# Caring for the earth, caring for each other: a radical industrial strategy for adult social care

**Isaac Stanley, Adrienne Buller & Mathew Lawrence**
October 2020

GND
Green New Deal

**Please print on recycled Paper**

This PDF has been designed to mininimize paper and Ink use.

While the views expressed in this paper represent the authors, we would like to thank all those who made helpful comments and shared valuable insights at various stages, including: Emma Back, Miriam Brett, Maeve Cohen, Santiago José Gahn, Karolina Gerlich, Tom Lloyd Goodwin, Miranda Hall, Amelia Horgan, Emily Kenway, Jonty Leibowitz, Neil McInroy, Kathryn Mackridge and Karel Williams.

We also thank Drs Sandy Hager and Joseph Baines for their contribution to the financial data used in this report.

Produced by Common Wealth and Centre for Local Economic Strategies

common-wealth.co.uk ——— cles.org.uk

CLES
Centre for Local Economic Strategies

COMMON WEALTH

Contents

# Executive Summary

The inadequacies of England's current adult social care system have been harrowingly exposed by Covid-19. As of July 2020, there had been more than 30,500 more deaths in care homes than would usually be expected in the same period,[1] as well as 312 deaths of people working in the sector in England and Wales.[2]

However, the origins of the present crisis long precede the pandemic. We need to understand it in the context of the broader devaluation of 'reproductive labour' - that is, the caring and nurturing work, predominantly performed by women, which sustains our existence. In adult social care provision, this devaluation has been supported by privatisation and commercialisation since the 1980s: private care provision increasingly dominates the market as non-profit market share declines, despite private care being rated lower on average by the Care Quality Commission (according to analysis of its ratings for 2016-18) than its public or non-profit counterparts.[3]

Concurrently, larger care homes have been on the rise, despite tending toward lower ratings than smaller homes. A particular problem has been the rise of a financialised model in residential care provision, in which investors have increasingly appeared to approach the sector with a view toward real estate opportunities, rather than investing in a vital service. Over time, debt-fuelled acquisitions and extractive ownership models have created a highly leveraged sector plagued by under-investment, which increasingly places care services at risk, as the collapse of Southern Cross and Four Seasons over the past decade has shown.

Reimagining the care system should therefore be at the heart of the plan for a just recovery. Critically, it is also key to a green recovery. Care work is green work. Care work – both paid and unpaid – is a socially vital and collective service that contributes significantly to individual and collective wellbeing by addressing a core human needs; it also by its nature tends to be low-carbon work. Care work also embodies the principles of reparative action, reciprocity, and a focus on meeting needs that is at the heart of a Green New Deal.

In designing the more just and sustainable decarbonised economy of the future, care must therefore be recognised as a service that needs to be substantially expanded and better valued. The Green New Deal should not be limited to bold industrial strategy for tradable sectors such as manufacturing and technology; a radical strategy for transforming care work should also feature as a key pillar.

Industrial strategy debates in the UK increasingly pay attention to adult social care; however, they tend to approach it as a 'low productivity' sector in which productivity must be raised to both increase wages and tackle the UK's 'productivity problem'. There are a number of fundamental issues with this approach. The first is an overly simplistic understanding of the relationship between productivity and wages. The second is a neglect of the distinctive human dimension of care as a service – where increasing productivity would, beyond a certain point, inevitably lead to a deterioration in quality.

Finally, the approach fails to appreciate the significance of care as a collective service that secures wellbeing, rather than simply a source of income.

To bring about a transition from a sector dominated by for-profit provision to one that puts the needs of people first, an alternative, radical industrial strategy is needed for adult social care in England. Such a strategy would not narrowly target the private sector, but would rather focus on increasing and strengthening public provision, as well as innovative forms of cooperative, voluntary and community provision. Anchoring this transition, **we believe that the public sector must return to its historic role, delivering the majority of adult social care.** Rather than being narrowly directed towards raising productivity, a radical industrial strategy would aim to increase the **social value** of adult social care, in an expansive sense. This would encompass:

- Developing care services which meet the holistic needs of care-receivers, securing them a full set of 'capabilities', rather than treating them as a maintenance problem serviced in 15-minute slots.
- Ensuring a real Living Wage, as well as dignity, fulfilment and opportunities for creativity in work for care workers, through new models of care provision as well as through more funding.

Radical industrial strategy, then, is concerned **not just with increasing productivity through a narrow lens and boosting the efficiency with which wealth is produced, but with reshaping the distribution (or 'predistribution') of wealth**.

The strategy aims for a radical overhaul of adult social care over the next decade, without leaving local authorities responsible for delivering services exposed in the process. Alongside national-level measures to enable long-term transformation, it includes local authority-level measures to enable interim reshaping.



The strategy is summarised in fifteen key recommendations. It should be emphasised that the proposed strategy applies to England, rather than Scotland, Wales or Northern Ireland (for which adult social care is a devolved responsibility). This focus was chosen as it is in England that attempts to reform social care are least developed, and change is thus most needed. There is nevertheless much that will be of relevance for transforming care in the other nations of the UK and indeed throughout other countries more broadly.

- **Recommendation 1:** Establish a new funding settlement for adult social care, (including free personal care for over 65s), based on progressive taxation.
- **Recommendation 2:** Local authorities (with central government support) should commit to a full transition to public, cooperative, non-profit and community-only forms of provision by 2030.
- **Recommendation 3:** Introduce a suite of measures to tackle financialisation and improve transparency in private care provision, as part of the transition away from private for-profit care.
- **Recommendation 4:** Bring those care home properties that are privately owned by a company that is not the care provider into public ownership.
- **Recommendation 5:** Introduce a robust national system of social licensing for all care providers, requiring a real Living Wage for all care workers, and leaving space for local authorities to add their own additional requirements.

- **Recommendation 6:** At local authority level, commissioners should experiment with a range of other measures to reshape provision for the better, including pre-qualification criteria, Fair Tax Mark accreditation, creative use of service specification design and local spend policies.

- **Recommendation 7:** Establish a new national innovation mission directed towards 'Dignity in Adult Social Care', built around a major fund to support diverse new models of provision, to be devolved to local authority level.

- **Recommendation 8:** Ring-fence a segment of mission funding for building the capacity of local authorities as the orchestrators of innovation.

- **Recommendation 9:** Ring-fence a further segment of mission funding to set up a review of adult social care inspection, tasked with developing a new set of participatively-developed metrics.

- **Recommendation 10:** Introduce compulsory registration for all adult social care workers in England, along with the development of a suitable variety of pathways for registration. The cost of registration should be covered by employers.

- **Recommendation 11:** Significantly increase resources allocated to Skills for Care, and work with key stakeholders to define appropriate forms of continuous training, to be enforced through social licensing regulation.

- **Recommendation 12:** The UK government should legislate to establish a new system of sectoral collective bargaining for Adult Social Care in England: the Adult Social Care Sector Forum.

- **Recommendation 13:** Introduce a new statutory requirement to decarbonise the sector by 2030 with care providers - backed by a new Decarbonising Care Fund - required to set out measurable plans to reach net-zero by the end of the decade, including through upgrading their building stock, electrifying mobility, and decarbonising supply chains.

- **Recommendation 14:** Establish a properly funded state system to provide social and emotional support services for informal carers in all parts of the country.

- **Recommendation 15:** Introduce a full package of measures to promote a fair gender distribution of unpaid care, including reduced working time, improving workers' rights and access to flexible working, and wider actions to tackle gender inequalities in the labour market - whilst continuing to improve gender balance in paid care work.

# Introduction

The inadequacies of England's current adult social care system have been dramatically underscored by Covid-19, but the roots of this crisis lie far deeper than the pandemic. This report sets out a radical industrial strategy for social care in England, which would move towards ensuring the wellbeing and dignity of care receivers and care workers alike. In the process, it would help move us towards an economy organised around human flourishing, defined by care for the Earth and care for each other.

Section one, Understanding the crisis, provides an overview of the current crisis around adult social care in England, locating this crisis in the context of the broader devaluation of 'reproductive labour'. It explores the consequences of privatisation and financialisation for care workers and care receivers, highlighting how extractive, debt-fuelled private equity acquisitions and ownership models have created a highly leveraged sector that places these care services at risk.

Section two, Care for the earth, care for each other**,** explores the place of care work within a Green New Deal (GND). Care work is socially vital and collective service that contributes significantly to wellbeing by addressing a core human need; as we design a more just and sustainable economy, care should be recognised as a service that should be substantially expanded and better valued. This section also identifies a fundamental connection in our current economic system between the exploitation of care work, and of the natural environment. It explores this connection and its implications for women both in England and in the Global South where the gendered impacts of climate change will be most stark. Decarbonisation measures, too, have gendered impacts which a socially just GND must address, just as it must address differential impacts on socio-economic groups.

Section three, Care and productivity**,** considers the dominant approaches to social care within current UK economic debates. Mainstream industrial policy approaches link the low wages received by care workers to the sector's 'low productivity' and attempts to devise ways of raising this productivity. However, there are a number of problems with this productivity-centred approach. The first is an overly simplistic understanding of the relationship between productivity and wages. The second is a neglect of the distinctive human dimension of care as a service - where increasing productivity would, beyond a certain point, inevitably lead to a deterioration in quality. Finally, it fails to appreciate the significance of care as a collective service that secures wellbeing by addressing a core human needs, rather than simply a source of income.

Section four, Towards a radical industrial strategy for adult social care**,** sets out an alternative approach. It argues that a radical industrial strategy for adult social care, as a key plank of any GND, should aim not to increase the productivity of social care but rather its social value, in an expansive sense. This would require developing care services that meet the full needs of care-receivers, rather than treating them as maintenance problems. It would also require ensuring a real Living Wage for care workers, as well as dignity, fulfilment and opportunities for creativity in work. It sets out fifteen key recommendations towards achieving this, including measures aiming towards major transformation over the next decade, and measures to support interim changes.

# 1 Understanding the crisis

The era of COVID-19 has been marked in England by a widespread and unusual upsurge in public recognition of 'key workers.' In making it impossible to ignore the essential nature of the work performed by supermarket staff, cleaners and care workers, the pandemic has exposed the inadequacy of the conception of social and monetary value which underpins our current economic consensus.

However, it is unclear how deep or enduring this epiphany will be. Ministers have already, for example, insisted that "now is not the time" to discuss improvements in nurses' pay.[4] Their contribution is most frequently evoked in the idiom of heroic sacrifice, and comparatively high rates of Covid-19 deaths among many key worker occupations suggest that sacrifice is, distressingly, exactly what has taken place.[5]

While UK headlines have focused on placing immediate responsibilities for the current situation, there are deeper causes that go beyond the decisions of current political and public service leaders. The devaluation of key workers and key work did not start with Covid-19; rather, it reflects a long history and persisting devaluation of 'reproductive labour'.

## — 1.1 Reproductive labour



Low-paid key workers are usually characterised as 'low-skilled'. Their sectors are often thought of as 'low-value' and associated with low gross value added (GVA) and low productivity. But this apparently straightforward 'low-skill', 'low-value' status can only be fully grasped when we understand many of these forms of work as reproductive labour.

Feminist economists have drawn attention to the firmly embedded hierarchies in capitalist societies resulting from the gendered division of labour: 'Productive' labour is associated with men, while 'reproductive' labour is associated with women.[6] Reproductive labour can be understood as the work of **'social reproduction'** or **'life-making'**: sustaining our everyday existence through providing care, preparing food, maintaining relationships, and attending to hygienic, emotional and other needs. It is closely associated with the domestic sphere, where it is usually unpaid. However, in contemporary capitalist societies much of it also takes place outside the home, in schools, hospitals, creches or in offices by out of hours cleaners.[7]

From the viewpoint of mainstream economics, this reproductive labour is both undervalued-valued and under-appreciated. And yet, 'highly productive' sectors are entirely dependent on unpaid or low-paid reproductive labour for their profits. The existence of 'low-value' labour is a precondition for others - by guaranteeing their healthcare, education and everyday nourishment - to generate profits. The result of this deeply embedded hierarchy is that even in societies with high rates of employment and high GDP, people who carry out reproductive labour often struggle to secure their own wellbeing. The crisis surrounding adult care in many high-income countries, including England, is a striking illustration.

## — 1.2 Care work, adult social care, and privatisation

In England, the recent trends of an ageing population, increasing life expectancy, and a growing proportion of women entering waged labour outside the home have not been matched by an expansion in publicly-funded services to meet the care needs of the elderly, sick and disabled. The consequences are well-documented.[8] For unpaid family members - usually women - the attempt to provide care at the expense of or in addition to paid employment leads to exhaustion and/or material hardship.[9] In some circumstances, a person - usually a woman - is hired to carry out this work, often suffering from low pay, poor working conditions, high levels of informality and non-standard employment. Further, the tendency for women to bear a disproportionate burden of unpaid care work not only results from the patriarchal subjugation of women and division of labour but also reproduces it, by reducing their paid employment opportunities. For example, unpaid care responsibilities make it considerably more difficult for women to enter or advance in professions which penalise part-time work. This contributes to gender pay gaps both within sectors and, through occupational segregation, across society.[10]

Although the majority of care work in England continues to be unpaid, a proportion has moved from the unpaid household sector into paid sectors.[11] Its low social status, however, has not been changed by this shift. Where healthcare has come to be the domain of a hallowed national institution, providing universal coverage 'free at the point of need', social care continues to be provided on a means-tested basis by local authorities, largely using the non-ring-fenced Revenue Support Grant from central government.

Public discussion of the crisis in adult social care has tended to focus on the questions of a long-term funding settlement (often trumpeted by politicians, but never delivered), and of entitlements. Less attention has been paid to the problems created by the massive shift towards privatisation in the sector seen over the last 30 years.[12] Starting with the 1987 Griffiths Report produced for Margaret Thatcher on the funding and organisation of 'community care', a series of reforms have called on local authorities to act as 'enabling authorities', contracting care to external providers rather than delivering it directly.[13] Austerity measures since 2010 have exacerbated this trend. As recently as 1993, local authorities directly provided 95% of home care; by 2012 they provided only 11%.[14] And while in 1979 local authorities and the NHS provided 64% of residential and nursing home beds, by 2012 it provided only 6%.[15] As of 2019, 84% of care home beds were in the (for profit) private sector.[16]

### — 1.3 The financialisation of residential care

The privatisation of adult social care services has been associated with increasing rising **financialisation**, a process involving the increased prominence of financial entities and activities in the economy, as well as the penetration of financial logics and mechanisms into non-financial sectors.[17] In the case of the UK's social care sector, financialisation has followed from privatisation, driven by investors seeking to capitalise on the consistent publicly-backed cash flows; growing demand from an ageing population; and, crucially, the real estate opportunities stemming from the significant land and property associated with the infrastructure of social care.[18]

As a case study, this section examines financial data pertaining to the 'Big Four' private care providers – Barchester, Care UK, Four Seasons and HC-One alongside a discussion of the issue of financialisation facing the sector in the UK. It also provides an in-depth look at the 2019 collapse of Four Seasons to illustrate the dangers of the financialised model of care. Within the private care sector, the 'Big Four' provide approximately 15% of private beds (a total of 46,000)[19], three with private equity backing.[20] While they thus do not account for a majority of the sector's beds, within a highly fragmented sector of approximately 20,000 providers,[21] the

'Big Four' chains occupy comparatively high market share and are thus examined as a cohort, as in publications elsewhere.[22]

The Big Four operate with complex corporate and ownership structures involving several holding companies, at times used to take advantage of low tax jurisdictions (see Diagrams 1 and 2 below). Four Seasons, for example, is reported to have a full corporate structure of 181 companies, with many of these subsidiaries registered in Caribbean and Channel Island tax jurisdictions.[23] These structures are also used for complex (although apparently lawful) financial engineering of company accounts, shifting profits and losses to lower tax burdens, as well as using holding companies to carry external debts and/or make intra-group loans to maximise investor returns.[24]

Figure 1.

