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WHO WILL CARE?

HOW CAN WE MEET THE SCALE OF THE CARE CHALLENGE?

DISCUSSION PAPER

Abby Jitendra

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FOREWORD

When our son John was little, we were told he would almost certainly never walk or speak.

John has an undiagnosed neurological condition, meaning he is severely disabled. The care he has received from the NHS – especially the brilliant team at Great Ormond Street Hospital – has been incredible. But if we'd followed all the advice we got when John was little – if his only care had come from the state – he would be in a wheelchair now, probably not able to hold his own weight. He would be looked after, but have no independence.

He wouldn't be able to go for rides on his tricycle – one of our great joys together. He wouldn't be able to wake me up each morning with shouts of "Get up, Daddy!" He can only do those things because of another kind of care – the most important kind of care: family.

It's thanks to my wife Emily above all. Her utter determination for John. Spending two years teaching him to crawl. Massaging his tongue and practising sounds until the magical moment he first said the word "Daddy", age nine.

That's what family is all about: caring for our loved ones. You can hear it in the conversations around every kitchen table, but not often enough around the Cabinet table. And when ministers do turn their attention to care, they too often focus only on care homes, nurseries, care workers, childminders, and how they are funded. Those are crucial, but they are only part of the picture.

Most care happens not in care homes but in people's homes; provided not by paid care staff but by family members and other loved ones. Parents and grandparents, husbands and wives, siblings and children. We don't talk about it much, but we are a nation of carers.

So the answers to the care crisis can't just be about tinkering with the formal systems of childcare and social care as they exist today. We need to take a step back as a country and ask some more fundamental questions about how we can better support families – all the way from parents raising young children to those children when they're older looking after their parents or grandparents.

This is personal for me, because I've been a carer for most of my life. First as a teenager, nursing my mum during her long battle against bone cancer. Later for my Nanna, organising her care and trying to make her last few years as comfortable as we could. And now for John.

I know how rewarding caring can be. It's full of love, and the bond between you and your loved one is ever so special. When I speak to family carers, they don't complain about having to look after their loved ones – they want to do it. They just wish it could be easier. And they are deeply frustrated with a system that should be there to support them, but instead makes it harder.

Of course there are specific policy changes that could help: overhauling carer's allowance, for example, so it gives carers the proper financial support they need. But building a truly caring society requires more than just individual policy changes. Both the government and politics as a whole need to change the way they think about care altogether.

We need to start valuing carers properly – both care workers and family carers. We need policies that understand and reflect the reality of life as a carer – whether that's tailoring services to the needs of carers and their loved ones, or making it easier to juggle work with caring responsibilities.

But more than that, we need an approach to the NHS, care and our whole society that has families at its heart. That would be truly transformational.

Sir Ed Davey, leader of the Liberal Democrats

INTRODUCTION

Care is ubiquitous in our lives. It has already been a defining feature of our life in ways we might not remember – and may be again in ways we don't yet know.

Paid care helps toddlers learn and disabled and older people live fuller lives. The care sector employs millions of people in total and receives billions of pounds of government funding. Social care reform now enjoys cross-party support, with progressive and conservative governments committing to reform. In fact, according to a recent poll, Conservative voters are 10 points and Reform voters 20 points more likely than Labour voters to say social care is the most important issue facing the country today (More in Common 2025). And as we, like other developed economies, see the health of our population advance, more people are living longer and the demands of care on individuals and the state are growing.

For a time, it seemed like the ubiquity of care in our lives was finally being reflected in national politics. We clapped for care workers during the pandemic as they braved a killer virus while the rest of us sheltered, and more recently, Jeremy Hunt's childcare reforms significantly expanded government funding into the system. The Labour Party's 2024 manifesto promised a National Care Service, with the hope of etching care into the legacy of the social democratic movement just as they had with health. Ed Davey, the leader of the Liberal Democrats, made his experience as a carer for his son a central focus of the party's 2024 election campaign, and promised wide-ranging reforms if his party won the election.

But change has not yet met the scale of the challenge. Our clapping did little to improve the lot of care workers, who continue to rank among the poorest workers in the labour market (Cominetti 2023). Four hundred and thirty thousand people languish on waiting lists for care or an assessment (ADASS 2024). The stalemate on reform of adult social care support continues, with the chancellor scrapping already very delayed plans to include a cap on lifetime care costs – with no agreement on how to fund it. Unpaid carers, who provide the bulk of care for older people (Jitendra and Bokhari 2024) and fill the large gaps in support, disproportionately face poverty. All the while, councils struggle to keep up with the growing cost of local authority funded care and local public services find themselves cut to the bone to pay for it. In turn, voters lose trust in a government which seems to charge more in taxes for less in public value.

A CARE-FULL FUTURE

This paper traces the history around care transformation over the last century and finds that the inertia around change in the care system has political and fiscal drivers. Care is undervalued and is therefore politically sidelined. It is also labour intensive and so is expensive to pay for, while unpaid care is priced in and lacking policy attention since women are expected to do it. Generally, political inaction and economic logic has convened to prevent meaningful change. But when an economic case can be compellingly made for change, change has tended to happen, as with the 2023 childcare expansion.

