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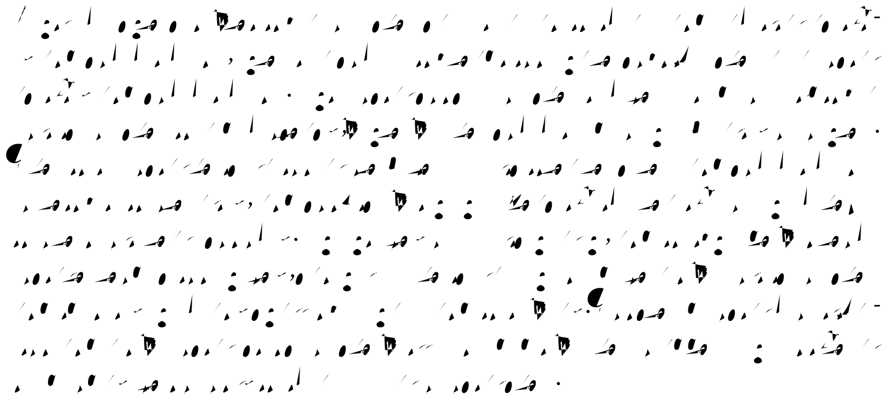

What kind of politics might we build in the wake of neoliberalism? Inspired in part by our own work with activists, and witnessing others in parallel– from activists demanding "care not cops" to ones urging a just energy transition and rights for the disabled– we have suggested that care might provide an alternative center for our politics.[1] We believe such a politics could offer a vision capable of describing what might come after the neoliberal order because it links together a systematic critique of our current political economy with a vision of what values and institutions are worth struggling for together– ones that would allow us all to live longer and better, that would generate more freedom in how we spend our time, and that would give more meaning to our lives and our democracies.

But what is "care," and how might it help us redefine what our politics and political economy are for? And what might this have to do with the wreckage that neoliberalism has wrought? To understand this, we need to reach beyond the conception of care as fundamentally , and instead recognize and value care as a activity and commitment. Today, our embodied lives are unthinkable, unlivable without shared infrastructures of care that rely heavily on not just intimates but also

politics and in conversations about social reproduction and care– though they are essential to our lives and are systematically exploited and extracted in an economy organized by profit-seeking. We have not only weak care infrastructures in the Unit-

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care. In this social conception, care is a kind of undervalued work that people do—often women, immigrants, and people of color—that becomes embodied in mate-

> each one of us–what is irreducibly our own–is not property or goods but the time of our lives.[11]

Neoliberalism oriented our politics toward the maximization of profit and wealth. Hägglund urges us to redefine wealth, to recognize that "the more free time we have to pursue the activities that matter to us, the wealthier we are."[12] In this vision that centers care, "own[ing] the question of what to do with our time" requires

sult, these infrastructures were partial, delimited, and undermined as soon as they began.

This dialectic is foundational to an understanding of how even as great advances were made in the nineteenth century, our profit-oriented political economy has curtailed and eroded them, especially as it was intensified in the neoliberal era. Programs and policies found support particularly in times of social and

ogist, Snow and a local Anglican minister, Reverend Henry Whitehead, showed through what would be an early example of a difference-in-differences (that is, a controlled before and after) study that the contaminated water from the local well was responsible for the 1854 outbreak, not miasmas or the anger of a god. What happened next was critical: Snow and Whitehead went to the St. James Vestry, the local administrative authority, to present their case and get the Broad Street pump h.02ue feemo4 (rf 5 Tw 11 0 0 11 72321 ƁDCea3)T0.09 Tw 11 0 0 11 wl 11 0 0 11 72 619.te

ized and gendered coercion. Sociologist Evelyn Nakano Glenn's book [illegible] describes a history of care coercion in the United States that goes back to the founding of the country, in which care is provided to some by others who are denied the same care themselves. "The social organization of care" in the United States, as she describes, "has been rooted in diverse forms of coercion that have induced women to assume responsibility for caring for family members and that have tracked poor, racial minority, and immigrant women into positions entailing caring for others."[33] Slavery was such a system, and Nakano Glenn identifies others that are more contemporary and subtle. For example, home care workers have long been excluded from labor and employment protections available to other workers, including the ability to unionize and earn overtime pay.[34] Historians Eileen Boris and Jennifer Klein have traced this long history of subordination, and shown that it is very much still with us.[35]

