The Social Life of Care

Gregg Gonsalves & Amy Kapczynski

While much recent writing about care casts it as an intimate and familial activity and commitment, there is a competing tradition that recognizes care as a social activity and commitment. This social concept of care is more suited to building a politics of care in a democracy, where we are committed to the equality of others. Care in its social articulation also requires public infrastructures and commitments to bring it into reality, and conflicts with the extractive imperatives of the market in our neoliberal economy. The history of public health, and insights drawn from social reproduction theory, can help us articulate the need for a new politics of care and identify the many challenges that stand in its way. Concerted social mobilization and a new social science of care will be needed if we are to address the universal need today for not only intimate but also social care.

What kind of politics might we build in the wake of neoliberalism? Inspired in part by our own work with AIDS 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 *intimate,* and instead recognize and value care as a *social* activity and commitment. Today, our embodied lives are unthinkable, unlivable without shared infrastructures of care that rely heavily on not just intimates but also the care work of strangers. We tend to overlook these infrastructures, both in our 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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ed States today but fundamentally unequal and unjust ones that extract care from some to provide it preferentially to others. If we are to reorient our politics and economy toward equality and freedom for all, it will require a focus on care in its social sense – and massive social mobilization as well as concerted efforts by academics to reorient what we measure, debate, and value in our own work.

The word *care* has Old English roots. It comes from *caru*, which first meant sorrow or grief, and then came to mean concern and provision. Nothing in the word suggests that care should be limited to the family. Yet many conversations about care begin with the family and treat relationships between parents and children as the ur-type. This conception of care emphasizes *care as intimate*, a kind of activity and commitment that happens between *particular* persons, commonly within the family. Care theorist Virginia Held adopts this view when she argues that the "central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility," such as "caring for one's child."[2] Alison Gopnik also understands care as an intimate commitment and activity. For Gopnik, care "typically emerges in the context of close personal relationships," and is "evolutionarily rooted in biological kinship relationships," even if "not restricted to those relationships."[3] For Anne-Marie Slaughter, care is a "relationship," or "a sustained connection between two people; a caring relationship is a loving, affectionate, or at least respectful and considerate connection."[4]

This concept of care-as-intimate draws on work in psychology, biology, and theories developed by difference feminists to argue that people can willingly subordinate their needs to others. A politics of care based on this conception asks that social institutions protect and promote these kinds of relationships, including beyond the nuclear family. Gopnik, for example, wants public policy to enable more opportunities for intimate care by expanding the contours of marriage or providing other kinds of legal recognition of caring relationships, such as allowing siblings the formal recognition of a care relationship.

There is another concept of care that treats care as a *social* activity and commitment. Care in this context is defined as the life-sustaining activities and infrastructures that enable all other things we do. This tradition of care is associated with political theorists Joan Tronto and Bernice Fisher, who define care as "everything we do to maintain, contain, and repair our 'world' so that we can live in it as well as possible."[5] Care, understood in this way, focuses on what materialist feminists call activities of "social reproduction." These are the "activities of provisioning, caregiving and interaction that produce and maintain social bonds," and sustain people "as embodied natural beings, while also constituting them as social beings."[6]

Care understood this way is found among intimates, but also in public among strangers. This is the "care" that corresponds to health care, childcare, and home

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 material infrastructures that help organize and ensure the provision of care to others, even others whom we may never know.

The social conception of care implies affective commitment too – the "concern" and "worry" you find in the etymology of the word – but does not conflate care with the feeling of love or commitment we expect characterizes a relationship with a child or parent. Health care, day care, and home care should not be expected to provide this kind of intimate love. But good care in these settings requires affect we commonly call care: close attention to particular persons and commitment to their well-being.