To overcome this inertia, progressives need to see a better future for care as both a necessity and an opportunity to shape a critical future public service. In practice, this will mean turning the existing patchwork of paid care into a functioning, reliable and affordable public service – not through incremental changes but through transformation, by scaling good quality provision and finding a way to pay

for care which has political and economic backing. It also demands progressives to look beyond paid services and listen to the human wish to care, embedding real choice into the system – not to renege on state responsibility but to widen its scope to the labour market and beyond. The short-term payoff will be a chance to form an alternative politics of family *and* deliver tangible improvements in economic security and trust. The long-term payoff is for the legacy of a new care settlement to be claimed by progressives, and for that system to really transform the lives of the many who need it.

A NOTE ON TERMINOLOGY

Throughout this paper the word 'care' is used to mean the help and support people give or receive to help perform the activities of daily living themselves. This primarily means paid and unpaid care for children, disabled people, and older people. Here we focus on care for adults and childcare – and not children's social care because the state's role in caring for children whose families are unable to look after them is a distinct issue in a system with distinct characteristics.

1. CARE WAS WOMEN'S WORK

The barriers blocking reform of our care systems have deep roots. Understanding them shows us how the recent history of care is driven by the state's economic needs, interwoven with a gendered view of women's work. Alongside this, how care should be delivered (and by whom) has remained contested. All of these tensions have shaped the problems we need to solve today.

First, care is undervalued because our recent ancestors believed that a woman's place is in the home. That primarily meant that for the last 200 years, care in England was out of the purview of government intervention.

This was true of childcare – until the second world war, nurseries were scarce and places were reserved for women who 'needed' to work, like widows.[1] It was also true of other kinds of care, with women in the family or female domestic servants charged with helping the disabled and elderly, supplemented by Christian charity. This gendered conception of care was both oppressive for some who wanted to work or broaden their horizons, and an aspiration for others who couldn't afford to stay at home. For example, poor women and women of colour were not afforded such privilege, having to work in factories, fields and other people's homes to survive (Davis 2019). It also meant that care – like other feminised professions – was valued less highly than other kinds of work, seen as inexpert, and generally commanded a low wage for those doing it.

Contemporary debates about the design and sensitivity of state services echo longstanding tensions that emerged even in the earliest phases of formal care delivery. When the state first took on the role of providing care, the results were more violent than benevolent. From the 1830s, more punitive new 'poor laws' placed orphaned children, and unemployed, disabled and elderly people in workhouses which were indistinguishable from prisons. It is not difficult to see, then, why disabled people today can mistrust the state's role in care provision.

The need for female labour as men went to fight in the century's world wars represented the first major shift towards seeing care as a responsibility of the state.[2] As women took on war work, and after lobbying from women's groups, government set up a system of subsidised day nurseries (Riley 2022). This was limited to childcare – for adult social care, in the absence of a clear association with getting young women involved in the war effort, there was little change.

After the war, views about the domestic role of women prevented the emerging welfare state from making care a public concern like healthcare, pensions and education. Fundamentally, Beveridge's view of the social contract was of his time – one between a male breadwinner and the state (Blackburn 1995). His views on care as women's work – reflecting the reality of contemporary family life – infused the design of the modern welfare state by bifurcating men as workers and women as caregivers (Beveridge 1942). In this conception, women would always be available to care for the family, leaving no need for the state to step in.

1 State-run nurseries also opened during the first world war to meet wartime needs, but the government's response to the second world war was more extensive.

2 Before this, there was some funding given to local authorities to fund 'early education' from 1918.

The lives of women were unmistakeably improved by the postwar welfare state, through public services and direct cash transfers. But by making men active agents in the labour market and women dependents, its architects doomed care to a secondary and private concern. And the spectre of care as woman's work continued to rear its head well into the 1970s: new subsidies to help people caring for disabled or elderly people were initially denied to married women until the European Court of Justice forced the government's hand (Hansard HC Deb 1986).

THE ROAD TO TODAY

As our conception of the role of women in public life has expanded, successive governments have inched forward on care reform.

Childcare saw the most significant transformations, partly because child-rearing kept women out of the workplace and limited the UK's human capital base. In addition, Blair's government was also centrally concerned with childcare as a form of early education to tackle educational inequalities. Against a favourable fiscal backdrop, from 1997 all nursery age children became newly entitled to state-funded early education and childcare from age three, parents got more subsidies to cover childcare costs, and new legislation strengthened councils' responsibilities to provide early education and childcare places locally. In addition to this broad-based support, disadvantaged families benefitted more – Gordon Brown's 2003 working tax credit reforms covered the majority of childcare costs for families on low incomes, while Sure Start gave all families with young children, and especially more disadvantaged families, quality local support.

More recently, the Conservative chancellor Jeremy Hunt could make the case to the Office for Budget Responsibility that expanding childcare would boost growth through increased female labour market participation. In a time when discussion about the UK's post-pandemic labour market inactivity rate, as well as its weak growth rate, was raging, this overturned the economic and political barriers to change. The ensuing change is the biggest transformation to the childcare offer in a generation, with funding to the system doubling and care entitlements subsidised by the government for children as young as nine months for working families.