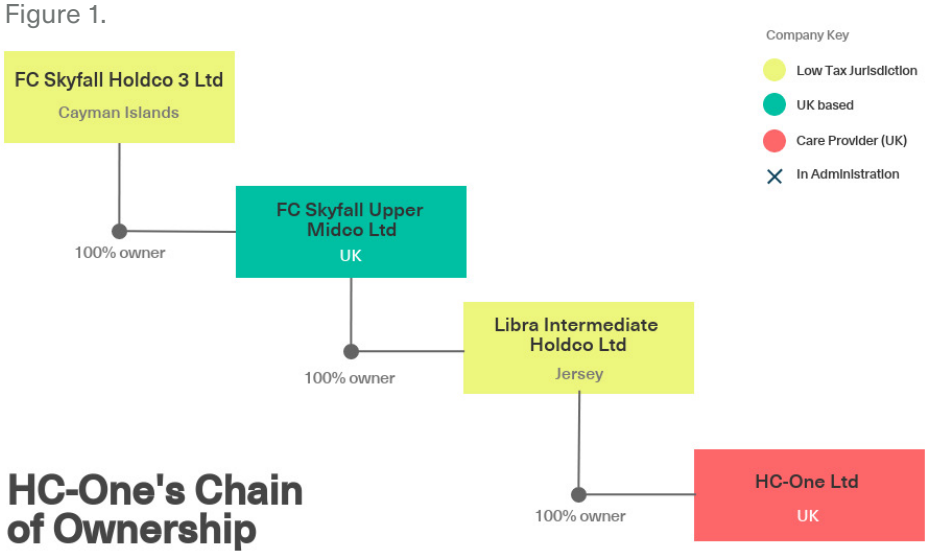
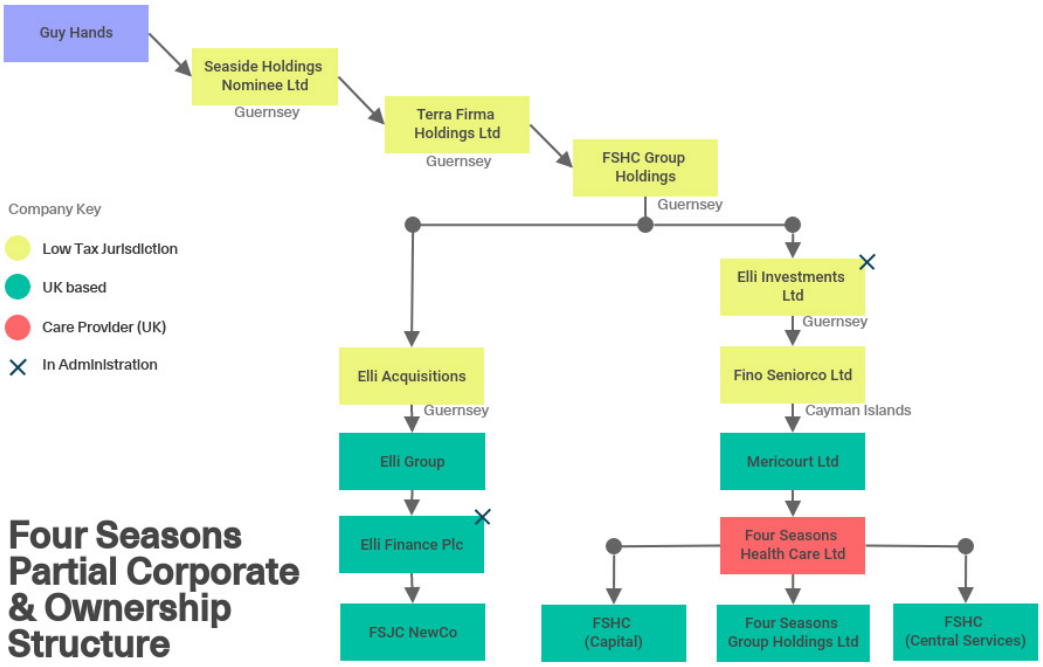



Figure 2.



Over the past 20 years, private for-profit residential care in England has become increasingly marked by private equity and investment fund acquisition of care providers through highly debt-fuelled transactions. [25] For instance, in the 2006 purchase of Four Seasons by private equity firm Three Delta, 80% of the cost was debt-funded.[26] HC-One, similarly, has changed hands several times over the past decade, each time incurring additional debt.[27]

Within the residential care sector as a whole, providers also engage in rapid acquisition and/or sell-off of real estate assets in sale and leaseback deals (meaning the care provider comes to rent land which it previously owned from a property company). This so-called 'op co/ prop co' model, in which the companies running services are divided from companies engaged in property ownership, development and management, in theory enables specialisation of functions between companies.[28] However, previous research suggests it is often used for financial gain, with the asset sale used to reduce debts,[29] extract cash from the company, or fund further acquisitions.[30]

The financialised model also tends to involve a shift from equity to debt finance, which reduces tax burdens while leaving care companies highly leveraged and with potentially unsustainable interest payments.[31] In combination with increasingly inadequate social care funding by the state as a consequence of austerity, the conditions of financialisation have contributed to a highly vulnerable sector: according to November 2019 analysis by Future Care Capital, over 25,000 beds were, even before the pandemic, 'at risk', meaning that they are likely to experience financial difficulty should conditions not change.[32] As recent comments from HC-One suggest,[33] the pandemic is negatively impacting the financial situation of some providers, which could exacerbate this issue.

Understanding the specific consequences of financialisation for the quality of care itself is complex, owing in part to a lack of robust data. However, as a recent report from IPPR notes, the current private model of care provision has been correlated with rising instability in care markets, with three-quarters of councils reporting provider closures in 2019.[34] Moreover, there is evidence that private providers on average have higher staff turnover; and reduced staff pay, training and numbers. [35] There is also a correlation between increasing private market share and the market share occupied by larger homes, despite large homes receiving a lower quality rating on average than smaller homes from the Care Quality Commission (CQC).[36] Finally, according to research published in the Financial Times, the explosion of debt – and with it, an explosion in interest costs – has tended to be accompanied by low and consistently declining investment.[37],[38]

It should be noted that the picture is not uniform, even among the Big Four. For example, at Barchester, staff numbers fell by 16%, but aggregate staff pay increased by 21% according to the accounts for the four years to 31 December 2018 filed at Companies House (accounts for 2019 had not been filed at the time of writing, and resident numbers are unknown). Care UK has seen staff numbers decline in part because it has divided portions of the Care UK Group including its health care services into distinct companies; it notes that within its care business specifically, like-for-like staff numbers have increased, though part of this cohort are engaged in social care provision while being employed by other companies in the group.

As of 2018, these four companies alone carried debts equivalent to £40,000 per bed, paying out annual rates of interest of nearly 12% on their £2.2bn in total debts.[39] The high debt model - and the "unsustainable" level of return it demands - has been described by a debt restructuring adviser at Opus as "completely inappropriate", for low-margin businesses like residential care.[40] For instance, between 2014 and 2019, Care UK alone reported over £320mn in

debt service costs – an average of £53mn per year, while consistently recording pre-tax losses of tens of millions of pounds each year.[41] Importantly, shifting profits (and losses) between entities in a corporate structure can be used as a strategy for alleviating tax burdens; indeed, the complexity and 'black box' nature of the financialised care chains enable their accounts to be presented (lawfully) in various ways according to the interests of the company at a given time.[42]

Companies reliant on property portfolios for their financial health can also be vulnerable to downturns in the real estate market - a distinct risk of the economic impact of Covid-19 – or property revaluation. As highlighted in the box below, Four Seasons exhibited this tremendous dependency on real estate valuations when it recorded a £265mn loss in 2015 that corresponded with a write-down in its real estate asset values.[43]

**Case Study: The Financialisation and Fall of Four Seasons**

In April of 2019, Four Seasons Healthcare Group announced it was entering administration - or rather, the holding companies carrying a large portion of the corporate group's debt were. The operating companies providing care services, management assured, would remain functional. Nonetheless, the news sent tremors through an industry still marred by the collapse of Southern Cross Healthcare, once the UK's largest care provider, between 2011-2012.[44]

This was not the first sign of trouble for Four Seasons: following its acquisition in a debt-heavy transaction by private equity group Terra Firma in 2012, in April 2017, and facing a debt payment of £27mn that it couldn't pay, the Group's primary creditor, H/2 Capital Partners, became effective owners of the company, though Terra Firma remains the nominal owner,[45] allowing H/2 to "sell the business without any ongoing obligations."[46]

As of 2019, Four Seasons operated some 214 homes in the UK, for a total of 11,856 beds - down significantly from the 320 homes and around 17,500 beds that it provided in 2015 prior to its financial troubles.[47] Though it provides care for both self-funded and publicly-funded recipients, Four Seasons has a "high exposure to public pay",[48] with its revenue therefore hit by austerity over the past decade. However, this dent in public funding alone did not drive Four Seasons into crisis.

Rather, the debt associated with the company – primarily incurred by holding companies in the Elli Investments Limited group to which Four Seasons belongs – soared since acquisition by Terra Firma. While data specific to Elli Investments Ltd. was unavailable, Table 2 shows the unsustainable debts accumulated by holding company Elli Finance. Over the five years between 2013 and 2017, Elli Finance reported nearly £690mn in debt service, while its net debt grew by 40% to over £560mn. By the time it entered administration in 2017, the cost of servicing the company's debt was nearly 4000% of its normalized after tax profit.

However, the holding companies were not the sole problem: according to data from Thomson Reuters Eikon, shareholders' equity in Four Seasons Health Care Ltd. plunged from an already weak -£46mn in 2014 to -£305mn by 2018. Over the same period, the company reported eye-watering debt service costs totalling £765mn, with £330mn of this paid out in a single year in 2018.

The experience of the Four Seasons Health Care group offers a warning of the risks from financialisation plaguing the UK's private social care sector, particularly among those companies with private equity backers. As the second major private

provider to collapse in less than a decade, the Four Seasons case fired a warning shot over an industry that was struggling even prior to the impact of the Covid-19 pandemic.

Table 1 in the appendix highlights key financial indicators for the Big Four. Four Seasons is shown alongside Elli Finance, one of the two holding companies associated with the group of companies (Elli Investments Limited group) to which Four Seasons belongs. Elli Finance entered administration in 2017, alongside Elli Investments Ltd., for which no data was available in mainstream financial databases or on Companies House, due to its registration in Guernsey. It is important to emphasise that the opacity and complexity of Four Seasons' corporate structure - comprised of some 180 companies in various jurisdictions and with extensive intra-group lending - creates challenges for arriving at a full picture; we have therefore presented data pertaining to each company branch itself, rather than attempting to arrive at topline figures reflecting the full group. Similar challenges exist for the other members of the Big Four as well; we have therefore presented consolidated data for the highest relevant member of the corporate chain, where available.

Most striking is the amount expended on debt service among the Big Four, with £1bn in debt service costs reported since 2014[49] (note that this excludes the debt service of both HC-One and other members of the Elli Investments Limited group). Group-level figures show all three of Barchester, Care UK and HC-One reported a decline in employees from 2014 until their most recent filings. [50] Collectively, the workforces of these three providers shrank by one fifth during this period, though Care UK notes their residential care-specific staffing rose over this period. [51] At the same time, salaries of all three companies' highest paid directors have grown during this period by hundreds of thousands of pounds. According to research published in the Financial Times, these shifts with have coincided with declining rates of investment, with capital expenditure falling short of the amount needed to keep up with wear and tear of assets.[52],[53]

As pressures grow from an ageing population as well as declining public funding for social care - despite political rhetoric suggesting plans to the opposite - a model of high debt and under-investment will become increasingly untenable, raising the likelihood that the sector may require public intervention to keep care services operating. The crisis unleashed by Covid-19 has underscored this risk, with HC-One recently suggesting it may need assistance to stay viable amid higher pandemic-related expenses.[54]

### — 1.4 The consequences of the devaluation of care for care workers and care receivers

In a highly fragmented market, currently comprising an estimated 20,000 providers,[55] the drive to cut costs has led to pressure on care workers in terms of wages, conditions and security. Austerity since 2010 has increased this squeeze. In residential care in particular, heavily financialised business models - discussed in more detail in the preceding section - encourage ownership churn, financial fragility and poor pay.[56] Average weekly pay for female care workers is £385 a week - nearly £200 below the UK median.[57] Research carried out by the Smith Institute in 2014 comparing the median hourly wages of care workers across the public, private and voluntary sectors revealed significant differences, with the public sector paying substantially more than both the private and voluntary sectors.[58] This gap was even wider when other payments, training and pensions were taken into account.[59]

**Table . Median Hourly Wage by Care Sector and Occupation, 2014**

| Occupation | Sector | | |
|---|---|---|---|
| | Public | Private | Voluntary |
| Residential Care Workers | £9.45 | £7.23 | £8.50 |
| Senior Care Staff | £14.19 | £7.30 | £10.57 |

Source: Smith Institute/Unison 2014, *Outsourcing the Cuts: pay and employment effects of contracting out.*

Insecurity and working conditions are also areas of concern. Skills for Care data suggests that in 2019/20, 24% of those employed in the social care sector in England were on zero-hours contracts; however, within the sector, the rate for care workers in was higher, at 34%, while for care workers in domiciliary services the proportion stood at a remarkable 56%.[60] Zero-hour contracts give employees no guarantee of how much work they will have and when their shifts will be, whilst also precluding access to sick pay, holiday pay or employer pension schemes. Underpayment or non-payment for travel time and sleep-in shifts have been recurrent problems in the sector.[61]A 2016 study of twelve UK care homes identified a range of widespread austerity-era changes in the domiciliary care sector with major implications for job quality, including restricting annual leave, removing sick pay, moving to unpaid on-line training to be completed at home, removing paid breaks and no longer paying for handover meetings at the start and end of shifts.[62]

The poor pay and insecurity faced by care workers need to be understood as drivers of poverty and deprivation among women and ethnic minorities. Both women and ethnic minorities are overrepresented among care workers. A 2020 study by Skills for Care found that 82% of the social care workforce in England identified as female, compared to 47% of the economically active population. Workers identifying as female were less likely to be in managerial jobs (79%), and especially senior management roles (67%), compared to direct care providing roles (83%).[63]

The study also found that around 21% of care workers identified as black, asian, mixed or minority ethnic (BAME) - compared to 14.6% of the population across England.[64] Around 12% of adult social care workers identified as black, compared to 3.5% of the total English population.[65] As the Institute for Fiscal studies has suggested, the over-representation of ethnic minorities within the social care sector is also potentially significant in explaining higher rates of Covid deaths among ethnic minority groups. (The impact of Covid-19 on care workers is further discussed in section 1.4 below).

