to care for both people and planet, through all areas of policy. An analysis of TB in London brings this into sharper relief.

3. CASE STUDY: TB IN LONDON

To many in the UK, TB has Victorian associations. Yet it remains a pressing issue: in 2011, TB incidence in England was the highest in Western Europe. Figures then declined steadily until 2019, when cases increased 2.4%. They rose a further 7.4% in 2021 compared to 2020, and the highest number of drug resistant TB cases were recorded since enhanced surveillance began (UKHSA, 2021).

London accounts for over 40% of all TB cases in England. One third of London boroughs are classed as high incidence by the World Health Organisation, among them the boroughs of Newham, Harrow, Hounslow, and Brent, which despite decreases since 2011, have case rates that remain above 30 per 100,000. These figures contrast starkly with wealthier areas such as Richmond upon Thames, Bromley, and Havering, which in 2020 recorded rates of 2.5, 3.9 and 4.6 per 100,000, respectively. 1 in 3 people diagnosed with TB in London had either one social risk factor (homelessness, illicit drug use, imprisonment, or alcohol misuse), or a key comorbidity (diabetes, hepatitis B, hepatitis C, chronic renal disease, chronic liver disease or immunosuppression), and 79% were born outside the UK. The most common countries of origin were India, Pakistan, Somalia, and Bangladesh, yet most had lived in the UK for more than 10 years prior to diagnosis (UKHSA, 2020). This suggests that they were unlikely to have been carriers of latent TB when they entered the UK, and rather that it was the structural conditions they found themselves in that made them vulnerable to the disease.

London's TB figures illustrate a systemic breakdown of care. TB thrives in conditions of overcrowding, poor ventilation, and mal/under-nutrition, and therefore highlights issues relating to housing, nutrition, disenfranchisement, and engagement with public health systems. Yet TB control policies, in both national and global context, have continued to focus predominantly on health-care specific interventions, such as BCG vaccination, antibiotic treatment and Directly Observed Therapy (DOT). Social protection systems are central to the state's capacity to care, and their role in mitigating TB epidemics has been illustrated convincingly in recent research. In a multi-variate, cross-national statistical study, Reeves et al found a strong inverse association between per-person special protection spend and TB incidence mortality. Each per person increase of USD 100 in social protection spending was associated with a decreased per 100k population number incidence rates of 1.70%, non-HIV-related TB mortality rate of 2.74% and all cause TB morality rate. Significantly, they noted no interactions between increases in GDP and any measures of TB incidence, prevalence, or mortality (Reeves et al, 2014). This highlights the fallacy of equating economic growth with improved population health. The prevalence of TB in London is symptomatic of a structural crisis, and the UK needs a stronger social protection system, underpinned by care, to help address it.

1 These can be defined broadly as "policies and programs that help individuals and societies to manage risk and volatility, protect them from poverty and inequality, and help them to access economic opportunity" (World Bank, 2022).

4. ANALYTICAL FRAMEWORK: LITERATURE REVIEW

The updated social protection system needed to address London's TB problem, and the wider care crisis, must be underpinned by a new analytical framework for care. Care as theory has been analysed across academic disciplines. The following literature review categorises these analyses, and the problems they identify, under three overlapping umbrellas: power, value, and scale. We then propose an analytical framework that addresses issues in care on all three levels, and argue for its application through an updated social protection system.

POWER

Many scholars work broadly with the theme of power, highlighting that care is a political concept with its own history, tied to modern state-building, colonial activity, and patterns of structural violence. Care, as both theory and practice, is therefore marked by uneven power dynamics.

For Woodly (2021), care is central to a wider politics of state and community-building. It is an "inherently interdependent survival strategy, a foundation for political organising, and prefigurative politics for building a world in which all people can live and thrive." Foucault's work on biopower famously explores how caregiving, in a biological context, is a key avenue for the exertion of state power. Nguyen (2007) and Petryna (2002) explore these dynamics further in their respective work on therapeutic citizenship, arguing that citizenship, and political rights, are both demanded and extended based on need for, and compliance with, biomedical care.

Mol (2008) highlights that power is exerted through the categories we use to index caring subjects. Discourses of dependency, for example, allude to a normative state of independence, that both reflects existing power dynamics and fulfils a biopolitical purpose: justifying the control of one population by another. These discourses were central to the 'ideology of colonial healing', which helped to cast colonialism as a humanitarian endeavour (Comaroff and Comaroff, 1992). McKay (2018) builds on this analysis in her work on the politics of global health, highlighting that "conceptualisations of care not only draw attention to health inequities and serve as calls for action; they also reflect normative political claims about what the state is or should be and serve to index caring subjects and subjectivities in ways that are raced, classed, and gendered."