That has not been the case for adult social care. Cameron, Johnson and, to lesser extent, Blair, all focussed their attention on the 'catastrophic costs' of paying for care. But shifting these costs from families to the government was no easy feat and their governments were bowed by the economic and political cost of redistribution. By 2010, while Blair's government had improved some parts of the system – most notably the creation of a new funding stream for disabled people to employ care workers directly – costs were still high. For the Conservatives, repeated commitments around funding were delayed by questions of cost, culminating in the electorally damaging hysteria around a new funding model dubbed a 'dementia tax' which recouped uncapped costs from inheritances. At the same time, austerity hollowed out local government budgets and left adult social care taking an ever-bigger slice of diminishing funding.

FROM CRADLE TO GROWTH?

More money for the early education and childcare system is a very good thing. But making childcare interventions valuable because they will drive growth in the short term *alone* hamstrings us from making change for other reasons – like redistributing the burden of care away from women or giving children the best start in life.

This kind of reasoning makes change in the adult social care system, where our political debate focusses heavily on the significant cost of reform, more

challenging. Attempting to implant the logic of growth, people have tried to make the case that cheaper and more accessible paid care services will free up those who care to go into work, or position the care economy as a growth industry aligned with our climate commitments (Diski 2022).

These avenues are fair and deserve more attention. But narratives of growth alone as a reason for funding the adult social care sector are limiting – because for one, a large proportion of unpaid carers are of retirement age so getting them into work is not an option. Another reason is that the cost of fixing the system properly is significant and may not be negated by immediate growth benefits.

Public services – those services Beveridge thought were the preserve of the state, like health and education – are generally governed not only by economic incentives but also by moral ones, and maintained because of the popularity of their continued existence and the political jeopardy associated with their decline. What might it look if care were run on a logic more like health and education?

2. MAKING CARE A PUBLIC SERVICE

Society believes that healthcare and education are fundamental components of individual and collective flourishing, so we can't leave their access to chance. Health and education are founded on rights-based principles, whereby everyone can expect some access for free. Conversely, social care doesn't have this principle at all, while childcare and early education has a limited component (the universal, early education element of 15 funded hours a week in term time).

These differences are historic and began to be felt early in the creation of postwar public services – older and disabled people who were classed as 'sick' were placed in hospital for free, while those deemed needing 'care and attention' were placed in residential homes for a fee (Thane 2009).

DIVERGING PRIORITIES

From this fundamental difference flows others. Generally, people don't need to pay for public services because they are primarily funded, delivered and managed by national and local governments. But in care systems – both adult social care and childcare – privately delivered services are either procured by the public sector for some free use or exist alongside free services for those who want or can afford it.

Most people needing paid care pay towards services, private actors deliver most provision, and local and national governments preside over markets of these private actors with regulation to shape user experience. In adult social care, there is a rigid means test which leaves out many on low incomes or with limited savings, while for childcare the very poorest now get the least support (Drayton and Farquharson 2023). Finally, workers in health and education tend to be on stepped pay bands, with much better pay than in the care sectors. They have higher union membership and can negotiate with the government directly for better pay and conditions.

How does this affect the nature of the care system? Care costs are high and unfairly distributed, and government funding is insufficient to cover the cost of quality care or even the costs of operation for some providers. Meanwhile, inadequate regulation is not achieving value for money or consistently good quality. Unpaid care, whether by parents, spouses or adult children, is relied on too heavily to fill in the gaps of this inadequate and expensive system. Workers are underpaid and undervalued, stuck in a fragmented system with limited autonomy or progression opportunities – leading to churn, vacancies and reliance on labour from overseas (which leads to exploitation).

The impacts resound beyond care systems. Insufficient childcare prevents parents – especially mothers – from working, and insufficient government funding for 'free' entitlements drives up costs for some families while keeping down pay for workers. People who need but can't access appropriate adult social care draw on healthcare for longer periods, putting pressure on limited resources for others. The cost of subsidised adult social care is a key driver in the bankruptcies of a number of local councils and squeezes budgets for other local services.

THE STATE IN FLUX

Long waiting times, unhappy workers, low pay, people paying out of pocket. Those words wouldn't feel out of place in a headline about today's NHS. Before we advocate a replication of existing public services, we should ask ourselves how well the post-1945 model of the state is faring under the strain of modern demography and demands.

Public services are themselves seeking new ideas for how to adapt universalist and statist principles for an uncertain world where costs seem to be increasing significantly. NHS spend is due to increase to almost £227 billion by 2030, comprising 40 per cent of the nation's spending (Arnold and Jefferies 2025). For health, these ever-growing costs have meant a growing discourse around prevention, community outreach, technology and self-management, as well as more outsourcing, charges for some immigrants, and supplementing funding with user fees. It has also meant that over the years, marketisation and competition have been adopted and abandoned to make services more efficient when critics say budgets are bloated. While it would be quite an understatement to say that these changes have not been uniformly welcomed and there has been a decisive turn in some areas against competition and towards collaboration.

A decade of austerity has left deep scars on our public services, and there needs to be a commitment to maintain and increase funding to retain the public's trust that the system will continue functioning. But there is a sense now that things need to change to meet growing and uncertain demands. There is a healthy debate ongoing about how the government can do that, inflected with writer and innovator Hilary Cottam's thinking about the importance of solving problems by starting with individual needs, building on existing capabilities within communities, and experimenting (Cottam 2018). A 'test and learn' approach seems to be the growing consensus, reflecting the changing landscape and wish to work nimbly and locally where possible (Cabinet Office 2024).