The social costs of care work are borne not only by care workers and the§ir families in the UK, but globally. Around 16% of the English social care workforce was found to have non-UK nationality, with more than half of these being from outside the EU.[66] As Fiona Williams, among others, has described, migrant women are often forced to leave behind their own children or elderly parents, to be looked after (more or less attentively) by relatives, thus driving the formation of a “global care chain.”[67]

Inevitably, poor pay, conditions and insecurity for care workers have impacted on the quality of care. Contrary to the assumption of successive governments that increasing market competition would ‘drive up’ the quality of care, there are increasing reasons to believe that the opposite has happened. In line with evidence from the US, Canada, Australia and Sweden,[68] England’s Care Quality Commission (CQC) has tended to rate private sector care as lower

quality than its public and not-for-profit counterparts.[69]

Outsourcing has also encouraged the entrenchment of inadequate service models. In home-care, outsourcing has encouraged a conception of care work in terms of bio-maintenance - i.e. the delivery of essential maintenance tasks in 15-30 minute slots.[70] This is easy to quantify and cost. However, this bio-maintenance model ignores the wider social interactions and values that give independent life its meaning.

The negative consequences of these trends in the sector for care receivers are predictable and increasingly unavoidable: in short, the positive effects of a longer lifespan are increasingly negated by loneliness, social exclusion, and vulnerability to abuse,[71] with major scandals exposing instances of neglect and ill-treatment in both home and residential care.[72]

### — 1.5 Care and the Covid-19 pandemic

Covid-19 has dramatically exposed the inadequacies of England's current adult social care system. As of July 2020, there had been more than 30,500 excess deaths in care homes relative to what would usually be expected in the same period.[73] The decision to discharge care home residents from hospital during March and April at higher than usual rates has received widespread media attention. In line with guidelines at the time, many of these residents were returned to care homes without having been tested - a move which is now widely seen as the cause of the outbreak in care homes. However, a leaked Public Health England report indicates that the movement of care workers (specifically agency staff) between care homes may also have played a major role.[74] It is worth noting that the increased death rate among people receiving domiciliary care was even higher than among care home residents (225% of the usual number of deaths, compared with 208%).[75]



While the media has focused on the scandal of care home deaths, the early failure to provide care workers with adequate PPE or access to testing has also led to high rates of deaths among care workers themselves; indeed, not until 3rd July did the government commit to testing all staff in care homes regularly.[76] Between the 9th of March and the 20th July, the ONS recorded 312 Covid-19 related social care worker deaths in England and Wales.[77]

In the most recent period for which more detailed data is available (covering 9th March - 25th May) ONS analyses show significantly raised death rates among both men and women working in the sector. The rate of deaths among female health care workers such as doctors and nurses in the same period stood at 11 deaths per 100,000, among social care workers it stood at 19.1 deaths per 100,000 (171 deaths). Among male social care workers, it stood at 50.1 deaths per 100,000 (97 deaths).[78] Although the ONS does not make data by ethnicity and occupation (together) available, the considerable overrepresentation of ethnic minorities within social care work would suggest at least some role for care-work related exposure in explaining high rates of Covid-19 deaths among ethnic minority groups.

In addition to exposing the under-valuation of care workers, Covid-19 has also brought new scrutiny to the financial fragility of much of the private residential care sector, with major provider HC-One warning in April of this year that it was struggling to repay its debts as a consequence of falling revenues and PPE costs. More broadly, the falling occupancy rate in care homes as a consequence of Covid-19 is now creating a significant risk of mass closures in this already fragile sector.[79] And while the adult social care winter plan announced by the Government in September 2020 has almost doubled the infection control fund for care homes, the Chief Executive of Care England has cautioned that short term funds are not a substitute for the longer-term support which the sector requires.[80]

There have been fleeting moments in the response to Covid-19 when politicians have been forced to prioritise life-sustaining activity over the normal functioning of our economic system. More generally, however, the pandemic has laid bare and exacerbated the profound injustices in current approaches to organising reproductive labour. It has also revealed the incapability of these approaches to respond effectively and safely to a pandemic - resulting in grave dangers not only for care receivers, care workers and their families, but for society as a whole.

# 2Caring for the earth, caring for each other

After much destruction, mastery will fail, because the master denies dependence on the sustaining other: he misunderstands the conditions of his own existence and lacks sensitivity to limits and to the ultimate points of Earthian existence.

Val Plumwood, Feminism and the Mastery of Nature[81]

The climate emergency has become the focus of burgeoning global social movements, whose demands have become impossible for mainstream politicians to ignore. Calls for a Green New Deal (GND) have emerged in different forms in many parts of the world, defined by a commitment to systemic change and a 'just transition' to an economy that is both environmentally sustainable and socially just.

A core project and challenge for the GND is defining what forms of work should comprise the decarbonised economy of the future, in order to ensure that all life can flourish within planetary limits. As a socially necessary, life-sustaining service that provides for a fundamental human need, care work should play a key role in this new economy. However, a recent paper for the Women's Budget Group highlights that care work is an under-developed theme in many existing GND proposals.[82] While some of these proposals include calls to 'transform care', they offer little detail on why or how. This begs the following questions: why, and how, should a GND address care work?

One possible response is to highlight the virtue of investment in care jobs as 'green jobs'. Some authors have conceived growing rates of employment in services such as care optimistically from an environmental point of view, arguing that a shift from the consumption of goods to the consumption of services, (especially ones with a collective dimension such as health or care), can underpin a new "green mass consumption" model.[83]

However, while intuitively compelling, it may be deceptive to understand a growth in care jobs as a straightforward route to decarbonisation. First, because a domestic shift from producing goods to services – even socially beneficial ones – may simply lead to the export of harmful production processes to other countries, if overall levels of domestic consumption

are not reduced.[84] Second, while care and other services meeting our basic needs may create less carbon emissions than traditional manufacturing, they still have a material basis – and thus their growth still has environmental implications.[85]

We need, instead, to understand that **care jobs** are indeed **'green jobs' - but for reasons more fundamental than the level of emissions with which they are associated.**

Ecofeminist scholars and activists have drawn attention to the close links between the exploitation of reproductive labour and the exploitation of natural resources. The point here is not to suppose some kind of inherent affinity between women (essentialised as mothers and caregivers) and the natural world (often conceptualised as 'mother nature'). Rather, the point here is the structural relationship between women and the natural world, created by a common and connected experience of being treated as an 'externality' in our current economic system - and thus exploited.[86]

Contrary to the impression given by mainstream economic theory, humans cannot and do not perpetually seek to maximise their resources. We are not abstract, footloose units of 'human capital', but creatures living in bodies, and particular places. The sphere of reproductive labour has always served as a 'dumping ground' for the necessary tasks that come from these inevitable features of human existence. Unlike a growing proportion of work in tradable sectors, reproductive labour cannot be easily off-shored, digitalised or otherwise relocated. It therefore tends to be more embedded in a particular place, and more directly connected to a particular ecological context.

Changes to this or ecological context, or deliberate attempts to change the way we relate to it, therefore tend to disproportionately impact those who perform reproductive labour. At the more extreme end of this link is the growing evidence of the disproportionate impact of climate change on women in the Global South. A study produced by the Georgetown Institute for Women, Peace and Security offers numerous examples of this intersection, such as the greater burden of provisioning water and food due to increased droughts and crop failure.[87]

Similarly, in the Global North attempts to reshape our relationship with the environment risk disproportionately burdening women. As ecofeminist thinkers have observed, it would be perfectly possible to introduce bold and far-reaching policies to reduce carbon emissions while doing nothing to address the unfair gender distribution of reproductive labour.[88] Indeed, just as there is a danger in socially regressive climate policies that unfairly affect poorer sections of a population - as the Gilet Jaunes demonstrations famously showed - there are many decarbonisation measures which could, implemented thoughtlessly, increase the reproductive labour load on women.[89] For instance, without careful design of alternative travel options, a car-free city would imply a significant increase in the time and labour involved in shopping for a family.[90]

A just GND, then, must also be a feminist one. The climate crisis, as experienced by humans, is ultimately inseparable from the devaluation of reproductive labour. Because the exploitation of reproductive labour and of the natural environment are fundamentally connected, they must be tackled together. This means addressing the devaluation and unequal distribution of reproductive labour - and especially care work - alongside the devaluation and exploitation of the natural world, and centring a new understanding and distribution of reproductive labour in the new economy and society envisioned by the GND.

Placing social reproduction and care work centre-stage is an important reminder that although an ambitious GND will involve the creation of good 'green jobs' of multiple kinds, it is ultimately about more than job creation. As Tithi Bhattacharya has highlighted, despite the

relentless focus of mainstream economic policymaking on growth and jobs, the vast majority are struggling not for wages, but the life that wages can afford. By putting care work - the work which makes and sustains our lives - at the core of a GND, we can "demand that the labour of society be organized around jobs that enrich life rather than be harnessed in the irrational production of endless commodities."[91]

The call to rediscover life-making and care as the organising principle of our economic system, rather than one of its casualties, has echoed through a number of programmatic calls to action that have emerged across the globe in the last few years . In Canada, the Leap Manifesto, produced by a coalition of labour, environmental and indigenous groups, has called for an economy centred on "caring for one another and caring for the planet." In a Latin American context, prominent thinker Leonardo Boff was calling in the late 1990s for the rediscovery of care as a fundamental ethos of the human being, to underpin a paradigm shift in the way we interact both with the earth and each other.[92]

More recent calls have emerged out of the turmoil of Covid-19. In the UK, the Care Collective have advocated for a shift to an economy and a politics organised around care, foregrounding our interdependence.[93] Senegalese economist Felwine Sarr has similarly set out a vision for a post-Covid shift to an "economy of the living", which would give priority to those economic activities which secure our health, care, well-being, as well as our more spiritual and cultural needs.[94]

Conceiving of care in this broader, humanistic sense invites a concern with the qualitative dimension of economic life as much as the quantitative. It implies that when addressing care, a GND should not limit itself to job creation targets for 'care jobs as green jobs'. Rather, its ambition should extend to transforming the nature of care services and care work, as part of a broader ambition to revalorise and redistribute reproductive labour, and build an economy that prioritises life and well-being over productivity and growth. The form this transformation could take is explored in the next two sections.



# 3 Care and Productivity

The previous section explored the place of care work in a sustainable and socially-just economy, and made the case that the transformation of adult social care must be central to a GND. To design specific recommendations for achieving this, we must first take stock of the way that adult social care is currently approached in English economic strategy and surrounding debates, particularly the limitations of the currently widespread preoccupation with raising productivity in the adult social care sector.

As in other high income countries, where populations are ageing and where a substantial proportion of care work has moved from the unpaid household sector into paid sectors, adult social care is an increasingly important source of employment in England. It accounted for 6% of all employment in the UK in 2016,[95] and the number of jobs in the wider social care sector grew

by 9% between 2012 and 2020.[96] However, the poor wages in the sector remain unaddressed, with the problem, according to the productivity perspective, being that pay is low because the productivity of social care is low, and must therefore be raised in order to raise wages.

This perspective needs to be understood in a wider context of prevailing approaches to industrial strategy. Here again, the core objective is to raise productivity, and to solve the UK's much-invoked 'productivity puzzle'. It has often been characterised by a 'fetish of the frontier',[97] laying heavy emphasis on high-tech industries such as robotics and life-sciences which are geographically concentrated and employ few. As one study has identified, the sectors likely to benefit from the Industrial Strategy Challenge Fund account for little more than 1% of the whole UK economy (by employment), and just 10% of manufacturing jobs.[98]

In response to this evident blindspot, non-tradable sectors such as retail, hospitality and care have received increasing attention within industrial policy circles. The common feature of these sectors is understood to be low productivity (a problematic characterisation, as will be discussed below). However, many have argued that because of their large employment footprint and wide geographical spread, even relatively modest productivity increases in 'everyday' sectors could contribute significantly to aggregate productivity growth.[99] Raising productivity in this 'long tail' is understood to be critical to boosting wages in low-pay sectors and the regions where they dominate. However, while the aspiration to raise wages in adult social care (and other low-pay sectors) is important, there are a number of problems with the productivity-centric approach to doing so.

### — 3.1 Productivity and wages

The first problem is an **overly simplistic understanding of the relationship between productivity and wages**. Contemporary UK industrial policy thinking tends to accept the neoclassical assumption that wages are determined by the marginal productivity of labour. But this assumption, and the 'productivity reductionism'[100] associated with it, have come under significant theoretical and empirical challenge.

In the realm of economic theory, productivity reductionism has been challenged by post-Keynesian thinkers, who have have influentially argued that wages are set exogenously to the production process, rather than as a function of marginal productivity. According to this view, while net productivity, or 'surplus', may create a 'ceiling' for wages, the distribution of the surplus between profits and wages is ultimately determined by social norms and political decisions.[101]

Empirical approaches, too, cast doubt on the idea of productivity growth as the sole basis of wage growth. A study of UK data over the period 2011-2015 found little evidence of a strong relationship between rising productivity at firm, sector or local labour level market and nominal wage growth.[102] Indeed, there is also evidence that this relationship can work in the opposite direction.[103] A study of the introduction of the UK national minimum wage in 1999 indicates that the resulting increased labour costs stimulated productivity increases within firms - thus providing some empirical support for the idea of exogenously determined wage.[104]

To push this interrogation a step further, it is worth considering how productivity-centric thinking may not only misconstrue the causal relationship between productivity and wage growth, but erroneously conflate 'productivity' with the social valuation of labour. In many service sectors, what comes to be understood as 'productivity' may be better understood as reflecting the social valuation of labour, expressed in the willingness or ability to pay higher prices or wages.

For example, in the hospitality sector, productivity is around 45% higher in France than it is in the UK.[105] This may, in part, result from more efficient working practices. But it is also likely to be at least partly explained by a willingness to pay more, or more frequently, for higher quality services that are more socially valued.[106] Lower levels of inequality, and thus greater private ability to pay, may be also part of the explanation.