Geographical power imbalances are embedded in our entire economy of care, as Fraser (2016) explores through her discussion of 'global care chains'. Financialised capitalism has diminished public provision and reduced real wages, increasing the number of hours of paid work per household needed to support a family. Migrant workers are employed to fill the subsequent 'care gap', creating crises of care in their countries of origin. The global south is thus implicated in even longer 'global care chains', as the net effect is displaced.

VALUE

Value, in this context, refers to the financial and social capital invested in care. It is shaped by the power dynamics outlined above and has received most attention in feminist scholarship.

Fraser (2016) and Tronto and Fisher (1990) have argued respectively that over time, care has become a gendered practice: cast as 'women's work', and subject to the same social and economic

devaluation that women experience in patriarchal societies. This argument overlaps with the framing of care in terms of precarity. Fraser contends that we are ultimately facing a crisis of 'social reproduction', rooted in the extractive structures of financialised capitalism. Capitalist economic production, waged labour, and the accumulation of surplus value all rely on social reproduction: the activities of "provisioning, caregiving and interaction… that form human subjects while also constituting them as social beings." Yet these activities are accorded no monetised value, and as money became the primary means of power, those who carried out the care work that enabled economic production became structurally subordinate to those who earned wages. According to Fraser, the contradiction of capital and care creates an inherent instability: "on the one hand, capitalist economic production is not self-sustaining, but relies on social reproduction; on the other, its drive to unlimited accumulation threatens to destabilise the very reproductive processes and capacities that capital – and the rest of us – need. The effect over time… can be to jeopardise the necessary social conditions of the capitalist economy" (Fraser, 2016).

Himmleweit (1999; 2005; 2021) builds on Fraser's analysis of value through a broader political-economy lens. She highlights the while caring is an economic activity, it is fundamentally the development of a relationship, and therefore isn't subject to the same economic norms as the traditional market of goods and services. What in other industries would be seen as measures of high productivity, represent an erosion of quality when it comes to care. Value, in this sense, must be reconceived, and government caring strategies reformulated, independent of traditional market norms and practices (Himmleweit, 2005).

SCALE

Issues of scale can first be understood practically, in the context of chronic underinvestment in our care systems. This has received increasing attention since the introduction of austerity in 2010: a period that brought major cuts to social protection. Reeves (2018) highlights that although spending on health was 'ring-fenced' during the austerity period, demand for services increased while public spending remained flat; this resulted in the most sustained decline in NHS spending as a percentage of GDP since its inception in 1948. Funding for mental health services decreased 8% in real terms between 2010 and 2015, and local councils in England lost approximately 27% of their budgets (Kingori and Kerasidou, 2019). Austerity policies more broadly have kept wages low and earnings insecure (Reeves, 2018), eroding our capacity to care on a societal level.

These declines are best described by Galvin and Hacker's (2020) notion of 'policy drift': when the "maintenance of the status-quo prevents adaptation to social conditions and changing risks". The health implications of policy drift, in the context of care, are stark: between 2014-15, 12 out of 18 high-income countries surveyed by Reeves experienced declines in overall life expectancy (Reeves, 2018). The UK's infant mortality rate increased from 2.6 deaths per 1000 live births in 2014 to 3.9 in 2017: the first time in over 50 years that it had risen for three consecutive years. The UK's worsening population health markers over the past decade have contributed to its classification as a fragile state. Of the 178 countries surveyed for the Fund for Peace's 2019 Fragile State Index, the UK was the fourth 'most-worsened', after Venezuela, Brazil, and Nicaragua (Hiam, Dorling, McKee, 2021).

Kingori and Kerasidou (2019) highlight that policy drift and the scaling back of care took a significant toll on the UK's A&E departments. Successive cuts to elderly and psychiatric care mean that more patients end up in emergency departments, yet 40% of all admissions are discharged without treatment. Qualitative interviews highlight that budget cuts had profound effects on the professionalism experienced by A&E staff: "When staff operate within a system that doesn't support their work, and hinders their ability to operate in ways they believe compatible with their professional role, they experience a

sense of disengagement and detachment" (Kingori and Kerasidou, 2019). Staff disengagement, in turn, has negative impacts on patient care.

Issues of scale also extend to conceptual framings of care. All areas of social policy have implications for health and wellbeing. As Marmot et al (2022) highlight, for example, high rates of household overcrowding and poor housing quality are major drivers of poor health in London. The effects are patterned along ethnic lines: 40% of those who experience overcrowding identify as black-British, compared to the 14% who are white. We need to extend our framing of what counts as 'care' to include social policy more broadly: questions of housing, food security, education, and legal services. But efforts to scale-up spending and infrastructure mustn't come at the expense of care's human quality. The 19th century institutionalisation of care brought a reliance on numeric indictors of health and a narrow focus on the body, rather than the whole social being. As caregiving crossed new scales, from families to institutions, it lost the fundamental qualities of warmth and humanity (Cottam, 2018; 2020; 2021). The UK needs an expanded social protection framework that is sensitive to these qualities, and supports caring relationships on a human level.