BUILDING A NEW VISION FOR CARE

This is instructive for care. First, we need principles as a foundation to a new system. For childcare, this should be that all parents should have real choice when deciding to work or care, and should be supported in the early years to give children a good early education. For adult social care, the principles should be aligned with the NHS – we rely on our health system in times of need because the health of our country is a public good, and as more of us live longer, this should encompass care needs.

How might these universalist principles be applied in the world we find ourselves in? And in practical terms, how might this solve four big problems in the care system.

1. Finding a way to pay for and subsidise care which can get political backing and feels sustainable.
2. Securing a settlement for workers which addresses the recruitment and retention crisis.
3. Designing dignified and quality care services.
4. Creating a system of regulation and delivery which ensures care is high quality, responsive and efficient.

The answers are neither settled nor plainly obvious, and progressives will have to think deeply about what a vision in practice should constitute. Experience and experiments here and abroad give us hints of how this vision might work, and how we might pay for it.

Some countries, like Finland, treat early education like primary school and offer free, state-run nurseries. This means it can have a wide reach, is reliable and engenders a sense that early education and childcare are a public good we all benefit from.

But this is not the only way. There are countries rooting universalist principles in progressive co-payment models so that people are paying in if they can. Some of these countries, like Ireland, are less concerned with who is running the care home or nursery and more concerned about the standards and conditions the setting is subject to, so that people drawing on that care are getting a good service. Ireland's recently re-designed childcare system uses means-tested co-payment alongside block grants for private providers to build a quality system – though providers have been calling for more government funding to improve pay. France has some free provision for early education and some paid-for provision for childcare (Azad et al 2023), as does Estonia and parts of Australia (Jitendra 2024).

Adult social care systems in other countries also distribute costs between the state and individuals – and even the most universalist models of social care funding and subsidy, like Norway, include an option to privately pay for additional care. In Australia, individual care costs are subsidised by taxation for people on lower incomes, while wealthy people pay more but have costs capped. In Japan, costs are covered by taxation, insurance contributions and individual fees. In the Netherlands, insurance contributions and means-tested user fees pay for social care, with a panoply of private care providers delivering care. This can encourage innovative models, like Buurtzorg – a private community care provider that empowers workers to make decisions, has driven up quality and reduced costs, and has been piloted in England (Maybin 2019; Health and Social Care Academy 2016). In Scotland, all eligible adults can get free personal care (such as help with showering and making meals), and accommodation in a care home is subsidised by the state but generally paid for by individuals and the system is delivered primarily by private providers.

Our own social care and childcare systems – though in need of serious reform – have strengths that we can build on. They are locally managed and delivered by businesses, which offers more flexibility and personalisation, with the potential for more if funding pressures eased off. This is particularly helpful in the childcare system where parents often work irregular hours or evenings and weekends, and is something which state-run kindergarten systems lack (Ville et al 2022). There is also, theoretically, a greater opportunity for innovation – however, government underfunding and high capital costs for starting up mean this opportunity remains largely unrealised. Lastly, our care systems being localised should mean local authorities can plan to meet the community's needs. But again, government underfunding has meant early years teams have been decimated, while spiralling costs and ever-tighter budgets leave adult social care commissioning teams in a race to the bottom on the cost, and sometimes quality, of care.

A NEW VISION IN PRACTICE

Rooted in universalist principles of access, support and choice, we should expect care to be well funded to deliver quality and be responsive. As in the health service and education system, there could be an element of support which is available to everyone for free, regardless of need or means, to build a sense of public trust and ownership. The state would fund a significant portion of the system but, in recognition of the need to make it sustainable, people relying on the system would also contribute what they can. It should offer those working in it a good job which they want to stay in.

The workforce

This process has already been started on the social care workforce by the Labour government. The ambitious and welcome promise of a fair pay agreement in the social care system, a mechanism for collective bargaining, could provide a strong antidote to the fragmentation, low pay and poor conditions in the workforce and should be extended to childcare when in effect. Other reforms promised in the Employment Rights Bill like improved 'day one' rights and stronger enforcement will also naturally support workers in care sectors – who have fewer rights and are more likely to suffer from rule-breaking employers (Citizens Advice 2024).

There is a robust list of asks on what else government should do from the childcare and adult social care sector, which broadly seeks to move the profession to one more akin to a public sector workforce, with professional bodies, better pay and conditions, and increased opportunities for training and progression (for example, Hardy et al 2024 Skills for Care 2024). The challenges in adult social care are particularly acute and as the government makes it harder to recruit from abroad, it will be even more important to improve pay and conditions to attract workers. After the NICs rise, which care providers are experiencing particularly sharply (Tobi and Harris 2025), the question of who would pay for these has become more acute. There are also critiques of this view from some disabled people who employ personal assistants, for whom further professionalisation would affect flexibility and care costs. But given the poverty and disadvantage of people in caring professions, better pay and conditions for this group will be crucial to building a progressive care system.