Comparable dynamics may be relevant in understanding 'productivity' in other services, in part, collectively, such as adult social care. A recent ICF study found that workforce productivity in the adult care social sector is higher in Scotland than other UK nations, whether calculated using income, expenditure or output.[107] The care worker to population ratio is also higher in Scotland than in the other UK nations, with 20.3 full time equivalents for every 1000 people, against 18.6 in England suggesting that higher productivity is not driven by efficiencies in each care worker serving a larger case-load. Rather, the report finds the explanation in Scotland's introduction of the (Scottish) Living Wage in the care sector, and its higher levels of public spending per capita on adult social care services - over £100 higher than in any other UK nation. Rather than productivity increases enabling wage rises, it was a political decision to increase the valuation of care work that appears as an increase in productivity.

### — 3.2 The 'human' dimension and the question of quality

A second major problem with productivity-centric approaches is their **blindness to the distinctively human dimension** of an activity like adult social care, where the 'product' is a personal service - and the implications of this for service quality.

As William Baumol famously observed, 'handicraft' services - like health, education, or musical performance - differ fundamentally from manufacturing, in that labour is not only an input, but also, in effect, the output.[108] The essential 'human' dimension of these services means that beyond a certain point, productivity cannot be increased without a deterioration in quality. Rather, excessive productivity growth may violate the very purpose of these services. Indeed, as Susan Himmelweit has noted, measures of productivity here may also serve as indicators of poor quality - for example a low staff-to-child ratio in a nursery.[109] Current attempts to automate adult social care work, such as the fast-developing industry of care robots in Japan, provide a troubling portent of a myopic focus on productivity; while robots may facilitate daily tasks, they cannot address the anxieties associated with age – and may increase loneliness.[110]

### — 3.3 Care as productive activity vs. care as core human need

A third set of problems with productivity-centric approaches to industrial strategy for adult social care result from the very decision **to conceptualise care as an income generating activity, rather than as a means of meeting an essential social need.**

It was noted above that as UK industrial policymakers and thinkers have begun to extend their attention to traditionally neglected non-tradable sectors, there has been a tendency to define these in terms of low productivity. There are a number of issues with this tendency. First, it is inaccurate as a characterisation of all non-tradable sectors, some of which have levels of productivity well above the UK average.[111] Second, this focus on raising productivity is based on a tacit assumption that welfare depends primarily on individual income, which sustains private consumption.[112] However, wide variations in housing costs and availability in different regions of the UK mean that income alone is not enough to secure 'liveability'.[113] Moreover, the focus on individual income and private consumption obscures the importance of forms of collective consumption and infrastructure in shaping wellbeing.[114]

An alternative approach to industrial strategy would be to recognise care as part of the "foundational economy" or "everyday economy", defined not by low productivity but by a function: meeting core needs, and providing the "infrastructure of everyday life".[115] These range from 'providential' services like education, health and care, to 'material' essentials like utilities, high-street banking and food. (Distinct but related is the 'overlooked economy', providing things socially defined as essential, such as haircuts or house maintenance).

Conceptualising social care (and other foundational services) in terms of its purpose rather than its productivity level could encourage a different approach to industrial strategy for this sector. A key goal would become adequately providing for care needs - that is, in the terms developed by Amartya Sen, securing a full set of capabilities for care-receivers.[116] This in turn would require fair pay and dignity and fulfillment in work for care workers. The elements of such an alternative industrial strategy are set out further in the next section.

# 4 Towards a radical industrial strategy for adult social care



The issues raised in the preceding section have a number of implications when it comes to imagining an alternative approach. Our challenge is not simply to raise the output or efficiency of these sectors, but to raise the value attributed to them. This ultimately means increasing the amount that society is willing and able to pay for them - a political, rather than purely technical challenge.

However, contrary to the tenor of much political and media discussion in England, this is not just a matter of 'plugging the funding gap'. Pumping more money into the current social care system would not result in improved pay or conditions without resolving the problems of financialised provision, as argued by Manchester's Centre for Research on Socio-Cultural Change in 2016.[117] Nor would increasing entitlements on its own do anything to change the narrow prevailing models of care, which are so clearly inadequate in meeting the needs of care receivers.

To bring about a transition from a sector dominated by for-profit provision to one that puts the needs of people first, an alternative, radical industrial strategy is needed for adult social care in England. Such a strategy would not narrowly target the private sector, but would rather focus on increasing and strengthening public provision, as well innovative forms of cooperative, voluntary and community provision. Anchoring this transition, **we believe that the public sector must return to its historic role, delivering the majority of adult social care.**

Rather than being narrowly directed towards raising productivity, a radical industrial strategy would aim to increase the social value of adult social care, in an expansive sense. This would encompass:

- Developing care services which meet the holistic social needs of care-receivers, securing them a full set of 'capabilities', rather than treating them as a maintenance problem serviced in 15 minute slots.
- Ensuring a real Living Wage, as well as dignity, fulfillment and opportunities for creativity in work for care workers, through new models of care provision as well as through more funding.

Radical industrial strategy, then, is concerned **not just with increasing the efficiency with which wealth is produced, but with reshaping the distribution (or 'predistribution')[118] of wealth**. It can also be characterised as going beyond a 'formal' objective - raising productivity - to focus on a 'substantive' one: securing the wellbeing and dignity of both care workers and care receivers.

Achieving this goal, and changing the social valuation of care work, will require a multi-pronged strategy. Its goal is a radical overhaul of adult social care over the next decade, without leaving local authorities responsible for delivering services exposed in the process. Alongside national-level measures to enable long-term transformation, it includes local authority-level measures to enable interim reshaping.

The sections that follow set out the key elements of such a strategy:

**4.1 A new settlement for funding and entitlements**

**4.2 Reclaiming care from extractive provision: 'activist' commissioning, insourcing and financial regulation**

**4.3 Social licensing**

**4.4 Innovation in provision and inspection**

**4.5 Professionalisation, training and continuous learning**

**4.6 Sectoral collective bargaining**

**4.7 The adult social care sector as part of a green industrial strategy**

**4.8 Justice in unpaid care work**

It should be emphasised that the proposed strategy applies to England, rather than Scotland, Wales or Northern Ireland (for which adult social care is a devolved responsibility). This focus was chosen as it is in England that attempts to reform social care are least developed, and change is thus most needed. There is nevertheless much that will be of relevance for transforming care in the devolved nations, and indeed in many other countries more broadly.

## — 4.1 A new settlement for funding and entitlements

As discussed above, there is no way to improve wages, conditions and service quality at the scale required without an increase in funding. While some efficiencies may be possible from new operating models (see section 4.3), these will not be enough to improve wages and quality at the scale required.

A fully-modelled estimate of the amount of additional spending required is beyond the scope of this report - such estimates have, however, been provided in a number of other recent studies.[119] Clearly, costs will depend also on the question of entitlements. The cross-party health and social care select committee has recently recommended that ministers should invest at least £7bn a year in the care sector by 2023-24, while indicating that this was only a "starting point" and would not address unmet care needs nor improve access to care.[120] A strong case can be made for moving gradually towards universal free entitlement to personal care for over 65s as a logical extension of the NHS principle of care 'free at the point of need'. In Scotland,

personal care is provided by your local council for free if you are aged 65 or over, regardless of income, capital assets, or marital or civil partner status.[121] Extending this universalist principle will likely be important in bringing about greater parity of esteem between NHS and social care services, and increasing public buy-in. IPPR has suggested that such an approach would require social care spending to increase from £17 billion per annum today to £36 billion by 2030 (excluding the cost of a cap or more generous means test). Though not insignificant, this would represent an increase of less than one per cent of total government expenditure, or seven per cent of NHS spending (indeed it is only marginally more expensive than the Conservative party's 2017 election pledge of a cap and floor system). [122]

There are various possible means of supporting this increased spending, including through raising income tax or national insurance contributions; taxing income from wealth in line with income from work;[123] or, as has become a major topic during the Covid-19 pandemic, a new form of wealth tax. Given the growing political awareness of the structurally unequal impacts of Covid-19, and of the enormous and long unpaid debt of the richest in our society to the underpaid 'key workers', it is entirely appropriate to explore progressive taxation solutions to the funding of social care. The charity Independent Age has suggested that in order for National Insurance to close the gap between government spending and the cost of

free personal care in 2021, it would need to be increased by 0.68%.[124] Significantly, recent polling from the Women's Budget Group found strong support for using taxation to fund a system of free social care for over 65s and disabled people, with 82% of respondents saying access to care should be based on need not ability to pay, and 75% stating they would willingly pay more tax to support this service.[125]



**Recommendation 1: Establish a new funding settlement for adult social care, (including free personal care for over 65s), based on progressive taxation.**

### — 4.2 Reclaiming care from extractive provision: 'activist' commissioning, insourcing and financial regulation

While a new funding settlement is crucial, it is also insufficient. Unless accompanied by other changes in the structure of care delivery, more funding is likely to simply prop up current inadequate forms of care provision and care work.

Central to achieving a more fundamental shift will be changes in the **commissioning process.** As in many other public services, funding pressures and growing demand has meant that cutting costs have tended to dominate over other considerations. As discussed in section 1.2, commissioning in care has come to involve large block contracts, often with extractive, heavily financialised providers.

The Social Value Act 2012 requires local authorities in England and Wales to 'consider' wider economic, social and environmental benefits when commissioning and procuring goods and services. However, it does not require any enforcement of the measures which are supposed to promote social value, with predictably uneven results.[126] There is increasing evidence that social values frameworks for social care commissioning are being manipulated, with larger providers becoming adept at gaming the system. A bid-writing industry has emerged around social value, assisting extractive providers to tick the box and win the contract.[127]

Analogously, the Care Act 2014 placed a new responsibility on local authorities in England to act as 'market shapers', by facilitating and nurturing a diverse, sustainable and good quality local market for care provision. In practice however, carrying out these duties on top

of maintaining core services and contending with funding pressures has been a considerable challenge.

A bolder, more 'activist' approach is needed to social care commissioning.[128] In line with experiments in progressive procurement taking place across the UK,[129] market shaping and driving social value should move from the margins to the centre of the commissioning process, with the core aim of securing dignity for care receivers and care workers alike.

A major element of this shift should be the **insourcing of a large proportion of adult social care services.** To anchor the transition from a sector dominated by for-profit provision to one that puts the needs of people first, we believe that the public sector must return to its historic role, delivering the majority of adult social care. Building up in house local authority provision will be vital to ensuring that access to good care is not a postcode lottery, in addition to strengthening the resilience of local care systems and their ability to weather crises such as Covid-19. This will require restoring the capacity of local authorities to deliver care after a decade of austerity, outsourcing, and privatisation.

Alongside the expansion of public provision, there are also a range of non-state models, including cooperatives, social enterprises and other forms of community provision, with much to offer. By sharing power and agency between care workers and care receivers, such models have the potential to promote fulfilling work and high quality care relationships. In contrast to the more extractive ownership models discussed in section 1.3, these models can be understood as economically 'generative': public spending on them is largely directed towards wages, which in turn are often spent in local economies.

Rather than enshrining or imposing a single standardised model, then, commissioners should create space for plurality in local care provision. The particular mix of models will vary according to different local contexts and histories of care provision. In some places, there will be a large base of voluntary sector and other generative activities which can be mapped out and strengthened. In others, where the ecosystem of generative care provision is more nascent, there will be a stronger role for the local 'entrepreneurial state' in developing and stimulating new forms of provision (see section 4.3 below). In all places, local provision should come to consist of a diverse range of public sector and other 'generative' forms of provision, with the former accounting for the majority.[130] This shift cannot be achieved overnight, but we recommend that local authorities (with central government support) should commit to a full transition to public and generative-only forms of provision by 2030. It should be noted that projections anticipate a gap of 75,000 beds between current trends in provision and projected demand in 2030 as a result of the UK's ageing population; a commitment should thus be made for public provision to fill this gap.[131]

**Recommendation 2: Local authorities (with central government support) should commit to a full transition to public, cooperative, non-profit and community-only forms of provision by 2030.**

For a new funding settlement to improve care services, there is a clear and pressing need to combat the problem of financialisation, value extraction, and the consequent financial fragility in the private for-profit care sector, exemplified by the collapse of both Four Seasons and Southern Cross over the past decade. Otherwise, additional funding would be equivalent to "pouring water into a leaky bucket."[132] However, in the immediate term, many local authorities find themselves with no alternatives to major financialised providers.

Rather than an immediate ban on such providers, tackling these issues should therefore be achieved through the implementation of a multi-pronged programme of drastically

improved transparency; mandated improvements in financial resilience among providers and their affiliated holding companies; and strong disincentives against extractive investment. To accomplish this, we propose reforms which: mandate open-book accounting; place firm limits on leverage, based on an assessment of the appropriate average leverage for the private care sector commensurate with necessary capital expenditure for maintenance and expansion of services; and a phaseout of public funding for private providers which have companies in their corporate structure or majority owners registered in tax havens. To avoid a cliff-edge for provision as a consequence of this phaseout, a reasonable timeline should be negotiated for companies to adjust their tax jurisdictions.

These changes should form part of the strategy for achieving Recommendation 2, by pushing out extractive business models as public and 'generative' forms of provision replace them.

**Recommendation 3: Introduce a package of measures to tackle financialisation and improve transparency in private care provision, as part of the transition away from private for-profit care.**

Additionally, as a key mechanism for extractive investment practices in the care sector is the value of real estate assets affiliated with care home infrastructure, we propose the public purchase of care home properties currently under private ownership, but by a private company other than the care provider; in other words, properties on which providers are paying rent to a private company or landlord. In England, land purchase could be carried out through NHS Trusts or local authorities, both of which have the right to enact Compulsory Purchase Orders (CPO). As suggested by Manchester University's Centre for Research on Socio-Cultural Change (CRESC), part of this investment could come from local authority pension funds, delivering an equivalent rate of return to beneficiaries as currently obtained by private asset management while investing in the community.[133] Alternatively or additionally, a new public body, similar to NHS Property Services, could be established with CPO powers to centrally purchase and steward the property, as well as manage its leasing to care providers. This would be charged at a rate commensurate with the costs of property maintenance, in lieu of the often excessive rents charged relative to property market value.

It is worth noting in light of the recommendation for a full transition away from private for-profit provision by 2030 that the CPO process can be lengthy, often spanning multiple years. However, beyond serving as a disincentive for extractive investment, bringing the land currently owned by property companies (i.e. those companies not directly providing the care service) into public ownership will be a necessary separate step in the transition to a solely public and generative system of care (which will also see the transition of private providers that do own the care properties associated with the service by other mechanisms). This shift would lower costs for service providers and enable providers to specialise on care delivery, rather than property development and management. In line with recommendations from CRESC,[134] this shift would enable the 'op co/ prop co' model to be used for public benefit, rather than to serve financial interests.

More broadly, returning privatised care home infrastructure and land to public ownership could form part of a deeper long-term shift away from the failed models of outsourcing and privatising vital public services and assets, and the wider rentierisation of the UK economy that this process has driven.