Infrastructures of care can also only be sustained if we feel social concern for others we will never meet. In this way, social care depends profoundly on commitment and feeling, though of a different kind than intimate care. That we were ever able to build a politics that established care infrastructures, threadbare though they may be today, is a monumental collective achievement. It reflects the fact that humans are what biologists call an "ultra-social species," not just capable of but inclined to care beyond kin.[7] New insights in evolutionary biology show theoretically and empirically how the social and the individual are intertwined.[8] Even slime molds cooperate, it turns out. Humans are just better at it, and can build complex social infrastructures to sustain one another – or destroy one another – at a massive scale.[9]

The social tradition for theorizing care asks us to think about care not as something any one of us is capable of providing alone, but as something that we must provide together, through social choices and commitments that can be costly. This vision of care connects to a broader critique of political economy and the widespread sense of crisis that surrounds us. The rise of capitalism, and its current neoliberal form, involved valorizing a certain kind of market relation and actor. As the Care Collective writes, "the archetypal neoliberal subject is the entrepreneurial individual whose only relationship to other people is competitive self-enhancement. And the dominant model of social organisation that has emerged is one of competition rather than co-operation. Neoliberalism, in other words, has neither an effective practice of, nor a vocabulary for, care."[10]

What is distinctive about care here is the *role* it plays in our social and material lives. Care is what allows us to live longer and better, and what must be distributed equally to all if we are to live in a just society. Care in its social form thus can be understood as a predicate of real freedom, as philosopher Martin Hägglund describes:

> To live a free life, it is not enough that we have the *right* to freedom. We must have access to the material resources as well as the forms of education that allow us to pursue our freedom and to "own" the question of what to do with our time. What belongs to

> 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 both time and the ability to decide to use that time for what is meaningful to us – as well as the acknowledgment of the dependences we have upon others.[13] This dependence is not just between intimates, but between all of us as social beings who all deserve the regard and material supports that might enable us to live freely. We need infrastructures of care and a commitment to equal care for all, so that each of us might be "freed up" to live our lives as well and as meaningfully as we can.

Care in its social sense is central to secular freedom, enabling us to live our lives with meaning. It has a politics because it is something we can alter, demand from others, and build collectively. Though we take it for granted, it was bold action from groups of activists and scholars that established the social care infrastructures we have today. Aspects of these infrastructures remain and are foundational to social reproduction, but they were also built in ways deeply marked by our political economy: they were exceptions to laissez-faire, acceptable to the extent that they protected our political economy, but foreshortened by social relations of subordination that persisted. Seeing what helped us build these infrastructures – and what limited their reach, what picked away at them until they became just bones in so many places – is important to understanding what it might take to reorient our political economy toward social care today.

Mainstream economists often describe a broad association between the rise of industrial capitalism and rising life expectancy and population growth.[14] In fact, what followed most immediately from the advent of industrial capitalism was a tidal wave of sickness and death.[15] The emergence of waged labor in urban centers both created conditions for major new outbreaks of illness and tracked shifting social relations that tolerated astronomical levels of injury, hunger, and malnutrition for workers and poor families. Many at the time, particularly the pioneers of what we today call social medicine, recognized this phenomenon contemporaneously. We only now associate capitalism with longer life for more people because of the work of early scientists and reformers, who not only helped identify the biological causes of disease, but also saw that disease had structural and social causes – and then devised institutions and scholarly practices to support infrastructures of care that could protect people. What was built in this period is in one sense astonishing, but it also never managed to displace the profit logic that defined what the modern political economy is for; and as a re-

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 economic crises, during which they were necessary to the stability of capitalism. But they were organized in ways that did not fundamentally challenge the broader political economy, with its emphasis on the primacy of profit-seeking, and the fear of dependency. Periods of expansion were followed by the clawing back of resources and the extraction of profits from these same systems once the political pressure had subsided. But the insights of reformers in the nineteenth century have salience today as we think about how a care economy and a new politics of care might be possible.