Design and quality

On design and quality, other experts have detailed what good looks like.[3] For adult social care, that would involve personalised care which meets people's physical needs, but also networks of care which meet emotional needs; commissioning care would be based on outcomes rather than tasks which instrumentalise workers, and building on the strengths of unpaid carers while not burdening them (Kenway 2025). Here it is essential that disabled people, care workers and carers are coproducing the design of any future system – this should be a central tenet of the Casey Commission. Early education and childcare should be good quality and safe and offer real opportunities for children to learn. Here too, parents, including of children with special educational needs, and childcare workers, should be brought into the design of the future system.

Funding an ambitious vision

However, without a funding settlement which the public feel is ambitious, sustainable and fair, these plans are likely to fail as they have in past decades. A new funding model needs to start with the problems of the system today – not just high and unpredictable costs but outdated co-payment systems which don't distribute costs fairly, and government funding which is short-termist and inadequate. It needs to recognise that more government funding is desperately needed to meet the scale of the challenge but that the unpredictability of care needs and the limited appetite of the public to pay for large-scale reform necessitates a compromise.

A 'progressive universalist' model which includes some level of co-payment could address the problem of high costs but also allow for people to pay in. There is some evidence that this could be popular with the public, particularly in the adult social care system (Jitendra and Bokhari 2025). This would mean everyone drawing on the system would see the benefit through some affordable subsidised services, while the poorest would pay the least. It would also secure the future of these

3 Here, I would defer to the work of organisations like Social Care Future, and Think Local Act Personal.

systems, with evidence from other countries suggesting care systems should be funded by a range of funding mechanisms to ensure they are enduring in times of political or economic change (Connon 2022).

In *childcare* that could look like moving from a system of 'funded hours', which gives all working families the same support and supplements this with user fees, to a more progressive and predictable form of co-payment. Here parents would pay according to their means and needs, with predictable and affordable fees, and there would be a universal element for everyone which, as now, would ensure all children can access some help.[4]

For *adult social care*, this debate is unsettled, with a justified but unhelpful focus on a cap on costs which would privilege the wealthy (Hu et al 2025), and deep division over how to pay for it. These debates reach into the heart of what we value. How much is too much to pay over a lifetime for care, and what might this mean for what we pass on to our loved ones once we are gone? Progressives will need to grapple seriously with these questions. But rather than framing the debate around cap levels, progressives should focus on creating a fairer means test which encompasses incomes and savings so more people can get help to pay for care. In addition, some care should be free to all, like Scotland's subsidy towards personal care.

In both systems, government would need to move to a more active role. Users would pay government according to their financial situation and need, and government would pay providers directly.

A co-payment system for care costs could bring security and certainty to people drawing on care and raise some revenue to pay for the system in part. But it won't be a replacement for a sustainable funding settlement to build a high-quality system. For that, we will need government to fund the system more generously and find ways to raise the revenue needed. On childcare, government has already made a commitment to increase the system's funding, and it now needs to go further to boost quality. On social care, where the cost of transforming the system and offering a generous means test will be particularly expensive, hard choices and smart politics will be essential. Tax rises on income or wealth are unpopular, but creating a new insurance mechanism is more popular (Jitendra and Bokhari 2025). Progressives will need to be politically astute about how to balance what is popular with what might be needed (Ansell 2023).

To bring costs down and improve access, more focus – and funding – is needed to develop and roll out technology which can make care cheaper while maintaining the dignity of those drawing on it. We know people can be nuanced about trade-offs – JRF research found people were willing to compromise on face-to-face visits from health professionals for cheaper care (Jitendra and Bokhari 2025).

Underpinning this will need to be a rethinking of the regulation of the system. First, availability and quality need to be paramount – if people are paying into the system through taxation and co-payment, the system needs to look and feel like a functioning public service. That means tackling waiting lists for care assessments, ensuring there are enough childcare places locally where parents need them, and that provision is good quality.

This will entail a maturation of the regulation of the system to move to a system of 'social licensing' as in the utilities sector. Like in Ireland and the Netherlands, private providers will be essential partners in delivering a public service – so should be supported financially to cover their costs, but not profiteer

4 Forthcoming analysis by the New Economics Foundation in partnership with JRF models a version of co-payment which institutes a 5 per cent household income cap on fees.

unreasonably or maintain precarious balance sheets laden with debt. They should also be held to high standards to ensure they are delivering the service well. In childcare, this means local authorities working closely with providers on quality, and Ofsted undertaking proper financial accounting to ensure value for money. In adult social care, this means moving away from 'time and task' to paying workers for shifts and professionalising the workforce. In both sectors, this means local authorities taking a more central role in managing their local markets and being supported financially to do that well (Jitendra 2024).

Taken together, these should make care systems feel, to those who draw upon them, like public services – reliable, affordable and recognisable – while still harnessing the flexibility and variety of care sectors which offer genuine benefits.

3.
WE COULD ALL BE CARERS

A huge amount of care is done – willingly or unwillingly – in private, by family, friends, and social networks. Despite increases in the availability and affordability of paid care services, this remains the case both for children and adults who need care (Jitendra and Bokhari 2024). A vision for the future care system which doesn't find a place for unpaid care, and a way to support unpaid carers, will fail.