The care infrastructures built in the nineteenth century bear these same traces of extraction and marginalization, reproducing more of the same for the same subordinated groups. While sewage and public utilities are often seen as universal infrastructure, these public goods have never been enjoyed equally in America. Modern public health recognizes that the infrastructures necessary for good health go far beyond this, encompassing housing and decent work while also addressing systematic group subordination and inequalities. Yet these systems have never been available to all.

Public infrastructures of care are not, in theory, allocated or organized according to a logic of profit, so they remain vulnerable in a political economy that prioritizes financial gain. One feature of the neoliberal turn, in fact, is that infrastructures organized for care became more aligned with profit motives, which ultimately undermines them. Dynamics of financialization and austerity have tended to push institutions, including those providing care services, to prioritize market-measured efficiency, with effects we are just beginning to understand. For example, new empirical work shows that while hedge-fund takeovers of nursing homes were heralded as a way to increase the quality and efficiency of services, they have actually made them markedly more deadly.[36] Consolidation in the for-profit dialysis sector has had similar effects.[37] Health care settings today have become places where sickness is turned into profit– in which infrastructures of care are crafted to drive revenue for others in a form of "care extractivism."[38] Even though access to health care was expanded in recent decades in the United States, we are still far from having infrastructures that ensure equal access to the kind of freedom envisioned by Hägglund. We see significant disparities in the time we have on this earth, with people in the same city experiencing a difference of ten to twenty years in healthy life expectancy.[39] The public health literature on the social determinants of health shows how social sub0 0 116T3 ila3w 1ETEMC /603USen-HSagill1ho)TjETEMC a3w 1ETEMC /79

For example, "unequal access to technological innovations, increased geographical segregation by income, reduced economic mobility, mass incarceration, and increased exposure to the costs of medical care," in a set of feedback loops, can lock the poor into a "health-poverty trap."[40] As writers like Matthew Desmond have noted, poverty traps are made by design by public policies that subsidize care for some, direct resource and financial flows to others– not just to the rich but to the middle class– and leave millions of the poor behind.[41] It's not that we can't afford to address poverty in the United States, Desmond maintains, but we simply have created an economic and social architecture that incentivizes the status quo.

This kind of extraction is felt corporeally; it seeps into who we are. As social epidemiologist Nancy Krieger describes, "we literally biologically embody exposures arising from our societal and ecological context, thereby producing population rates and distributions of health."[42] The pathways that connect health to social and ecological factors are complex. Racism, for example, influences geography, which in turn can expose people to higher rates of violence or diminish access to good schools or walkable neighborhoods. It also influences individual micro-exposure to disease (because, for example, it impacts access to safe workplaces and homes) as well as groups' macro-abilities to organize to address health inequities.[43] Biology, of course, also influences disease: only people with prostates get prostate cancer. But the incidence and impact of diseases like this are profoundly shaped by socioeconomic status and race.[44]

The effects of racism on health also play out through public infrastructures and the politics around them. As historian George Aumoithe has shown, the fiscal crisis of the 1970s and the elevation of efficiency in the neoliberal era created an in-

at the turn of the last century: all feel hollow when we think of the collapse of these systems in places like Flint, Michigan, and Jackson, Mississippi. In fact, half a million Americans live in households without plumbing, with hundreds of water systems in the United States operating in violation of the Safe Drinking Water Act.[48] This is a story of privatization and neglect, but also of the hollowing out of the state and public services in the name of fiscal prudence and restraint over the past forty years. From the closure of hospitals to the decay of water and sanitation services and the weakening of social protections, this systematic disinvestment in the health and welfare for America's poor, many of them people of color, is part of that legacy of advances cut short, curtailed, reversed.