Before the nineteenth century, diseases were commonly thought of as the result of personal failings. Illness was interpreted as a sign of god's wrath, or constitutional weaknesses of certain social groups.[16] Nonspecific environmental causes ("unpleasant odors," "poisonous vapors," miasmas blamed for cholera, bad air for malaria) were also popular theories.[17] The late nineteenth century saw the gradual emergence of germ theory linking microorganisms to disease, culminating in microbiologist Robert Koch's articulation in 1884 of his four postulates for establishing causation between the two.[18] However, a contemporaneous set of theories was on the rise as well. Rudolf Virchow, Edwin Chadwick, Florence Nightingale, and Friedrich Engels were among those who showed that social forces influence individual health in patterned ways. As they pointed out, the conditions in which we live and work can make us sick, and the lives and the deaths of the rich and the poor have starkly different trajectories.[19] They also understood that the social conditions driving ill health were remediable, that our environments could be remade to ward off sickness. This understanding gave birth to modern public health, which helped to drive the need for large-scale investments in public infrastructure development, particularly in sanitation, water, housing, and the workplace. But the story of the birth of modern public health is also the story of how new forms of social organization rose to elevate care for others and changed the way we live together. It is part of the genesis of a politics of care.

Cholera first appeared in the Western world in 1831 before germ theory was widely understood or established. At the time, miasmas were believed to be the cause of this new disease, though early advocates, scientists, and physicians began to link cholera with poor living conditions.[20] In the most severe cholera epidemic in the 1850s in Europe, the etiology of the disease was established with greater certainty. Everyone trained in public health knows the formative story of John Snow and the Broad Street pump.[21] Considered the first modern epidemiol-

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 handle removed. The victory was largely symbolic. The outbreak had already waned, and it would take several decades for Snow and Whitehead's theory on cholera to take hold. But it was the beginning of a revolutionary movement blending scientific insights with public action, leading to the so-called Great Sanitary Awakening of the nineteenth century that generated reforms in water and sanitation, housing, and urban design.[22] Here care becomes municipal and civic, and the benefits of these reforms become part of the city, shared in common citizenship.

But what controlled cholera in the Western world was not simply Snow's work to prove the disease was caused by a pathogen.[23] It was also the emergence of water provision as a public utility rather than a private good, which shifted care for others into a tangible infrastructure and into the built environment, democratizing access to clean water for the first time. In fact, in the United States, water provision became the first public utility, though the transfer from private hands happened over time from city to city. Philadelphia established a public water supply after an 1801 yellow fever outbreak raised suspicions of a connection between the disease and the "putrid matter" in drinking water for the municipality.[24] New York City didn't begin planning for public water provision until a severe cholera outbreak there in the 1830s.[25] In law, public utility regulation became a vast and critically important exception to the then-reigning idea that lawmakers could not "interfere" with the economy – the so-called ideology of laissez-faire that re-emerged in new form in the neoliberal era.

There is an intimate link in this history between material infrastructures of care and intellectual fights over the nature of freedom and the economy. Public utilities from water to electricity to transportation, and key health regulators like the Food and Drug Administration, were established in a period that heralded – even constitutionalized – "market freedom."[26] They were only possible through pitched battle between advocates, public health professionals, and private investors, which delimited market logics in the name of "the salus populi – the ability of a modernizing state to continue to provide for a democratic people's welfare."[27] While courts repeatedly struck down some efforts to shape markets, such as minimum wages and maximum working hours, they also carved out exceptions for a growing range of industries "affected by the public interest" that could be legitimately publicly regulated.[28] In fact, scholars and advocates at the time conceptualized the fight as one over the nature of the economy, arguing for a "democ-

racy of wealth," wherein "all industrial relations are to be regarded as subordinate to human relations."[29]

These developments, while opposed by business interests, were crucial to the emergence of a national and global economy based on commodity exchange and waged labor, as they made cities, products, and waged work survivable. They appeared during times of crisis – such as the revolutions of the nineteenth century, the Great Depression, and the social unrest of the 1960s in the United States – responding to organized agitation and evolving to address these challenges, yet always operating within limits. While improvements in water and sanitation, housing, food and nutrition, and education – all the things we would call the social determinants of health – increased life expectancy and blunted disease in many places, not everyone benefited equally. The poor and nonwhite populations in the United States still suffered disproportionately what social critic Lauren Berlant characterized as a slow death: "even if individuals managed to survive numerous infectious diseases, the typical details of everyday life led inexorably to early death: the hours and conditions of work, numerous pregnancies, chronic undernutrition, domestic labor, stress, and, for many, discrimination combined to wear down over the years a body's ability to function."[30]

As the modern political economy expanded both nationally and globally, care became commodified, driven by market forces and shaped by profit motives. The market itself was structured by ideas of productivity, efficiency, and entitlement, which meant that even as care work would more frequently be paid – for example, in new growth sectors like childcare, health care, and home care – care would still be undervalued and coerced.