Debates about 'who cares' usually pit conservatives as supporting more familial caring responsibilities, while progressives tend to see this as holding back gender equity and therefore something to overcome. The progressive diagnosis is partially true – both childcare and care for spouses or elderly parents is still done primarily by women, even as women's participation in the labour market has increased (ibid). This metes out a number of financial penalties on women – a 'motherhood tax' when they leave work to care for children, and a 'caring penalty' if they leave work to care later in life (Jitendra et al 2023). The answer, for many progressives and feminists, is universal free care provision to move the responsibility for delivering and paying for care to the state, and prevent women automatically being made to care.

Expanding paid care services will help reduce the burden of care on women. It will also help address inequalities in the choices available to rich and poor families when making decisions about care – which push poor women with caring demands out of the labour market (JRF 2025, forthcoming). This is essential, for we cannot continue to rely on goodwill and duty to prop up inadequate paid care systems. But the goal of policy should not be to eliminate unpaid care altogether; it should be to offer people real choice and, where people choose to care, support in the care they do.

Primarily, because many people want to care: JRF research found that, for people providing the majority of care for someone, 46 per cent of unpaid carers and 40 per cent of parents say their main reason is that they want to (Jitendra and Bokhari 2024). Having children or caring for family, friends and loved ones in times of need is, for most people, a crucial part of living a fulfilled and happy life.

It's also true that these wishes are gendered. While there is a consensus view among the general population that care is not just women's work, women still identify as caregivers more deeply than men (ibid), so we might question if people choosing to care themselves are really making free choices. But these are deeply personal decisions which policymakers should not only try to shape, but respect and accommodate.

We also need unpaid carers because it is hard to fully meet care needs through paid services. Most parenting happens outside of formal settings, while accessing and arranging paid social care often requires the help of unpaid carers (Kenway 2025). As carer and writer Emily Kenway has contested, health and care needs are 'lawless' (Kenway 2023) and don't conform to the rigid routines of planned care worker visits and check-ups. And as she has written, the preference of people needing care is often to be cared for by someone they know and trust, meaning the choice to care is by nature a constrained one and steeped in emotions.

Finally, moving the responsibility of care from family to the government can seem right in principle, but in practice, as long as we see care as a lesser value

act, this can mean shifting low paid, undervalued work from middle class families to working class, disadvantaged ones. In the extreme, this looks like middle class mums employing 'night nannies' who lose sleep on their behalf (Hodge 2024). Perhaps this is a price we are willing to pay for women to succeed in the labour market on their own terms – but it risks preserving a logic of care and value which further marginalises poor women.

The thinking of care ethicists like Joan Tronto is instructive here. For them, care is a 'species activity' which spans care for ourselves, our family, our community and the planet. It forces us to think about ourselves and our relationships with others differently. It is hidden but essential – as Ai-Jen Poo says, the "work that makes other work possible". Our own social security system acknowledges this through looser work-search requirements for parents and carers – but while both create value, only one shows up in the country's GDP estimates. New measures like the ONS' inclusive income measure (ONS 2024), which captures the value of care and other trends not measured in GDP calculations, are aiming to address this and should be championed by progressives.

BUILDING A CARE SYSTEM WITH CARERS

Any future care system needs to recognise people's wish to care. The kinds of 'model' countries like the Netherland, Finland, Norway and Denmark progressives like to mention in policy discussions all have subsidised paid care services alongside paid leave policies and cash transfers for people caring. Across the UK, we need long- and short-term care leave policies; currently, our maternity and paternity entitlements are some of the worst of comparable countries and there is no paid carer leave available at all (Jitendra et al 2023). And we need carer benefits fit for the modern day, which prevent poverty and recognise the labour carers do (Carers UK 2024). Finally, we need support for formal and informal peer networks in neighbourhoods which do the invisible work of looking after each other, often providing a level of practical and emotional support which professional actors cannot.

Affordable and available care services are also a crucial part of making sure people can make real choices when deciding how to meet care needs. In England, the adult social care system has a fundamental flaw in this regard – while a carer's wishes are legally supposed to be factored into the assessment of someone's need for support, in practice this often is not the case, and the existence of current or potential unpaid care can mean less support is offered. We need a system where assessments are carer-blind at the outset (Reimagining Care 2023).

To return to Beveridge, he believed the reason women were relegated to the home is that their domestic work was essential, and without it, "the nation could not continue" (Beveridge 1942). Contemporary feminists agreed with him. The view that women's domestic or caring work is in itself valuable, even if hidden, persists. Last year, the Irish public voted overwhelmingly to keep a sentence in their constitution which emphasised women's "duties in the home" as "woman gives to the state a support without which the common good cannot be achieved" (Carroll 2024).

We might be shocked by this vote, but we should think deeply about what it confirmed – that people believe there is value created by care which our economy doesn't measure. For social conservatives like David Goodhart, this might mean protecting the gender norm around care as women's work through tax incentives for single earners (Goodhart 2017). But for progressives, this should mean harnessing the intangible good we collectively agree caring produces, valuing it, and ensuring people are not pushed into hardship if they need to care.

4. BUILDING A PROGRESSIVE LEGACY FOR CARE

Welcome to modern Britain, where things are broken and something needs to change. Of all the problems we need to solve, why should care be on the list?