**Recommendation 4: Bring care home properties that are privately owned by a company that is** not **the care provider into public ownership.**

### — 4.3 Social licensing

Another key enabler for this transition would be a robust **system of social licensing for social care providers.**[135] Social licensing is a form of regulation imposing certain social and environmental standards on private companies.[136] In the context of adult social care, social licensing would impose certain standards as a condition of being considered for public contracts. Providers would need, for example, to demonstrate commitment to providing good training and opportunities for staff development (see section see section 4.5), engaging in sectoral collective bargaining (see section 4.6) and paying the real Living Wage. They should be committed to good environmental standards and actions to minimise carbon footprint. Notably, given the troubling rates of financial engineering discussed in section 1.3, contracted providers should be able to demonstrate financial sustainability, responsibility in tax payment, and willingness to share any financial data with commissioners.

Social licensing should not be overly centralised. While a national framework to set minimum standards is desirable, this should leave space for local authorities to add their own additional requirements, responding to local circumstances, needs and aspirations. However, enforcing social licensing should not be left entirely to local public bodies, and should be overseen by a central body, potentially the Care Quality Commission.

A key objective of social licensing should be to force poor quality, extractive providers out of the market. A major challenge will be the development of alternative forms of provision to replace it, in order to shift, over time, to 100% public sector and other 'generative' forms of provision (see discussion in next section). To support this shift, a special tier of license should be created for organisations that can be considered to play an economically 'generative' role in the local economy (or have the potential to). Where possible, social licensing legislation should allow organisations within this tier to be given priority in procurement exercises.[137]



**Recommendation 5:**

**Introduce a robust national system of social licensing for all care providers, requiring a real Living Wage for all care workers, and leaving space for local authorities to add their own additional requirements.**

Clearly, social licensing and these forms of financial regulation will depend on national legislation, and will not appear overnight. It is therefore valuable to explore the 'activist' measures that commissioners and local authorities could already explore, without any change in national laws, which could reshape local provision for the better. Some of these measures may turn out to be of enduring value, and could be maintained alongside any future social licensing system.

For example, **pre-qualification criteria** can be used to set out discretionary exclusion grounds and/or get a broader understanding of the suitability of potential providers. A good example of this kind of approach is the adoption by a number of councils of UNISON's Ethical Care Charter, or of Unite's Construction Charter, into their procurement procedures. This charter lays out 11 requirements for both construction contractors and their supply chains, such as developing and implementing skills and training opportunities, mandating direct employment of workers and ensuring access to trade union representation.

**Fair Tax Mark accreditation** can be used to reduce the presence of extractive providers. The Fair Tax Mark is a certification scheme which organisations can sign up to, demonstrating their commitment to paying their fair share of tax and encouraging this behaviour more widely. Local authorities are able to sign up to the Fair Tax Declaration and thus commit to pursuing fair tax conduct in both their own actions and – crucially – through their suppliers.

**Intentional, and creative use of, service specification design process** also offers much potential. Through a carefully crafted service specification, commissioners can enshrine features as core requirements, more exigent than social value frameworks and harder to 'game'. For example, Knowsley council was recently successful in commissioning a local CIC to deliver a community navigation service, (for a contract below the Official Journal of the European Union threshold) thanks in part to a service specification stating that the service should be "located firmly within the community" and should be "a recognised resource in the community".[138] Through such stipulations, commissioners thus favoured more locally generative providers in the tender process.

In some cases, such an approach could involve working with existing providers to drive up quality. An example is Tameside Council, which has reshaped its home care services away from 15-minute time blocks and towards a more person-centred model by retendering their contract, requiring selected providers to work with them closely on improving care outcomes and staff pay.[139]

**Local spend policies,** whereby local providers are favoured for any contract the Official Journal of the EU threshold, have been identified as another effective means of favouring generative providers.

**Recommendation 6: At local authority level, commissioners should experiment with a range of other measures to reshape provision for the better, including pre-qualification criteria, Fair Tax Mark accreditation, creative use of service specification design and local spend policies.**

### — 4.4 Innovation in provision and inspection



As indicated at the end of the previous section, forcing extractive providers out of the market will not be enough to transform the adult care sector. New approaches to commissioning will thus need to be accompanied with policies to support the development of new forms of provision, as well as new approaches to the inspection of care.

The fundamental objective here is not simply a 'formal' shift from profit-driven to non-profit driven forms of provision. An ethic of public service or social service as embodied in many state and non-profit organisations does provide a stronger basis for high-quality and high-dignity provision than heavily profit driven models. However, they are not in themselves sufficient to guarantee this. As Susan Himmelweit has emphasised, at the heart of care is a personal relationship between caregiver and care receiver.[140] Intrinsic to the quality of the care are the motivations of caregivers - care must be, or at least must appear to be, willingly given. A good care model creates the conditions for a good care relationship, in which care receivers are able to exercise agency and find genuine connection, while caregivers are able to find fulfillment, enjoyment and self expression. Developing such models should be the objective of a substantial major programme of investment, supporting imaginative experimentation in various aspects of provision.

**Ownership models** are a key area for experimentation. As discussed in section 4.2, we believe that the majority of care services should be publicly provided. Alongside the re-extension of public provision, there is an opportunity for local forms of provision that are democratically owned and governed to flourish alongside high quality care provided by local authorities. New governance models and new forms of worker ownership offer a means not only of raising pay and status, but of distributing power more fairly between workers, care receivers and other stakeholders (e.g. care receivers' families). Emerging examples of such experimentation include Wellbeing Teams, self-managing neighbourhood teams of carers inspired by the Dutch

Buurtzorg model,[141] Equal Care Co-op, a collectively owned online platform for care services, a

Equal Care Co-op and Cooperative Care Colne Valley

Equal Care Co-op (also known as Eccoo) is a platform-based social care and support co-operative currently being built in the Calder Valley, West Yorkshire. It aims to tackle power imbalances that can often characterise care work by giving agency to both caregivers and care receivers, and putting their relationship at the heart of the service.

Eccoo is being set up as an online platform, through which care workers and people seeking support can search for each other and find a good 'match' based on their respective needs. The platform technology helps create trusted relationships and removes much of the need for decision-making from managers. But unlike platforms backed by venture capital and beholden to shareholders, Eccoo is a multi-stakeholder co-operative, collectively owned by and run in the interest of care workers, care recipients and their families.

The use of platform technologies, self-management approaches and collective ownership models helps reduce overhead and management costs so that more money can be directed to the front line. These efficiencies are designed to enable a minimum wage for care workers set at 25 per cent above the industry average, while keeping pricing at market medium rates.[142]

Another interesting nascent example is Co-operative Care Colne Valley (CCCV), a multi-stakeholder care cooperative that is being established in the Colne Valley, West Yorkshire. CCCV, which recently achieved its fundraising target through a community share offer, is designed to permit hyper-local provision, pairing care workers with care receivers who live within walking distance of each other. This example is suggestive of the potential of locally-embedded care cooperatives not only to share power and wealth more fairly, but to localise services and thus cut down substantially on carbon emissions.

**Social micro-enterprises** are another form of provision that have gained attention for their ability to offer more personalised care, more autonomy for care workers, as well as wider social, economic and environmental benefits. Often registered as community interest companies (CICs), social micro-enterprises typically employ between one and five people, and are directed towards paying wages and providing good quality care rather than generating profits. Somerset Council, working with the social enterprise Community Catalyst, has successfully stimulated the creation of over 450 micro-enterprises providing care and home help, which have been found to achieve better outcomes than traditional home care agencies.[143] Wigan Council has similarly nurtured the creation of a series of CICs, and thus catalysed a major shift in the local social care market, with a reduction in the presence of national, private equity backed providers and, with it, improved standards in both care for the vulnerable and in employment for some of the lowest paid women in the borough.[144] Effective collaboration between care commissioners and business support services within the council was important in this transition, highlighting the importance of treating care as an important part of the local economy.

**Innovation in service models** is just as important as innovation in ownership models. As discussed in section 1.2, domiciliary care has become dominated by a narrow bio-maintenance

model, focused on delivering essential maintenance tasks in 15 minute slots. There is a crucial need to develop more holistic forms of care, with opportunities for a richer set of activities and social interactions, with more space for the agency and creativity of both care receivers and caregivers.

Co-production, in which care-receivers have a meaningful opportunity to shape services with their ideas and perspectives, has rightly become a widespread aspiration among commissioners - even if, in practice, embedding it systematically in services has proved challenging. Less widely recognised is the need to create more space for the autonomy, creativity and imaginative powers of front-line care workers. Nurturing co-production in this expansive sense would represent a step towards a genuinely inclusive innovation economy, where everyone has the chance to apply their imagination and creativity in work.[145] An interesting example of co-production which gives space for the creativity of both care recovers and front-line care workers is the '100 day challenge' approach used by Essex County Council. This method involves creating spaces for experimentation, in which care workers and care receivers with learning disabilities have worked together with local commissioners and other health and care system actors to redesign services.[146]

Experimentation with care models should not be limited to rethinking processes, roles and activities - it should also explore the way that care operates **spatially.** Researchers in the Foundational Economy collective have identified a narrowing of the care services available to elderly people in the UK.[147] The choice for many is now limited to either short, basic home visits, or moving to a residential home. However, there is no good reason to limit our institutional arrangements to these two polar options. A range of intermediate options exist which might improve the daily experience of both care givers and receivers. Experimentation is emerging, for example, with various forms of **co-housing,** which combine private living space with various degrees of shared communal facilities. As well as creating opportunities for agency and interaction for those who receive care, such arrangements could reduce the need for travelling by care workers, thus saving time and reducing carbon emissions.[148]



Finally, experimentation with **new digital technologies** may also have a role. While there should be no illusions about the capacity of technology to adequately replace human care, automating or facilitating administrative tasks could free up more time for the crucial 'human' and imaginative aspects of care work. New technologies could also give care recipients greater control over their daily lives and help them continue to interact with wider society.

To support all these forms of experimentation in provision, a major national programme of investment is required. An 'ageing society' currently features in the UK's industrial strategy as one of four 'Grand Challenges' to be addressed. But its stated aim of "harness[ing] the power of innovation to help meet the needs of an ageing society"[149] has often been understood narrowly, in terms of the development of tech solutions.

To reframe this challenge more broadly, we propose the establishment of a new, high-level national innovation mission: **Dignity in Adult Social Care.** This mission would not be understood as a top-down programme of reform, but a collective social project, harnessing the imagination of society at large. The local state would, however, play a crucial orchestrating role.

The centrepiece of this mission would be a substantial fund, coordinated nationally, but with spending largely devolved to local authority level. Local authorities could form interdisciplinary teams bringing together key departments (e.g. social care commissioning, local economic strategy), in concert with other local stakeholders (e.g. care worker representatives,

service user representatives, community and voluntary sector, the NHS, universities). These teams would be responsible for using the fund to support the development of alternative forms of social care provision, both by working with existing and nascent ethical providers, and by stimulating the emergence of new ones.

**Recommendation 7:**

**Establish a new national innovation mission directed towards 'Dignity in Adult Social Care', built around a major fund to support diverse new models of provision, to be devolved to local authority level.**

Investment in the capacity of local authorities to drive this process will also be important. As Timo Hämäläinen has noted, a characteristic feature of successful industrial upgrading in countries such as Finland has been the coordinating and facilitating role of state organisations.[150] This role is complex, and requires considerable capabilities and investment - which the market fails to provide. A segment of mission funding should thus be devoted to building the orchestration capacity of local authorities. This would include, for example, investment in specialised training, and in dedicated staff time for the work of coordination across departments and organisations. It would also support the development of capacities in the mapping of local provision, knowledge sharing, evaluation, and the creation of networks of best practice.

**Recommendation 8:**

**Ring-fence a segment of mission funding for building the capacity of local authorities as the orchestrators of innovation.**

Finally, if the value of new models of care is to be recognised, and if such new models are to be widely spread and embedded, innovation in the **inspection of care** will also be required. Current CQC metrics focus on the bio-maintenance needs of care recipients; their social needs, not to mention the working conditions of caregivers, are comparatively neglected.

It is vital to invest in the development of new metrics that better reflect the true value of care work and that leave room for experimentation with new models of care.[151] For this reason, we propose that further segments of the innovation mission funding should be used to set up a review of adult social care inspection, tasked with assessing current metrics and developing new ones.

Such new metrics are most likely to be meaningful if they result from a participative process in which both caregivers and receivers are allowed to identify what is important to them. An example of a more human and rounded approach to measurement is that adopted by Cornerstone, a Scottish care and support charity, which has stripped back the collection of key performance indicators to what is strictly required, freeing up time to capture stories exploring the difference being made in the lives of both care recipients and caregivers.[152]

**Recommendation 9:**

**Ring-fence a further segment of mission funding to set up a review of adult social care inspection, tasked with developing a new set of participatively-developed metrics.**

### — 4.5 Professionalisation, training, and continuous learning

New service models will be important in providing care workers with more autonomy, opportunities for creativity, and higher status. However, to ensure that such benefits are available for care workers throughout the sector, and not only those working in its emergent, experimental vanguard, a major revamp will be needed in approaches to **professionalisation, training, and continuous learning.**

The idea of social care as low-skilled work is reinforced by current low standards for training in the sector. Over half of the social care workforce has no relevant social care qualifications, and for frontline carers this figure is even lower.[153]

There is nothing 'low skilled' about the requirements of care work. We must move towards a system which recognises the depth of skill involved in care work and invests in it. An important step in achieving this will be introducing **compulsory registration for all adult social care workers in England** (a requirement that has already been introduced in Northern Ireland, Scotland and, from 2020, in Wales). Registration would make registered care workers accountable for their conduct, thus boosting professional standards. It would also change public perceptions about the role, affording it more professional status.

As the National Association for Care and Support Workers (NACAS) have highlighted,[154] Registration should not be based on the achievement of a single standardised qualification, but should rather be attainable through various pathways, including ones recognising skills gained through years of experience.

Critically, also, the cost registration should not fall on care workers; it should rather be covered by employers, either directly by providers, or via funding from a registration awarding body.

**Recommendation 10:**

**Introduce compulsory registration for all adult social care workers in England, along with the development of a suitable variety of pathways for registration. The cost of registration should be covered by employers.**



Crucially, training should not be a one-off activity, completed to satisfy minimum requirements for registration. As Riel Miller among others has argued, a society in which economic agency is democratised will necessarily also be a 'learning society', in which diverse forms of life-long learning play a crucial role.[155] Learning and development needs to be understood as a process that will continue throughout a care worker's career, just as it does for nurses and other medical professions. Access to continuous learning should be closely tied up with an explicit role for care workers as, in turn, the facilitators of life-long learning for the recipients of care. In Denmark, for example, care workers are trained to understand their role as helping care receivers to learn.[156] Life-long learning is widely recognised in policy documents as an important dimension of healthy ageing, but frequently neglected in practice.[157] A different approach to learning and professional development for care workers could be key in changing this.

Opportunities for continuous learning should also be associated with clearer pathways to progression. As Karolina Gerlich has argued, professional development should not only mean a move into management; pathways should be developed for specialisms in areas such as dementia, learning disabilities or palliative care.[158] Such progression should tie in with clear increases in responsibility and pay.