For instance, as waged labor emerged, we began to see the rise of classes of waged care laborers, from the domestic workers that powered households in the nineteenth century, to the category of "home care" that was born in the New Deal and that is among the fastest growing job sectors today.[31] But waged care work is subordinated and poorly compensated, even as it becomes part of a formal market.

It is well known that the paid care sector today is underpaid and underappreciated, but the reasons are less well understood. Feminist economists like Nancy Folbre provide one kind of explanation. Care work, whether paid or unpaid, "often involves more personal connection, emotional attachment, and moral commitment than other forms of work," and provides value that is hard to measure. In settings that are driven by profit and market efficiency, paid care work will be consistently undercompensated because employers fail to "see" and reward the value of good care, and because care workers' emotional investment in their work or those in their care makes them less likely to quit or strike, effectively weakening care workers' power to negotiate for better pay.[32]

Sociologists and historians describe other structural conditions that have made care work not just a realm of economic exploitation, but also of racial-

ized and gendered coercion. Sociologist Evelyn Nakano Glenn's book *Forced to Care* 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 subordination shapes health, highlighting both persistent inequities and those that have worsened in recent decades.

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 incentive for the rise of "Ghetto medicine," in which health care and public health infrastructure were stripped from Black and Brown communities in cities like New York.[45] This dismantling of public infrastructure over the past fifty years collided with the HIV and COVID-19 pandemics. In the 1980s, the city struggled with hospital capacity, and today it remains unable and unprepared to handle a surge in illness and death among the poor.[46] As sociologist Armando Lara-Millán has described, dynamics of disinvestment and reinvestment of health care dollars work to "redistribute the poor," shuttling them between different institutions – jails, prisons, hospitals – so some agencies can cut costs and others can accrue revenue, while maintaining an illusion that through services, care is being provided.[47] The broad social infrastructures of care that took generations to build were dismantled, with resources redirected to more lucrative care "opportunities" (such as large academic medical centers providing high-cost specialty care). Meanwhile, what was left behind in disadvantaged communities was designed to continue extracting profit at the expense of the poor.

And water and sanitation? The feel-good story of the Broad Street pump, the victory of the establishment of public water and sanitation utilities nationwide

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 required new theories of value – transitioning from utilitarianism toward concepts such as "Pareto-optimality" and the "Kaldor Hicks" or "wealth maximization" criterion commonly used in institutional analysis today – and along the way, they normalized the idea that it is moral for goods to be allocated to those who can pay the most.[49] Economists also developed "linking theories" that connected these philosophical concepts to both mathematics and law, claiming, for example, that the "measuring rod of money" could be used reliably to evaluate the welfare benefits of different regimes, thereby facilitating and institutionalizing logics of exchange and profit-maximization.[50] Significant legal innovations were also necessary, such as the development of the "fee simple" concept in property ownership. These changes transformed the corporation from a special and limited expression of state power into a form of pri-

vate authority that could exist indefinitely and be driven by market pressures rather than public objectives.[51] New accounting and managerial techniques were essential for defining "profits" and evaluating how specific institutional and social arrangements could enable their growth.

A political economy and politics oriented to care would require its own theory of value, such as those beginning to be developed by theorists like Tronto and Hägglund. It will also require legal and institutional innovations that can concretize these values and embed them in institutional cultures. We need new policy prescriptions, to be sure – for example, to identify how to organize and secure universal or decommodified childcare, health care, home care, and social housing. But we likely also need other kinds of innovations, comparable to those made in property and corporate forms as capitalism advanced. Can we develop new legal institutions that protect organized "countervailing power" for tenants and others, building on the example of labor unions?[52] Can we identify "non-reformist reforms" that empower opponents of the carceral state to both challenge the carceral state and create care-oriented alternatives to it?[53] Theorists in and out of the academy are debating and developing ideas such as these.