Childcare is now receiving the political attention it deserves. On adult social care, the government has fired the starting shot on reform – the announcement of a National Care Service. This presents an opportunity for a progressive legacy for social care, echoing that of healthcare. But a potential 10-year delay to meaningful action continues an unwelcome trend (DHSC 2025). Dishearteningly, inaction has not been politically damaging so far. But this political calculus is unlikely to hold for long.

CARE COSTS WORSEN COST-OF-LIVING PRESSURES

First, in the next decade more people are going to encounter an expensive and frustrating care system causing economic insecurity during a time when high costs are already front of mind. Between the 2011 and 2021 census, the population of over-65s grew by 2 million, making the country the oldest it has ever been (Cabinet Office 2022), and an ageing population is predicted to drive an increase of 2.5 million people living with a serious illness by 2040 (Watt et al 2023). We're also seeing more working-age adults seeking formal care services with higher needs, particularly adults with learning difficulties who need very long-term care (Hu et al 2020). Taken together, an older population better able to weather acute health issues but more likely to live with chronic ones will likely need more care. That means a higher demand for both paid and unpaid care and people needing to make consequential and difficult choices about their own future and those of their loved ones (Jitendra and Bokhari 2024).

Yes, older people are managing health conditions better through the NHS (Raymond et al 2021). But more of us will need help, meaning more strain on an already strained adult social care system. Birth rates are dropping, but we want more women in the labour market and more children are presenting with complex educational needs (National Audit Office 2024).

Labour once spoke of wanting to build "the best country in the world to grow up and grow old in". But the lack of public infrastructure to subsidise care costs now means the experience of doing or needing care can be difficult, destabilising, and, in many cases, staggeringly expensive. This is only likely to get more acute. People don't know yet about the high care costs awaiting them, or the financial hit caring can take (Jitendra and Bokhari 2025). As more do, the belief that delaying action on care is politically viable may change. In a political moment where the cost of living continues to be a significant driver of public sentiment (and frustration), reducing the cost of care and reducing the hardship associated with caring could be an important pillar in a strategy to address high living costs.

RESOLVING THE CARE CRISIS WOULD RESTORE TRUST IN GOVERNMENT

Second, the unsolved care crisis is accelerating the decline of other services whose functioning is central to the existing social contract. If politicians want to tackle growing mistrust in government, they would be wise to look at fixing the care system. Hospitals see continuing strain as people in need of care stay for long periods. 'Corridor care', or being treated in corridors because of a lack of available beds, is a new and shocking phenomenon with social care insufficiency as a key reason (Sunday Times 2025). This breeds mistrust in institutions more broadly – 86 per cent of those who are dissatisfied with the NHS say that the system of government needs to be improved (National Centre for Social Research 2024).

Local councils, who run and fund what the average person thinks of as 'the state', now spend 42 per cent of their budgets on adult social care, with per-person spend on adult social care up by 50 per cent since 2014 (Bancalari and Zaranko 2024; County Councils Network 2024). Incremental increases in grants to local government and powers to increase revenue through council tax increases have not plugged the funding gap. For care, this means long waiting lists and a race to the bottom on funding rates for local authority-funded care. But the impacts spill over – other services which people rely on but which aren't statutory, like bus services and libraries, are cut or reduced. For some, this isn't enough and they face bankruptcy (McKee and Bullock 2025). If an important front in the fight against growing mistrust is improving people's local communities, then properly funding care will be crucial.

A CHANCE TO BUILD A POLITICS OF CARE

Finally, the rise of the reactionary right poses new cultural questions – particularly around gender – to which a politics of care could be a constructive answer. First, more progressive policy could seek to capitalise on the progressive views of the public about the role of women – one of the strongest cultural beliefs people held was that care is the preserve of both men and women (Jitendra and Bokhari 2024). In the UK, women are still the majority of paid care workers and unpaid carers, and any change to the care system will disproportionately help them and gender equality in turn. In New Zealand, reforms to professionalise the social care workforce were justified as part of a move towards more gender equity in the labour market, while childcare reforms in a number of OECD countries have been explicitly justified on feminist grounds (Azad et al 2023).

Second, as the right turns away from the market and individualism and towards family and security as its animating values – sometimes with reactionary and patriarchal tendencies – a focus on care could help construct what an alternative vision would look like. One compelling progressive answer is that we need to take relationships and kinship seriously, and enable more care to be done in familial and peer networks if people choose to. The dividing line with the right would be that progressives want there to be genuine choice in the system, preventing women from being expected to care out of duty.

All of these trends present opportunities for progressives to capitalise on. Building a progressive care system can offer answers to all three – an anchor of economic security at people's most vulnerable moments, a bulwark against growing mistrust in government, and a clear signal about how progressives can deliver practical social justice.

CONSTITUENCIES OF CARE

Just as the NHS is now etched into the history of the progressive movement in the UK, care should be too. The National Care Service, like the NHS, is both a necessity and a powerful political idea which can build political support and an enduring

legacy. There are a broad range of constituencies ready and willing to support transformation in the care system. There is a well of sympathy among the public about care, even if it rarely scores at the top of opinion polls. JRF research found people are very sympathetic to government funding of adult social care, as ageing and disability are not seen as choices but are a surprise or an inevitability (Jitendra and Bokhari 2025).