Building, rebuilding, and reforming infrastructures of care should consider how these systems have been used and misused to perpetuate race and class subordination in America. And we have to learn the political lessons too– our progress in establishing infrastructures of care is fragile. Care only becomes a priority for those in power and with resources when it becomes impossible to ignore because of protests or unrest.

Can care, in its social conception, provide an alternative ethos and analytics to reorganize political economy today, and help us articulate a new politics that moves beyond the neoliberal paradigm that has governed over the last several decades? The answer will depend on the emergence and consolidation of social movements powerful enough to demand profound change– change that not only builds better infrastructures of care, but also undermines structures of social subordination and empowers low-income workers and carers within and outside the marketplace. Academics alone cannot bring about this change, but they can develop theories and conceptual innovations as well as gather data and evidence that can help us understand the present and shape the future.

Profit-oriented institutions took centuries, not decades, to develop. They needed intellectual theorization, legal and institutional innovation, and social scientific elaboration. Neoclassical economics reqt6solidation

Re-envisioning public health science in service to this kind of ethics means developing an evaluative framework built on quantitative and qualitative analyses that can measure whether these care imperatives are being met, how they are being degraded and undermined, and how they can be realized more fully across the spectrum of subjects listed above. This will require a shift in thinking beyond social epidemiology into the other, varied subdisciplines of public health science to address "local contextual factors but also to less tangible, high-level social ones" (for example, the roles of economic inequity and racial capitalism) at work in their impacts on health and on care.[58] Many scientists may resist addressing questions of justice in the context of their work, viewing them as "too political." But even in more abstract areas of epidemiology (such as mathematical modeling of disease), this resistance appears to be weakening.[59] Only by integrating the concept of care throughout public health science can we truly see how care works in the world, from child and elder care to care for our communities and our planet. The tools we use will be diverse depending on the subject. The metrics will also differ. But the broad notion of care that Tronto, Hägglund, and other theorists point us to requires this kind of comprehensive approach.

As this essay goes to press, a dark new chapter in the struggle over social care has opened up. The U.S. presidential election channeled a furious kind of reaction formation to the crisis of care, with Donald Trump and Robert F. Kennedy Jr. riding a wave of anger so many feel in response to a government that is unable or unwilling to do anything about how sick and precarious they feel. But what kinds of solutions do they have to offer? Not infrastructures of care, but a fantasy-fueled program of retribution. Instead of health care or housing, the incoming administration promises deportations.

If there is any nascent vision of the new Trump era arising at this moment, it is that we can Make America Healthy Again, whole again, through a mix of punishment for others and punishing self-improvement for the self– linking men like Kennedy, who would bring down public health in America, and alleged assassin Luigi Mangione, who in a spectacle of violence, took aim at our failing health care system, with both of them deeply fixated on the purity of their own bodies through diet and exercise. It is an era of techno-optimism where "great" men, like tech billionaires Marc Andreessen and Elon Musk, will drag us toward salvation in a "technocapital Singularity"– or retreat to their bunkers when it all explodes.[60] None of this makes much sense or has any ideological coherence. Those proposed to lead agencies in the new year have little understanding of how government works, and with their multiple conflicting agendas, chaos is more likely than anything else. We can already predict who will pay the highest price. As usual, the most vulnerable, most in need of care in our world will suffer the most: the homeless, the sick and hungry, and the immigrants and refugees who cannot go home because their homes have been laid to waste.

In the midst of all of this, our task is to rebuild the very ideal of care in its social sense, and the supermajorities and political programs must deliver it. Our earlier care awakenings came from periods of deep darkness– the industrial revolution and devastating wars and pandemics. That is small solace today, and yet no insignificant thing, as we try to imagine the future ahead, in which something rises from the ashes better than before.

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