Finally, the social sciences, broadly conceived to include public health science, have a major role as well. Social epidemiology already considers the larger social forces that we know shape health, influence our ability to minimize "disease or infirmity," and maximize overall "physical, mental and social well-being," a notion that comes close to Tronto's formulation of care as repairing our world so we can live in it as well as possible.[54] Despite this, for over a century, public health has largely subordinated itself to medicine, diverging from the tradition of its early pioneers. It sees itself now as part of "a technocratic exercise where state agents take steps to control disease."[55] Yet new movements are happening within public health that have begun to shift beyond a technocratic and utilitarian version of public health to scrutinize how policies, programs, and economic and welfare regimes can affect our ability to care, to be healthy in the broadest sense.[56] A new field of "political epidemiology" is emerging to help us trace how specific decisions influence health outcomes by treating policies and programs like we treat pathogens and medicines: that is, as exposures with effects we can measure. A new and explicit focus on care is emerging too, with public health academics advocating for the field to expand its study of the determinants of care, including

> wages, working conditions, housing affordability and accessibility, food security, transportation, education, childcare, environmental protections, and protections for immigrants, in addition to health and health care . . . [and] recognize that we all deserve to live in a decent and just society that cares about us, cares for us through its priorities and investments, and supports our ability to care for each other.[57]

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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ENDNOTES

[1] Gregg Gonsalves and Amy Kapczynski, "The New Politics of Care," in *The Politics of Care: From COVID-19 to Black Lives Matter* (Boston Review and Verso Books, 2020), 11–43.

[2] Virginia Held, "The Ethics of Care as Moral Theory," in *The Ethics of Care: Personal, Political, and Global*, 1st ed. (Oxford University Press, 2005) (emphasis added), 10.

[3] Alison Gopnik, "Caregiving in Philosophy, Biology & Political Economy," *Dædalus* 152 (1) (Winter 2023): 58, 61, https://www.amacad.org/publication/daedalus/caregiving-philosophy-biology-political-economy.

[4] Anne-Marie Slaughter, "Care Is a Relationship," *Dædalus* 152 (1) (Winter 2023): 71, https://www.amacad.org/publication/daedalus/care-relationship.

[5] Joan C. Tronto and Bernice Fisher, "Toward a Feminist Theory of Caring," in *Circles of Care* (SUNY Press, 1990), 36; and Joan C. Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York University Press, 2013).

[6] Nancy Fraser, "Contradictions of Care and Capital," *New Left Review* 100 (2016): 101.

[7] Joseph Henrich and Michael Muthukrishna, "The Origins and Psychology of Human Cooperation," *Annual Review of Psychology* 72 (2021): 207–240.

[8] Stuart West, "The Evolutionary Benefits of Cooperation," The Leakey Foundation, August 1, 2016, https://leakeyfoundation.org/the-evolutionary-benefits-of-cooperation.

[9] Tim Fox, Matt Pope, and Erie C. Ellis, "Engineering the Anthropocene: Scalable Social Networks and Resilience Building in Human Evolutionary Timescales," *The Anthropocene Review* 4 (3) (2017): 199–215.

[10] The Care Collective, *The Care Manifesto: The Politics of Interdependence* (Verso Books, 2020), 4.

[11] Martin Hägglund, *This Life: Secular Faith and Spiritual Freedom*, 1st ed. (Pantheon Books, 2019), 23.

[12] Ibid.

[13] Ibid.

[14] Lant Pritchett and Lawrence H. Summers, "Wealthier Is Healthier," *The Journal of Human Resources* 31 (4) (1996): 841–868.

[15] Simon Szreter, *Health and Wealth : Studies in History and Policy* (University of Rochester Press, 2007).

[16] Jo Nelson Hays, *The Burdens of Disease: Epidemics and Human Response in Western History* (Rutgers University Press, 2009).