To move to a situation where all care workers have access to rich opportunities for continued training, and clear pathways for professional development, Skills for Care (the

employer-led workforce development body for adult social care in England) should receive a significant increase in resources. It should work with providers, trade unions, care worker's groups, and academics to define appropriate forms of continuous training. Providers should then commit to providing appropriate levels of continuous training as a condition of receiving a social license to operate (see section 4.1 above).

**Recommendation 11:**

**Significantly increase resources allocated to Skills for Care, and work with key stakeholders to define appropriate forms of continuous training, to be enforced through social licensing regulation.**

### — 4.6 Sectoral collective bargaining

The measures set out in the previous sections would create the conditions for a significant improvement in wages and conditions for care workers, and thus in the quality of care. However, they will not in themselves be sufficient. First, while the changes outlined above should lead to an increase in the minimum level of wages paid in the sector, they would not guarantee improvements across the full income distribution. Second, while social licensing and encouraging alternative operating models would create the conditions for more autonomy and better working conditions, exploitation and abuse would not be eradicated across the sector.

To tackle these issues, a **new system of sectoral collective bargaining** should be established for adult social care in England. This system would involve the creation of an **Adult Social Care Sector Forum,** comprising employers, unions, independent experts and other key civil society stakeholders, under the oversight of the relevant government ministry (currently the Ministry of Employment). The task of the forum would be to negotiate issues around pay, employment conditions and training opportunities, on an ongoing basis. Various models and proposals exist for the running of such a forum, with examples being the Sectoral Employment Commissions proposed by the Institute of Employment Rights[159] or the Fair Work Wales Forum in Social Care, as recommended by the Fair Work Commission.[160]

**Recommendation 12:**

**The UK government should legislate to establish a new system of sectoral collective bargaining for Adult Social Care in England: the Adult Social Care Sector Forum.**

### — 4.7 The adult social care sector as part of a green industrial strategy

Given the negative impact of accelerating climate change and environmental degradation on public and individual health and wellbeing, the care system will benefit enormously from a rapid reduction in carbon emissions. What's more, as currently stands, the sector is a small but significant contributor: the NHS and social care system in England account for between 4 and 5 percent of total emissions.[161] There is a double imperative to seek to rapidly decarbonise the care sector as part of a Green New Deal alongside the wider 'greening' effects of an economy recentred around care.

Of emissions from the NHS and social care, the NHS - which has better data for its environmental impacts - is the most significant contributor. Though important gains have been made, with overall carbon emissions from English health and social care having fallen by 19% since 2007,[162] clearly any transformative reduction in England and wider UK emissions will require a comprehensive strategy for actively decarbonising the sector.

A breakdown of NHS emissions illustrates the challenge for decarbonising care: 59 per cent of NHS carbon emissions are linked to procured goods, 24 per cent to direct energy use in buildings and 17 per cent to patient and staff travel. This suggests decarbonising social care should be part of a wider green industrial strategy, one that seeks to purposefully reshape supply and demand within the economy toward a low-carbon, sustainable future. Strategies to decarbonise the sector should then be linked up to efforts to 'green' the NHS as well as wider health and mobility supply chains. Decarbonising the care sector, which is vital to securing a low carbon future society more broadly, should be as much a central part of industrial strategy as those industries that are typically the focus of concerted policy intervention.

The NHS, which recently completed a consultation, A Net Zero NHS,[163] suggests how such an approach could begin, one that can both decarbonise the sector while ensuring better quality of work and care for all. This has included redesigning outpatient services, taking measures to reduce air pollution from the NHS's vehicle fleet, seeking to minimise the carbon emissions linked to the health service's supply chains, and procurement strategies at a Trust level that take into account environmental factors.

To that end, a critical goal of a radical industrial strategy for care should be transitioning the sector to net-zero by 2030. Learning from best practice from the NHS - both Trusts and clinicians - we recommend the following measures are implemented:

- **Measuring progress:** new requirements should be introduced requiring all care providers to measure and publish their environmental impacts annually as a way to better understand the source of emissions and how best to drive toward net-zero.

- **Buildings and estates:** a new requirement to make the building stock of care providers net-zero compliant by 2030 should be introduced; the public company that manages residential care properties should have access to a Decarbonising Care Fund, which can provide capital grants to 'green' building stock (ideally working in partnership with local publicly owned retrofitting companies).

- **Decarbonising supply chains:** care providers should undertake a review of their procurement processes and set out a clear timetable and plan for decarbonising supply chains.

- **Transport:** to eliminate emissions linked to transport, care workers should be eligible for a grant from the Decarbonising Care Fund to cover the cost of an electric vehicle; care providers should be required to introduce 100% electric fleets by 2030.

**Recommendation 13:**

**Introduce a new statutory requirement to decarbonise the sector by 2030 with care providers - backed by a new Decarbonising Care Fund - required to set out measurable plans to reach net-zero by the end of the decade, including through upgrading their building stock, electrifying mobility, and decarbonising supply chains.**

### — 4.8 Justice in unpaid care work

A radical industrial strategy for adult social care also needs to encompass a strategy to ensure justice in unpaid care work.

While this report has focused on the (sizeable) challenges of achieving dignity in paid care work, this should not be taken to mean that it would be either possible or desirable for all care to move from unpaid to paid sectors. Care work for a loved one is a deeply meaningful activity, which many people wish to perform, and which philosophers and theologians have suggested as a means of discovering our own humanity.[164] The problem is the failure of patriarchal societies to collectively treat it as such, instead penalising those - typically women

- who perform it. Unpaid care work serves in our society to reproduce gendered inequalities - but it need not, if it was more fairly shared, and better supported.

A full discussion of the range of measures that would be needed to achieve this is beyond the scope. However, a number of indicative suggestions can be made.

First, proper investment is needed in social and emotional support for carers, beyond the carers allowance they are entitled to. As the New Economics Foundation has noted, unpaid care is not "free", but may extract a significant mental health cost from carers (as well as an economic one).[165] A 2017 NHS England survey found that only 2% of unpaid carers had access to respite care.[166] A properly funded state system should be established to provide social and emotional support services for carers in all parts of the country.

**Recommendation 14:**

**Establish a properly funded state system to provide social and emotional support services for informal carers in all parts of the country.**

Second, labour market policies are needed to encourage an equal gender distribution of unpaid care work. Reducing working hours for all could enable a fairer sharing of both employment and care time.

Third, flexible working needs to be extended and made available without penalty. As the Women's Budget Group has recently highlighted, the opportunities for flexible working were unevenly distributed during the Covid-19 lockdown, with 44% of the lowest paid working from home, compared to 83% of the highest paid.[167] And while the Equality Act 2010 affords UK employees (with 26 weeks service) the right to request flexible working, women continue to experience a pay-penalty for part-time working.[168] This could be tackled through legislation requiring employers to increase the number of part-time jobs advertised, and to hire flexibly, rather than only allowing current employees to renegotiate hours.[169]



Fourth, wider actions will be needed to tackle gender inequality in the labour market, in order to tackle the unequally gendered 'opportunity cost' of care work.

**Recommendation 15:**

**Introduce a full package of measures to promote a fair gender distribution of unpaid care, including reduced working time, improving rights and access to flexible working, and wider actions to tackle gender inequalities in the labour market - whilst continuing to improve gender balance in paid work.**

# 5 Conclusion

— **After the Applause**

Covid-19 and the experience of lockdown has undoubtedly increased public recognition for the vital contribution of care workers, among other groups of key workers. The challenge is to sustain this recognition beyond the crisis, and to translate welcome applause into something more concrete. How can we substantially improve the material conditions and wellbeing of care workers and care receivers in the long term?

This report has emphasised that pouring more funding into the current broken system will be insufficient to achieve this. This is not only due to privatisation and financialisation, but also the way that care work, like other forms of reproductive labour, has been fundamentally undervalued and thus reductively understood. Rather than creating the conditions for positive and fulfilling care relationships, our current system reduces care work to the performance of basic bodily maintenance tasks, treating care receivers as maintenance problems.

Nor will a narrow focus on driving up productivity in the adult social care sector be sufficient. As discussed in section three, low productivity in care comes back in the end to the undervaluation of care work. This undervaluation is in a way self-fulfilling: poor conditions, poor pay and low training standards lead to poor quality services, in turn fuelling perceptions of care work as 'low-skilled'.

To address these issues, we have called for a **radical industrial strategy for adult social care.** Its aim would not simply be to boost productivity, but to increase the social value of adult social care, for care receivers, care givers, and society at large. It would focus on developing care services which meet the holistic social needs of care-receivers, securing them a full set of 'capabilities', rather than treating them as a maintenance problem serviced in 15 minute slots. It would ensure as a basic minimum a real Living Wage, as well as dignity, fulfilment and opportunities for creativity in work for care workers, through new models of care provision as well as through more funding.

Such a strategy would not narrowly target the private sector, but rather would focus on increasing and strengthening public provision, as well innovative forms of cooperative, voluntary and community provision. Anchoring this transition, **we believe that the public sector must return to its historic role, delivering the majority of adult social care.**



In calling for such an industrial strategy, we have also drawn attention to the strong - if often overlooked - connections between the devaluation of care work and the climate crisis. We have highlighted the tendency of reproductive labour to be less mobile and more locally-embedded than work in tradable sectors, and how this means that women tend to be disproportionately affected both by climate change and by attempts to tackle it through decarbonisation. Crucially, we have argued that in designing a more just and sustainable future economy, we need to orient our investment and energies towards those activities which enable and sustain human flourishing. Transforming care work therefore needs to feature as a key pillar of the Green New Deal - just as important as green manufacturing, technology and infrastructure.

It is not only care receivers and care workers who stand to gain. Recognising the value of care allows us to come to terms with the vulnerability that we all share. It gives those who have been indifferent to care have the chance to rediscover the humanity of those who labour in it - and, in the process, to rediscover their own.

## Select Financial Indicators

| Indicator | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 |
|---|---|---|---|---|---|---|
| **Care UK** | | | | | | |
| Net Debt | 308 | 298 | 262 | 265 | 258 | 379 |
| Net Debt/EBITDA (Leverage) | 10.7 | 9.6 | 8.9 | 9.9 | 2.7 | 13.1 |
| Debt Service | 18.9 | 15.9 | 15.5 | 17.9 | 26.9 | 55.7 |
| Shareholders' Equity | -20.2 | -15 | -6.1 | 9.4 | 44.7 | 72.8 |
| Highest Paid Director Salary | | 1.0 | 0.9 | 0.9 | 0.5 | 0.6 |
| No. of Employees* (#) | | 15,900 | 15,150 | 14,560 | 18,890 | 22,100 |
| **Barchester** | | | | | | |
| Net Debt | | 172 | 182 | 209 | 213 | 190 |
| Net Debt/EBITDA (Leverage) | | 2.5 | 3.3 | 4.3 | 4.9 | 4.4 |
| Debt Service | | 53.8 | 67.6 | 86.0 | 85.5 | 50.9 |
| Shareholders' Equity | | 134 | 123 | 112 | 110 | 109 |
| Highest Paid Director Salary | | 0.9 | 0.9 | 0.7 | 0.7 | 0.6 |
| No. of Employees (#) | | 15,750 | 15,460 | 16,270 | 17,620 | 18,680 |
| **HC-One** | | | | | | |
| Net Debt | | | | | | |
| Net Debt/EBITDA (Leverage) | | | | | | |
| Interest Paid | 6.6 | 5.9 | 5.3 | 3.2 | 14.4 | 3.7 |
| Shareholders' Equity | 14.6 | 14.2 | 20.7 | 30.7 | 34.2 | -31.6 |
| Highest Paid Director Salary | 0.8 | 0.5 | 0.3 | 0.3 | 0.3 | 0.6 |
| No. of Employees (#) | 11,300 | 10,950 | 10,960 | 11,300 | 12,070 | 13,560 |
| **Four Seasons Health Care Ltd.** | | | | | | |
| Debt Service | | 330 | 41 | 42 | 129 | 223 |
| Net Debt | | 608 | 44 | 38 | 52 | 218 |
| Net Debt/EBITDA (Leverage) | | | 29.0 | 60.9 | 58.7 | |
| Shareholders' Equity | | -305 | -44.1 | -43.3 | -43.2 | -46.3 |
| Highest Paid Director Salary | | | | | | |
| No. of Employees (#) | | | | | | |
| **Elli Finance (UK) Plc** | | | | | | |
| Net Debt | | | 561 | 531 | 490 | 495 |
| Debt Service | | | 362 | 136 | 102 | 88.3 |
| Debt Service % of Normalized after Tax Profit | | | 3,935.3% | 2,820.2% | 35,001.9% | |
| Shareholders' Equity | | | 222 | 447 | 448 | 457 |



*Care UK notes their residential care staffing numbers have increased over the period shown, despite a decline in overall staff numbers due to the division of parts of the business. They provided like-for-like figures for the report, showing this value increased from 8,865 (2014) to 10,180 (2019).

A note on figures: Because of the opacity of the companies' structures and consequent variability in access to data, not all data points were disclosed for every provider. Sources include Companies House filings and mainstream financial databases Thomson Reuters Eikon and Orbis. The companies shown engage in a range of services including residential care, health care services etc.; however, due to data availability, the 'Number of employees' shown reflects the full corporate group, not residential care alone. Note that while consolidated filings were sought for each group, consolidated balance sheet data could not be obtained for HC-One, so these figures are omitted. Thus, due to data availability, in lieu of total debt service, annual interest for HC-One is reported. Due to complex corporate structures, a representative picture of total debts can be difficult to obtain for certain, as loans may be owed to other companies within the overall corporate structure, as opposed to externally. Data is derived from Thomson Reuters Eikon, Orbis and Companies House.