In America, campaigners are building coalitions of fragmented groups in the care system – people needing care, care workers, unpaid carers, care providers – and in part have driven the increased focus on the care economy in Democratic policy (Ways and Means Committee 2021). In England, angry mothers sick of paying over the odds for childcare formed a key power base which led to the reform of childcare subsidies, while increasingly angry young dads agitate for improvements in the meagre paternity leave offer (Russell 2025). For change in social care, Professor Nick Pearce argues that older voters could become this power base (Pearce 2017), and it could also act as a point of coalition for the centre left (Pearce 2024).

People who do care – unpaid carers and care workers – are rarely brought into discussions about the future of the care system, and yet they are relied upon to shoulder the burden of increasingly complex care needs. Organisations and unions like the Care Workers' Charity, Homecare Association, Unison, We Care, and Care Full are striving to change this – many are carer- or care worker-led and give people space and training to talk about their experiences to decisionmakers and advocate for change. More of us will face the impossible choices these unpaid carers already face as parents and spouses get older. We need to ensure these voices are central to the debate about what comes next.

Finally, organisations like Social Care Future and the Early Education and Childcare Coalition are already building alliances between previously disparate groups to marshal new constituencies of care. These partnerships (or their absence) can make or break eventual transformations – such as in Ireland where provider groups have resisted changes to the system, particularly around their ability to set fees and worker pay (Bracken 2023).

5. CONCLUSION

Care will be, or has been, a feature of all of our lives. We can hope that our experience of care in the future will be a pleasant one, but that is far from certain. The history of government intervention to help manage care needs has been piecemeal and limited, reflecting our gendered views about caring and its value. This has left our systems dysfunctional and meant that those who do care – paid or unpaid – are undervalued and disproportionately in poverty.

A progressive hope for a better system will not be enough. Instead, progressives should seize the political moment – one in which care needs are growing and the costs of inaction are spilling over.

We need action, particularly for adult social care where inertia has gripped the system. This will need new ideas and old ones – a new model for public services which meets the challenges of today and its political realities, as well as recognition that humans want to care, and help for them do it. It will require political leadership and new alliances to raise the political stakes and change minds. And it will demand tangible change to systems which exist not in pockets of the nation but across communities, to reach all of us who care or need care. It won't be easy but the payoff is generational. It will be a chance for progressives to show they have answers to the big questions of today and tomorrow, a lifeline for families at their most vulnerable, and a recognition of the central role care plays in our lives.

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APPENDIX: TRENDS IN CARE AND CARING IN THE UK

New analysis by the Joseph Rowntree Foundation to support this support report has found that the care challenge is changing and growing, all while policymakers fail to meet its scale.

1. DEMAND OUTSTRIPS SUPPLY FOR FORMAL CARE

Changing demographics and tighter budgets have limited access to care services, leaving care rationed for all but those who are the poorest and most in need of care.

The number of new requests for support to local authorities serves as a reliable measure of this demand. In England, new requests increased from 1.8 million in 2015/16 to 2.1 million in 2023/24, representing a rise of 15.2 per cent. This growth is primarily driven by working-age adults, whose requests grew by 31.5 per cent, compared to a 9 per cent increase among people aged 65 and over – this means requests from working-age adults grew at triple the rate of over-65s.

At the same time, the provision of services for adult social care has not being able to grow at the same rate as demand. Most notably, the number of people actually receiving care has not increased proportionately. Between 2015/16 and 2023/24, there was a 15 per cent rise in people requesting some form of adult social care, but only a 2.5 per cent increase in those receiving it. This widening gap shows that the system remains under sustained pressure and is unable to fully meet the needs of an ageing and growing population.

2. MORE OF US ARE UNPAID CARERS, AND WE ARE CARING MORE INTENSELY

Parallel to these changes in the provision of paid care services, more of us are now undertaking unpaid care. Over the past 20 years, since the last Labour government was in power, there has been an overall increase in the number of people providing unpaid care in the UK. Not only are more people involved in unpaid care, but a larger share are also providing substantial amounts of it.

The total number of unpaid carers has fluctuated over the years, but the overall trajectory shows an increase. Specifically, the proportion of the adult population providing unpaid care declined before the Covid-19 pandemic, but has risen since then. In absolute terms, in the UK the number of adults providing unpaid care grew from approximately 4.7 million in 2003/04 to 5.2 million in 2023/24 — an increase of 10.1 per cent.

Breaking this down by hours of care provided, the increase is mainly driven by a rise in people delivering more than 35 hours of unpaid care per week. The proportion of adults providing this level of care increased from 2.4 per cent to 3.6 per cent. This translated to an increase of 71%, from 1.11 million people to 1.90 million people caring for more than 35 hours. In contrast, there has been a decline in the number of people providing less than 20 hours of unpaid care per week.

METHODOLOGY

Formal care data: JRF analysis of NHS Digital, Adult Social Care Activity and Finance Report, Table 2, 2023/24. For the year 2015/16, data are drawn from Table STS002 and Table 1 of the same report. The analysis combines the number of people receiving long term adult care services with the number of short term support to maximise independence (ST Max) packages provided. Figures may overlap, as some people receiving long term care also receive ST Max within the same year, and some may receive more than one episode of ST Max in a year. The year 2015/16 is used as the baseline for calculating percentage changes.

Unpaid care data: JRF analysis of the Family Resources Survey, 2023/24.

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