5. AN IGP ANALYSIS

We contend that to address issues of power, value, and scale, as outlined above, care must first be reframed as follows:

ACTION ON POWER

Care is a relational term Many indigenous knowledge frameworks offer the whole-systems thinking needed to address our current crisis of care. State-level and transnational efforts to recentre and redefine care must therefore recognise it as a relational term, taking meaning from different groups, across contexts. This approach is key to achieving epistemic justice and overcoming power imbalances in our current economy of care.

New Zealand is one of very few national governments using indigenous conceptions of care and wellbeing to inform policy. The Treasury draws heavily on indigenous conceptualisations of care to inform its Te Tai Waiora wellbeing framework, addressing care as a relational term, with multiple, holistic definitions. The Maori understanding of wellbeing includes concepts such as manaakitanga (collective responsibility to care for others), kaitaiakitanga (guardianship) and kotahitanga (working in an aligned, coordinated way). These concepts have shaped the government's Living Standards Framework, which helps to inform policy across the areas of health, housing, and environmental protection (New Zealand Treasury, 2022).

ACTION ON VALUE

Care is as an inherently interdependent phenomenon (Woodly, 2021) Dependence on care is not necessarily pathological: it is part of the human condition (Care Collective, 2020). Delivering good care at all stages of life promotes overall wellbeing, and is therefore of mutual benefit to us all.

The Care Collective, a multi-disciplinary team of researchers from across the UK has argued for a radical redefinition of care, centred on interdependence. Dependence on care has often been pathologized, rather than recognised as a basic part of the human condition. The Care Collective contend that defining care in this way frees us to move beyond traditional gendered and racialised divisions of labour, "since both the need to care and the need for care are understood and shared by all." In a policy context, this redefinition means transforming the nation state: extending citizenship and rights based on the principle of care rather than birthplace and borders (Care Collective, 2020).

ACTION ON SCALE

Care is multi-scalar Care, as a practice, is delivered on multiple levels: in families, communities, nation states, and across borders. State level care has historically been delivered through narrow, vertical interventions. We contend that the state's duty of care must be expanded to include all areas of social policy, and must facilitate horizontal, community-led projects. This is key to addressing issues of both scale and power, broadly conceived.

Cottam argues that rather than expanding standardised, national institutions like the NHS, we need to invest in a 'web of care', that implicates individuals and organisations on every level. Sustained investment in this model would help to overcome the mismatch between care needs and state/market structures: instilling care with necessary warmth and humanity, while also acting structurally (Cottam, 2018; 2021). This amounts to broader reform of our welfare system.

5.1 SOCIAL PROTECTION FOR THE 21ST CENTURY

The IGP framework for care goes a step beyond existing policy proposals, introducing a whole-systems approach. Redefining and enacting care as a relational, interdependent, and multi-scalar phenomenon ultimately means addressing it proactively, rather than reactively. Embedding care across all areas of policy, as standard, is key to ensuring equitable and sustainable livelihood security.

The post-war era in Britain brought the establishment of a broad and progressive system of social protection. At the time, the UK was facing a unique set of challenges. Six years of war, and the unresolved financial crash of the 1930s, had decimated the country's infrastructure and labour market, and stability in the immediate aftermath was therefore a priority.

The UK's new welfare state was operationalised as a system for the mass distribution of medicine, resources, and knowledge (Cottam, 2020). It was underpinned by public institutions like the National Health Service (NHS), and a framework for National Insurance that provided workers with benefits, unemployment insurance, and pensions, in return for weekly contributions. Levels of wealth and income inequality fell steadily, and population health outcomes improved. But this period was short-lived: the neoliberal turn of the 1970s saw the erosion of public institutions, and the ideologies that informed them. They were replaced by a deference to the markets, the shrinking of the state and a renewed emphasis on individual responsibility. This rhetoric was reinforced during the period of austerity that followed the 2008 financial crisis: as Reeves and Patrick (2021) highlight, the introduction of universal credit, benefit freezes and changes to the welfare conditionality system 'eroded the possibility of conceptualising social welfare as a public good, of benefit to us all; and of course, with very real and significant positive health outcomes.' The 335,000 excess deaths linked to austerity highlight the human cost of this rhetoric (Walsh et al, 2022).