Endnotes

1 Hodgson, K. et al. (2020) Adult social care social care and Covid-19: Assessing the impact on social care users and staff in England so far, The Health Foundation. Available at: https://www.health.org.uk/publications/reports/adult-social-care-and-covid-19-assessing-the-impact-on-social-care-users-and-staff-in-england-so-far

2 Office for National Statistics (2020) Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 20 July 2020, available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/adhocs/12112deathsinvolvingthecoronaviruscovid19amonghealthandsocialcareworkersinenglandandwales-deathsregisteredbetween9marchand20july2020

3 Future Care Capital (2019) 'Data that Cares'. https://futurecarecapital.org.uk/research/data-that-cares/

4 Gilroy, R. (2020) 'Hancock asked if nurses should be paid more after Covid-19 crisis', Nursing Times. Available at: https://www.nursingtimes.net/news/workforce/hancock-asked-if-nurses-should-be-paid-more-after-covid-19-crisis-06-04-2020/

5 Khurana, I., Kikuchi, L., and Stronge, W. (2020) The Work of COVID: care work and care home mortality, Autonomy. https://autonomy.work/portfolio/careandcarehomes/#1588759570965-9424737d-e0ba

6 e.g. Federici, S. (2012 [2009]) 'On elder care work and the limits of Marxism', in Federici, S. (2012) Revolution at Point Zero: Housework, Reproduction and Feminist Struggle, Oakland, CA: Common Notions/PM Press; Verschuur, C., and F. Calvão. 2018. Revalorization of Social Reproduction through Social and Solidarity Economy Practices. UNRISD Issue Brief;

; Jancz, C. et al. (2018) Feminist practices for economic change: women's autonomy and agroecology in the Vale do Ribeira region. Sao Paulo: SOF - Sempreviva Organização Feminista

; Bhattacharya, T., (2018) Mapping Social Reproduction Theory, in ed. Bhattacharya, T., Social Reproduction Theory: Remapping Class, Recentering Oppression, London: Pluto Press

7 Federici, S. and Sitrin, M (2016) 'Social Reproduction: Between the Wage and the Commons'. ROAR Magazine, Issue no. 2, Summer 2016. Available at: https://roarmag.org/magazine/social-reproduction-between-the-wage-and-the-commons/

8 e.g. Age UK (2018) "Why call it care when nobody cares?" An Age UK campaign report about how older people and their families experience the crisis in social care. Available at: https://www.ageuk.org.uk/bp-assets/globalassets/north-staffordshire/resources/why_call_it_care_when_nobody_cares.pdf

9 Federici, S., op. cit.

10 Sweeney, R., and Thissen, L. (2020) Time to Care! Work, life and inequality in the care economy, Foundation for European Progressive Studies. Available at: https://www.feps-europe.eu/attachments/publications/feps_tasc_policybrief_timetocare.pdf

11 National Audit Office (2017) A Short Guide to Local Authorities. Available at: https://www.nao.org.uk/wp-content/uploads/2017/09/A-Short-Guide-to-Local-Authorities.pdf

12 Lewis, J., & West, A. (2014). Re-Shaping Social Care Services for Older People in England: Policy Development and the Problem of Achieving 'Good Care'. Journal of Social Policy, 43(1), 1-18. doi:10.1017/S0047279413000561

13 Hudson, B. (2016) The failure of privatised adult social care in England: what is to be done? Centre for Health and the public interest. Available at: https://chpi.org.uk/wp-content/uploads/2016/11/CHPI-SocialCare-Oct16-Proof01a.pdf

14 Ibid.

15 Hudson, B. (2018) Adult social care: is privatisation irreversible? London School of Economics Blog, Available at: https://blogs.lse.ac.uk/politicsandpolicy/adult-social-care-is-privatisation-irreversible/#-Author

16 Campbell, D. (2019) '84% of care home beds in England owned by private firms' The Guardian, Available at: 'https://www.theguardian.com/society/2019/sep/19/84-of-care-home-beds-in-england-owned-by-private-firms

17 Epstein, G (2005) Financialization and the World Economy. Edward Elgar Press.

18 Horton, A. (2019) Financialization and non-disposable women: Real estate, debt and labour in UK care homes. Economy and Space. https://journals.sagepub.com/doi/10.1177/0308518X19862580

19 Future Care Capital (2019) 'Data that Cares'. https://futurecarecapital.org.uk/research/data-that-cares/

20 It is noted that Four Seasons is now effectively owned by its primary creditor, H/2 Capital Partners, a hedge fund, though private equity firm Terra Firma remains nominal owner.

21 Mackridge, K., Five things social care workers need - that won't be fixed by a badge, Trades Union Congress, Available at: https://www.tuc.org.uk/blogs/five-things-social-care-workers-need-wont-be-fixed-badge

22 See e.g. Plimmer, Gill (July 2019) 'Britain's biggest care homes rack up debts of £40,000 per bed'. Financial Times. https://www.ft.com/content/17c353c8-91b9-11e9-aea1-2b1d33ac3271.

23 Birrell, Ian. The care home crisis that long predates coronavirus. The New European. https://www.theneweuropean.co.uk/top-stories/ian-birrell-on-historic-care-home-crisis-1-6664952

24 Burns, D. et al. (2016a) Where does the money go? Financialised chains and the crisis in residential care, CRESC Public Interest Report. Available at: http://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf

25 Ibid.

26 Ibid.

27 Hodgson, Leah, Pandemic deepens woes of UK's private equity-back care homes, Pitchbook. 21 September, 2020. https://pitchbook.com/news/articles/pandemic-private-equity-backed-nursing-homes

28 Burns, D. et al. (2016a) Op. Cit.

29 Plimmer, Gill (2016) HC-One plans £200m sale and leaseback deal to reduce debt. Financial Times. https://www.ft.com/content/9b49df6a-2d61-11e6-bf8d-26294ad519fc

30 Horton, A. (2019) Financialization and non-disposable women: Real estate, debt and labour in UK care homes. Economy and Space. https://journals.sagepub.com/doi/abs/10.1177/0308518X19862580

31 See Table 1

32 Naylor, A., and Magnusson, J. (2019) Data That Cares, Future Care Capital. https://futurecare-capital.org.uk/research/data-that-cares/



33 Hodgson, Leah, Pandemic deepens woes of UK's private equity-back care homes, Pitchbook. 21 September, 2020. https://pitchbook.com/news/articles/pandemic-private-equity-backed-nursing-homes

34 Blakeley, Grace and Harry Quilter-Pinner, Who Cares? The financialisation of adult social care, Institute for Progressive Policy Research. September 2019. http://www.ippr.org/research/publications/financialisation-in-social-care.

35 Ibid.

36 Ibid.

37 Plimmer, Gill (July 2019) 'Britain's biggest care homes rack up debts of £40,000 per bed'. Financial Times. https://www.ft.com/content/17c353c8-91b9-11e9-aea1-2b1d33ac3271

38 Though the research cited examined the Big Four as a group, findings are not always uniform. For example, Barchester noted that due to recent investment, 88% of its services were rated good or outstanding by CQC in 2020.

39 Ibid.

40 Ibid.

41 See Table 1. Data derived from Orbis and Thomson Reuters Refinitiv databases.

42 Burns et al. (2016a) 'Where does the money go? Financialised chains and the crisis in residential care: CRESC Public Interest Report'. Centre for Research on Socio Cultural Change. http://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf

43 Ruddick, G. (April 2016). Four Seasons Health Care reports £264m annual loss. The Guardian. Available at: https://www.theguardian.com/business/2016/apr/27/four-seasons-health-care-reports-264m-annual-loss

44 BBC (2011). 'Southern Cross set to shut down and stop running homes'. BBC News. https://www.bbc.co.uk/news/business-14102750

45 Plimmer, Gill (2019). 'Four Seasons to be taken over by H/2 Capital Partners'. Financial Times https://www.ft.com/content/eab8c4c4-d49a-11e9-8367-807ebd53ab77

46 Jarrett, Tim (Nov. 2019) 'Four Seasons Health Care Group: Financial difficulties and safeguards for clients'. House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/cbp-8004/

47 Future Care Capital (2019) 'Data that Cares'. https://futurecarecapital.org.uk/research/data-that-cares/

48 Jarrett, Tim (Nov. 2019) 'Four Seasons Health Care Group: Financial difficulties and safeguards for clients'. House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/cbp-8004/

49 2014 was selected as the start year to enable a minimum of 5 years data to evaluate for each company. HC-One and Care UK have filings up to 2019 available on Companies House, while Barchester and Four Seasons' filings, at the time of this report, are available only until December 2018. Unless otherwise indicated, figures reflect the most recent filings.

50 Equivalent data for Four Seasons group was not available.

51 Data derived from Orbis database. Note that 2018 the latest disclosure date with all companies reporting. Figures refer to full company staffing, not just residential care

52 Plimmer, G (July 2019) 'Britain's biggest care homes rack up debts of £40,000 per bed'. Financial Times. https://www.ft.com/content/17c353c8-91b9-11e9-aea1-2b1d33ac3271

53 Barchester state that capital investment and staff numbers have increased significantly in 2019-20, although their most recent accounts (for year end 31 December 2019) have yet to be filed.

54 Hodgson, Leah (21 September 2020). 'Pandemic deepens woes of UK's private equity-back care homes'. Pitchbook. https://pitchbook.com/news/articles/pandemic-private-equity-backed-nursing-homes

55 Mackridge, K., Five things social care workers need - that won't be fixed by a badge, Trades Union Congress, Available at: https://www.tuc.org.uk/blogs/five-things-social-care-workers-need-wont-be-fixed-badge

56 Burns et al.,(2016a) Where does the money go? Financialised chains and the crisis in residential care, CRESC Public Interest Report

57 Kikuchi, L and Khurana (2020) 'The Jobs at Risk Index', Autonomy. https://autonomy.work/portfolio/jari/

58 Smith Institute/Unison (2014), Outsourcing the Cuts: pay and employment effects of contracting out; quoted in Hudson, B. (2016) op. cit.

59 Ibid.

60 Skills for Care (2020) 'The state of the adult social care sector and workforce in England' (October 2020), available at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf

61 Hudson, B. (2018) Will 2018 be the year the adult social care market in England collapses? Research, Policy and Planning (so17/18) 33 (1), 27-34

62 Burns, D., Hyde, P. and Killett, A. (2016) How financial cutbacks affect job quality and care of the elderly. Industrial Labor Relations Review. ISSN 0019-7939; cited in Hudson, B. (2016) op. cit.

63 Ibid.

64 Local Government Association (based on ONS 2011 Census) 'Black and minority ethnic (BME) population (%) in England', Available at: https://lginform.local.gov.uk/reports/lgastandard?mod-metric=3296&mod-area=E92000001&mod-group=AllRegions_England&mod-type=namedComparisonGroup

65 Local Government Association (based on ONS 2011 Census) 'Percentage of usual residents who are Black/African/Caribbean/Black British in England', Available at: https://lginform.local.gov.uk/reports/lgastandard?mod-metric=2126&mod-area=E92000001&mod-group=AllRegions_England&mod-type=namedComparisonGroup; Skills for Care (2020).

66 Skills for Care, 'Workforce nationality figures: The impact of the EU referendum on the adult social care sector', https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Workforce-nationality.aspx

67 Williams, F. (2017) Migrant Women and the Global Care Chain, 'The Absence of Paths', Available at: http://www.theabsenceofpaths.com/commission/migrant-women-and-the-global-care-chain

68 Brennan D, Cass B, Himmelweit S, Szebehely M. The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. Journal of European Social Policy. 2012;22(4):377-391. doi:10.1177/0958928712449772

69 Naylor, A., and Magnusson, J. op. cit.

70 Burns, D., et. al., (2016b) Why we need social innovation in home care for older people, CRESC Public Interest Report. https://www.alliancembs.manchester.ac.uk/news/why-we-need-social-innovation-in-home-care-for-older-people/

71 Age UK, op. cit; Federici op. cit.

72 Commission on Dignity in Care, (2012); Delivering Dignity: Securing dignity in care for older people in hospitals and care homes, NHS Confederation. Available at: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Delivering_Dignity_final_report150612.pdf

73 Hodgson, K. et al., Op. cit.

74 Booth, R. (2020) 'Agency staff were spreading Covid-19 between care homes, PHE found in April', The Guardian, Available at: https://www.theguardian.com/world/2020/may/18/agency-staff-were-spreading-covid-19-between-care-homes-phe-found-in-april

75 Hodgson, K. et al.

76 Ibid.

77 Office for National Statistics (2020) Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 20 July 2020, available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/adhocs/12112deathsinvolvingthecoronaviruscovid19amonghealthandsocialcareworkersinenglandandwales-deathsregisteredbetween9marchand20july2020

78 Office of National Statistics (2020) Deaths involving Covid-19 among men and women health and social care workers, Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020#deaths-involving-covid-19-among-men-and-women-health-and-social-care-workers

79 Booth, R. (2020) 'Falling care home demand since Covid poses threat to UK', The Guardian, Available at: https://www.theguardian.com/world/2020/aug/27/coronavirus-impact-made-uk-social-care-crisis-even-more-acute

80 Booth, R., (2020) 'Coronavirus: infection control fund for English care homes to double', The Guardian, Available at: https://www.theguardian.com/society/2020/sep/17/coronavirus-infection-control-fund-for-english-care-homes-to-double

81 Plumwood, V. (1993) Feminism and the Mastery of Nature . London: Routledge

82 Cohen, M., and MacGregor, S. (2020) Towards a Feminist Green New Deal for the UK, Paper for the Womens Budget Group Commission on a Gender-Equal Economy. Available at: https://wbg.org.uk/wp-content/uploads/2020/05/Feminist-Green-New-Deal.pdf

83 E.g. Block, F., (2010) Crisis and renewal: the outlines of a twenty-first century new deal, Socio-Economic Review 9: 311 - 357

84 Dale, G., et al. (2016) Green Growth: Ideology, Political Economy and the Alternatives, London: Zed Books.

85 85 Wainwright, J., Mann, G., Climate Leviathan: A Political Theory of Our Planetary Future, London: Verso, 2018.; Graham, Stephen 'Green Capitalism': a critical review of the literature: part 3, RS21, Available at: https://www.rs21.org.uk/2019/03/16/revolutionary-reflections-green-capitalism-a-critical-review-of-the-literature-part-iii/#_ftn24

86 Mellor, M. (2017) 'Ecofeminist political economy: a feminist and green agenda' In S. MacGregor (ed.) The Routledge Handbook of Gender and Environment;

87 Alam, M., Bhatia, R., and Mawby., B. (2015), Women and Climate Change: Impact and Agency in Human Rights, Security, and Economic Development, Georgetown Institute for Women, Peace and Security, Available at: https://www.climateinvestmentfunds.org/sites/cif_enc/files/knowledge-documents/georgetown_women_and_climate_change_2015.pdf; see also WEDO (2008). "Case Study: Gender, Human Security and Climate Change: Lessons from Bangladesh, Ghana and Senegal". New York: WEDO, Available at: http://www.gdnonline.org/resources/WEDO_Gender_CC_Human_Security.pdf

88 Cohen, M. and MacGregor, op. cit.

89 Wilson, J. and Chu, E., (2020) The embodied politics of climate change: analysing the gendered division of environmental labour in the UK, Environmental Politics, 29:6, 1085-1104

90 Cohen, M. and MacGregor, op. cit.

91 Bhattacharya, T., (2019) Three Ways a Green New Deal Can Promote Life Over Capital, Jacobin, Available at: https://jacobinmag.com/2019/06/green-new-deal-social-care-work

92 Boff, L. (2008 [1999]) Essential Care: An Ethics of Human Nature, Baylor University Press

93 The Care Collective (2020), Care Manifesto: The Politics of Interdependence, London: Verso

94 Sarr, Felwine (2020), 'Pour une économie du vivant', Seneplus, Available at: https://www.seneplus.com/opinions/pour-une-economie-du-vivant

95 Kearney J and White A (2018) The Economic Value of the Adult Social Care sector -England. Final Report. Skills for Care and Development. Available at: https://www.skillsforcare.org.uk/About/Skills-for-Care-and-Development/The-economic-value-of-the-adult-social-care-sector-UK.aspx

96 Skills for Care (2020) The size and structure of the adult social care sector and workforce report in England, 2020. Available at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2020.pdf

97 https://media.nesta.org.uk/documents/Loves_Labours_Found.pdf

98 Fothergill, S., Gore, T., Wells, P. (2017) Industrial Strategy and the Regions. The Shortcomings of a Narrow Sectoral Focus. CRESR, Available from: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/cresr30th-industrial-strategy-regions.pdf

99 e.g. Jones, R. (2019) 'A Resurgence of the Regions: rebuilding innovation capacity across the whole UK. Working paper'. Available online at: http://www.softmachines.org/wordpress/wp-content/uploads/2019/05/ResurgenceRegionsRALJv22_5_19.pdf; Forth, J., Innes, D., and Rincon-Aznar, A. (2018) Where should low-wage sectors feature in an industrial strategy? in ed. Berry, C., What We Really Mean When We Talk About Industrial Strategy, Manchester: Future Economies, Available at: https://www.mmu.ac.uk/media/mmuacuk/content/documents/business-school/future-economies/WHAT_IND-STRAT___BERRY_NOV18.pdf;

; Jacobs et al., (2017) (2017) Industrial Strategy: Steering Structural Change in the UK Economy. A Discussion Paper. London: IPPR Commission on Economic Justice.