5.2 UNIVERSAL BASIC SERVICES

The UK's welfare state was designed to address the problems of 1948. Today, we're facing the intersection of multiple, slow emergencies: among them climate change, global conflict, structural and wealth inequality, and the rising cost of living (Moore and Moseley, 2022). This 'polycrisis' has been exacerbated by the interconnection of global systems, but our failure to address it ultimately reflects a lack of social solidarity.

The IGP contends that to reflect the challenges of the 21st century, we need a new form of social protection, underpinned by the analytical framework for care developed in this working paper. This system needs to be broad and flexible enough to address uncertainty in everyday life, and the effects of urgent problems. Unlike the standardised, mass distribution system of the 20th century welfare state, it should be generative (Cottam, 2021): expanding capacities and capabilities, and strengthening the UK's social fabric. Here, we adopt Scoones and Stirling's (2020) call for a new "a newly pluralised, inclusive politics of responsibility." Social protection should shift "from control to care and conviviality; the only meaningful ways to achieve robustness and reconciliation in the face of burgeoning uncertainties involve justice, equality and plurality." (Scoones and Stirling, 2020)

A programme of Universal Basic Services (UBS) provides a blueprint for what this form of social protection could look like. UBS is a collection of seven free public services that extend the same principles of universal access, free at the point of need, which we already manifest in our NHS, public education, democracy, and legal services (Portes et al, 2017; Percy 2021, 2022). UBS works to deliver a common floor to society, by guaranteeing a minimum standard of life to all. Ultimately, it provides an affordable and sustainable framework for delivering care, according to the definition outlined above.

RELATIONAL

UBS is underpinned by the notion that care is relational. Unlike monetary subsidies, or vertical welfare interventions, universally available public services provide flexible and need-specific support, reducing the basic cost of living, and 'raising the floor' of what citizens can expect from their state. This approach is underpinned by the notion of a social wage: the value of a public service to an individual citizen, expressed as a replacement for financial income. A social wage, in the form of UBS, ultimately frees people to make decisions about what wellbeing means to them (Portes et al, 2017), and empowers them to care for each other, according to their own definitions and practices, on both a family and community level.

INTERDEPENDENT

UBS works to increase social cohesion, by expanding the architecture of the state and emphasising the "principles of solidarity, collective responsibility and shared needs." (Portes et al, 2017) It therefore frames care as an interdependent phenomenon, emphasising that the provision of high quality care is of mutual benefit to society as a whole. This care is provided holistically, through an integrated approach to livelihood security that ties together housing, food, information, transport, and energy.

MULTI-SCALAR

UBS supports care on all levels. While it begins with a broad, state-level architecture for care, it facilitates devolution to a local level, shifting from control over the population to control by the population.

UBS ultimately performs the three functions of 'care' identified by Barnes (2012): it is simultaneously a way of conceptualising personal and social relations; a set of values that offers a way of thinking about what is necessary for human wellbeing; and a practice.

5.3 WHAT UBS COULD MEAN FOR TB

As Reeves et al. (2014) highlight, strong social protection systems can help to reduce susceptibility to TB disease by preventing the deterioration of social and economic conditions, alleviating economic hardship, under-nutrition, and co-morbidities such as diabetes and alcohol dependency. Adequate housing, nutrition, and access to information are key to this effort, and the core UBS package provides them all, going beyond most other proposals for welfare reform. Where TB cases already exist, or in the case of populations at high risk of TB (ex. people who use drugs, homeless people, immunocompromised people etc), the livelihood security ensured by UBS can help to mitigate the effects of the disease: reducing the period in which a patient is infectious and preventing the reactivation of latent TB. Case detection and treatment can also be improved, as an expanded social safety net such as UBS provides additional points of contact between citizens and state-provided care services (Reeves et al, 2014). A renewed sense of social solidarity, underpinned by the principles of equality and care, is an equally powerful feature of UBS where population health is concerned.

Livelihood insecurity is at the heart of London's TB problem, and UBS ultimately delivers the care necessary to address it. Care, in this context, is enacted on new terms: as a relational, interdependent, and multi-scalar phenomenon.

CONCLUSION

The UK is experiencing a care crisis, resulting from decades of siloed and market-based policymaking. This crisis is evident in London's protracted struggle with TB: a disease which highlights a breakdown of care on multiple levels. But recentring care in policymaking, equitably and sustainably, requires a reformulation of the terms on which we enact it. This means recognising interdependence on multiple levels, prioritising human and planetary wellbeing, and reshaping our economy to support this end. Enacting care in this way supports freedom, as defined by Tronto (2015): "a truly free society makes people free to care… Production is not an end in itself; it is a means to the end of living as well as we can. And in a democratic society, this means everyone can live well, not just the few." A system of UBS, as developed by the IGP, delivers care on these terms, through a social protection system fit to address 21st century problems.

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