100 Fischer, A., (2018), Poverty as Ideology: Rescuing Social Justice from Global Development Agendas, London: Zed Books

101 For an overview, see Nell, E., (1967) 'Theories of Growth and Theories of Value', Economic Development and Cultural Change, vol 16, 15-26; Blecker, R., and Setterfield, M., (2019) Heterodox Macroeconomics: Models of Demand, Distribution and Growth. Edward Elgar publishing.

102 Ciarli, T., Salgado, E., and Savona, M.,(2018), Does increasing firm and sector productivity drive up wages for workers? Joseph Rowntree Foundation. Available at: https://www.jrf.org.uk/report/does-increasing-firm-and-sector-productivity-drive-wages-workers

103 Froud, J., Haslam, C., Johal, S., & Williams, K. (2020). (How) does productivity matter in the foundational economy? Local Economy.

104 Riley, R., and Bondibene, C., R. (2015), Raising the Standard: Minimum Wages and Firm Productivity, NIESR Discussion Paper Number 449, Available at: https://www.niesr.ac.uk/sites/default/files/publications/Minimum%20wages%20and%20firm%20productivity%20NIESR%20DP%20449.pdf

105 Forth, J., Innes, D., and Rincon-Aznar, A. Mind the gap: productivity in the UK's low-wage sectors, NIESR, https://www.niesr.ac.uk/blog/mind-gap-productivity-uk%E2%80%99s-low-wage-sectors

106 Pemberton, E., (2018) 'A question of value: raising productivity by lowering inequality', in ed. Berry, C., What We Really Mean When We Talk About Industrial Strategy, Manchester: Future Economies, Available at: https://www.mmu.ac.uk/media/mmuacuk/content/documents/business-school/future-economies/WHAT_IND-STRAT___BERRY_NOV1

107 Kearney J, (2018) 'Economic value of the adult social care sector in the UK. Additional analysis' ICF Consulting Services Limited for Skills for Care and Development. https://www.skillsforcare.org.uk/About/Skills-for-Care-and-Development/The-economic-value-of-the-adult-social-care-sector-UK.aspx

108 This observation formed part of Baumol's famous analysis of the 'cost disease' in developed economies, in which (real) wages in services rise faster than any observable changes in 'productivity'. This appeared to violate the neoclassical theory of wages being determined by marginal productivity. Baumol reconciles this observation with neoclassical theory by treating rising service-sector wages as the result of increased competition for workers in a society where productivity (and thus wages) in manufacturing are constantly

rising. But it should be noted that there is no need to accept Baumol's marginalist logic wholesale to benefit from his insight into the distinctive features of what he aptly terms 'handicraft' services. See: Baumol, W. (1993). Social Wants and Dismal Science: The Curious Case of the Climbing Costs of Health and Teaching. Proceedings of the American Philosophical Society, 137(4), 612-637. See also: Himmelweit, S. (2013) 'Care: feminist economic theory and policy challenges' Journal of Gender Studies Ochanomizu University, 16.; Fischer, A., op. cit.

109 Himmelweit, op. cit.

110 Federici, op. cit.

111 Froud, J., Haslam, C., Johal, S., & Williams, K. op. cit. ; Reeves, R., (2019) A radical future: Rebuilding Britain with the Everyday Economy, in ed. Reeves, R., (2019) Everyday Socialism: How to Rebuild Britain, Fabian Society

112 Calafati L, Johal S, Froud J and Williams K (2019) Building foundational Britain: From paradigm shift to new political practice? Renewal 27(2): 13-23.

113 Froud J, Haslam C, Johal S and Williams K (2020) Cohesion through housing. Residual income, housing tenure and UK regional policy. Foundational Economy Collective: Working Paper No.6. https://foundationaleconomycom.files.wordpress.com/2020/02/fec-wp6-residual-income.pdf

114 Calafati, L., Johal, S., Froud, J. and Williams, K. op. cit.

115 Froud, J., and Williams, K., op. cit.; Reeves, R., (2019) A Radical future: Rebuilding Britain with the Everyday Economy, in ed. Reeves, R., (2019) Everyday Socialism: How to Rebuild Britain, Fabian Society

116 Himmelweit, S. (2018) Care as investment in social infrastructure, in ed. Berry, C., What We Really Mean When We Talk About Industrial Strategy, Manchester: Future Economies, Available at: https://www.mmu.ac.uk/media/mmuacuk/content/documents/business-school/future-economies/WHAT_IND-STRAT___BERRY_NOV18.pdf;

117 Burns D. et al. (2016) 'Where does the money go?' Op. Cit.

118 O'Neill, M. (2020). Power, Predistribution, and Social Justice. Philosophy, 95(1), 63-91.

119 Quilter-Pinner, H. (2019) Ethical Care: A Bold Reform Agenda for Adult Social Care, Institute for Public Policy Research. Available at: https://www.ippr.org/files/2019-11/ethical-care-nov19.pdf

120 Butler, P. (22 October 2020) 'Social care in England needs input of at least £7bn a year, say MPs'. The Guardian. Available at: https://www.theguardian.com/society/2020/oct/22/social-care-in-england-needs-input-of-at-least-7bn-a-year-say-mps

121 Personal and Nursing Care (2019), Scottish Government. https://www.mygov.scot/personal-nursing-care/costs/#:~:text=Personal%20care%20provided%20by%20your,may%20be%20charged%20for%20it.

122 Quilter-Pinner, H. and Hochlaf, D., Social Care: Free at the Point of Need, Institute for Public Policy Research, Available at: https://www.ippr.org/files/2019-05/social-care-free-at-the-point-of-need-may-19-summary.pdf

123 Corlett, A., Advani, A., and Summers, A. (2020) Who gains? The importance of accounting for capital gains. Resolution Foundation. Available at: https://www.resolutionfoundation.org/app/uploads/2020/05/Who-gains.pdf

124 Mitchell, R; McNamara, G and Seymour, C (2018) 'A taxing question reference', Independent Age. https://www.independentage.org/a-taxing-question-how-to-fund-free-personal-care-report

125 Women's Budget Group (30 Sept. 2020) https://wbg.org.uk/media/press-releases/new-polling-public-wants-an-economy-that-prioritises-care-and-equality-and-they-are-willing-to-pay-more-tax-for-this/

126 Goodwin, T. L., Bilsborough, J., and McInroy, N. (2020) Restoring public values: the role of public procurement, Centre for Local Economic Strategies. Available at: https://cles.org.uk/publications/restoring-public-values-the-role-of-public-procurement/

127 Goodwin., T. L., Burch, D., and McInroy, N. (2020) A progressive approach to adult social care, Centre for Local Economic Strategies. Available at: https://cles.org.uk/publications/a-progressive-approach-to-adult-social-care/

128 ibid.

129 see Centre for Local Economic Strategies (2020), Own the Future: A guide for new local economies, available at: https://cles.org.uk/wp-content/uploads/2020/07/Own-the-future-revised-mutuals-copy.pdf; Centre for Local Economic Strategies (2019) Community Wealth Building 2019. Theory, practice and

next steps, available at:https://cles.org.uk/publications/community-wealth-building-2019/ ; Guinan, J., and O'Neill, M., (2019) The Case for Community Wealth Building, Bristol: Policy Press

130 see: Goodwin., T. L., Burch, D., and McInroy, N. op. cit.

131 Grant Thornton (2018) Care Homes for the Elderly: Where are we now? https://www.grantthornton.co.uk/globalassets/1.-member-firms/united-kingdom/pdf/documents/care-homes-for-the-elderly-where-are-we-now.pdf

132 Burns, D. et al.,(2016a) Where does the money go? Financialised chains and the crisis in residential care, CRESC Public Interest Report. https://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf

133 Ibid.

134 Ibid.

135 **Goodwin, T. L., Bilsborough, J., and McInroy, N, op. cit.**

136 Froud, J., and Williams, K (2019) Adding Value: Social Licensing for the common good, in ed. Reeves, R. (2019) Everyday Socialism: How to Rebuild Britain, The Fabian Society

137 Goodwin, T. L., Bilsborough, J., and McInroy, N, op. cit.

138 Goodwin., T. L., Burch, D., and McInroy, N. op. cit.

139 Centre for Local Economic Strategies (2019) op. cit.

140 Himmelweit, S. (2013) op. cit.

141 See https://wellbeingteams.org/ and https://www.buurtzorg.com/

142 Interview with Emma Back, Equal Care Co-op, 23 January 2020; Borkin, S., (2019) Platform co-operatives - solving the capital conundrum. London: Nesta; Lloyd, J (2019) 'Equal Care: The platform co-op radically reimagining social care' Nesta, 12 June 2019, Available at : https://www.nesta.org.uk/blog/equal-care-platform-co-op-radically-reimagining-social-care-one-relationship-time/

143 Bedford, S., and Phagora, J., (2020) Community Micro-Enterprise in Social Care, New Economics Foundation, Available at: https://neweconomics.org/2020/05/community-micro-enterprise

144 Centre for Local Economic Strategies (2020), Own the Future: A guide for new local economies, available at: https://cles.org.uk/wp-content/uploads/2020/07/Own-the-future-revised-mutuals-copy.pdf;

145 Unger, R., Stanley, I., Gabriel, M., Mulgan, G., (2019) Imagination Unleashed: Democratising the Knowledge Economy. London: Nesta; Unger, R. (2019) The Knowledge Economy, Verso.

146 Salman, S., (2019) 'A chance to have my own voice': the care users redesigning support' The Guardian, 10 September 2019, Available from: https://www.theguardian.com/society/2019/sep/10/service-users-redesigning-care-learning-disability-autism-essex (accessed 9 February 2020)

147 Buns, D., et. al., (2016b) op. cit.

148 Hall, M. (2018) Public Land is a Feminist Issue, New Economics Foundation, available at: https://neweconomics.org/2018/08/public-land-is-a-feminist-issue; Hester, H. (2017) The World Transformed through Care, Juncture, available at: https://www.ippr.org/juncture-item/the-world-transformed-through-care-by-helen-hester

149 BEIS (2017) 'Industrial Strategy: Building a Britain Fit for the Future'. Department for Business, Energy and Industrial Strategy. https://www.gov.uk/government/publications/industrial-strategy-building-a-britain-fit-for-the-future

150 Hämäläinen, T, (2016) 'Structural Adjustment, Emerging Business and New Industrial Policy.' FInnish Innovation Fund, Sitra.https://www.researchgate.net/publication/322203196_STRUCTURAL_ADJUSTMENT_EMERGING_BUSINESS_ECOSYSTEMS_AND_NEW_INDUSTRIAL_POLICY

151 Burns, D., Froud, J., and Roper, A.(2018) 'Report from the care workshop at the Social Innovation in the Foundational Economy colloquium, Ebbw Vale, 6th September 2018.' Available online from: https://foundationaleconomycom.files.wordpress.com/2018/10/workshop-report-procurement-ebbw-vale-sept-2018.docx

152 Lowe, T. and Plimmer, D. (2019) Exploring the New World: Practical insights for funding, commissioning and managing in complexity. London: Collaborate. https://collaboratecic.com/exploring-the-new-world-practical-insights-for-funding-commissioning-and-managing-in-complexity-20a0c53b89aa

153 Quilter-Pinner, H. (2019) 'Ethical Care: A Bold Reform Agenda for Adult Social Care', IPPR. https://www.ippr.org/files/2019-11/ethical-care-nov19.pdf

154 Gerlich, K. (2019) Why should care providers in England demand compulsory registration for its workers, Home Care Insight, Available at: https://www.change.org/p/department-of-health-and-social-care-make-the-registration-of-care-workers-compulsory-in-england

https://www.homecareinsight.co.uk/opinion-why-should-care-providers-in-england-demand-compulsory-registration-for-its-workers/

155 Miller, Riel. (2009). Skills: Banal Creativity and Spontaneity in a Learning Intensive Society, in Andrew, C., et al., Gilles Paquet: homo hereticus, University of Ottawa Press

156 Himmelweit, S., (2018), op. cit.

157 Kydd, A., and Fulford, H., Access to Learning Opportunities for Residents in Care Homes: Reviewing the challenges and possibilities, Maturitas, Volume 140, 2020, Pages 14-23,

158 Gerlich, K., op. cit.

159 Hendy, J., and Ewing, K., (2017) What is Sectoral Collective Bargaining, Institute of Employment Rights, Available at: https://www.ier.org.uk/comments/ier-fact-news-what-sectoral-collective-bargaining/

160 Fair Work Wales (2019), Report of the Fair Work Commission, Available at: https://gov.wales/sites/default/files/publications/2019-05/fair-work-wales.pdf

161 A Net Zero NHS (2020), NHS England. https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/

162 Public Health England (2018) 'Reducing the use of natural resources in health and social care 2018 report', https://www.sduhealth.org.uk/documents/Policy%20and%20strategy/20180912_Health_and_Social_Care_NRF_web.pdf

163 A Net Zero NHS (2020), NHS England. https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/

164 e.g. Boff, L. op. cit.; The Care Collective (2020) op. cit.

165 Chapman, A., Unpaid Care Isn't Free, New Economics Foundation, Available at: https://neweconomics.org/2019/06/unpaid-care-isnt-free

166 NHS Digital (2017) Health Survey for England 2017, available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2017

167 Women's Budget Group (30 June 2019). Flexible working beyond COVID-19: Open Letter. https://wbg.org.uk/media/open-letters/flexible-working-beyond-covid-19/

168 Dias, Monica Costa et al. (2018). Wage progression and the gender wage gap: the causal impact of hours of work. Institute for Fiscal Studies. https://www.ifs.org.uk/uploads/publications/bns/BN223.pdf

169 Roper, Jenny (2018). Mothers suffer part-time pay penalty. HR Magazine. https://www.hrmagazine.co.uk/article-details/mothers-suffer-part-time-pay-penalty.