[17] Sylvia Tesh, "Political Ideology and Public Health in the Nineteenth Century," *International Journal of Health Services* 12 (2) (1982): 321–342.

[18] Mitt F. Loeffler, "Aus dem Kaiserl," *Gesundheitsamte* 2 (1884): 421–499.

[19] Mervyn Susser and Zena Stein, *Eras in Epidemiology: The Evolution of Ideas* (Oxford University Press, 2009).

[20] Edwin Chadwick, *1842 Report on the Sanitary Conditions of the Labouring Population of Great Britain* (Edinburgh University Press, 1843).

[21] D. Cameron and I. G. Jones, "John Snow, the Broad Street Pump and Modern Epidemiology," *International Journal of Epidemiology* 12 (4) (1983): 393–396.

[22] Institute of Medicine, Division of Health Care Systems, Committee for the Study of the Future of Public Health, "A History of the Public Health System," in *The Future of Public Health* (National Academies Press, 1988), 3; Martin V. Melosi, *The Sanitary City: Environmental Services in Urban America from Colonial Times to the Present* (University of Pittsburgh Press, 2008); and Jon A. Peterson, "The Impact of Sanitary Reform upon American Urban Planning, 1840–1890," in *Introduction to Planning History in the United States* (Center for Urban Policy Research, 1983), 13–39.

[23] Theodore H. Tulchinsky, "John Snow, Cholera, the Broad Street Pump; Waterborne Diseases Then and Now," in *Case Studies in Public Health* (Academic Press, 2018), 77–99.

[24] T. R. Witcher, "First of Its Kind: Philadelphia Municipal Water Supply," *Civil Engineering Magazine* 91 (1) (2021): 32–35.

[25] Gwynneth C. Malin, "What Is Public and What Is Private in Water Provision: Insights from 19th-Century Philadelphia, Boston, and New York," in *Oxford Research Encyclopedia of Environmental Science* (Oxford University Press, 2022).

[26] William. J. Novak, *New Democracy: The Creation of the Modern American State* (Harvard University Press, 2022), 1.

[27] Ibid., 15.

[28] *Munn v. Illinois*, 94 U.S. 113 (1876).

[29] Novak, *New Democracy*, 21 (citing John Dewey, *The Ethics of Democracy*).

[30] Susan Craddock and Tim Brown, "Urban Health in the US and UK: The Long 19th Century," in *Handbook of Global Urban Health* (Routledge, 2019), 33.

[31] Mignon Duffy, "Chapter 2: Domestic Workers: Many Hands, Heavy Work," *Making Care Count: A Century of Gender, Race, and Paid Care Work* (Rutgers University Press, 2011), 20–41; and Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (Oxford University Press, 2015), 6–11.

[32] Nancy Folbre, "The Care Penalty and Gender Inequality," in *Oxford Handbook of Women in the Economy*, ed. Susan L. Averett, Laura M. Argys, and Saul D. Hoffman (Oxford University Press, 2017), 749–766.

[33] Evelyn Nakano Glenn, *Forced to Care: Coercion and Caregiving in America* (Harvard University Press, 2012), 5.

[34] Boris and Klein, *Caring for America*.

[35] Ibid.

[36] Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, "Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes," *The Review of Financial Studies* 37 (4) (2024): 1029–1077.

[37] Paul J. Eliason, Benjamin Heebsh, Ryan C. McDevitt, and James W. Roberts, "How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry," *The Quarterly Journal of Economics* 135 (1) (2020): 221–267.

[38] Beatrice Adler-Bolton and Artie Vierkant, *Health Communism: A Surplus Manifesto* (Verso Books, 2022).

[39] Antonio Fernando Boing, Alexandra Crispim Boing, Jack Cordes, et al., "Quantifying and Explaining Variation in Life Expectancy at Census Tract, County, and State Levels in the United States," *Proceedings of the National Academy of Sciences* 117 (30) (2020): 17688–17694.

[40] Jacob Bor, Gregory H. Cohen, and Sandro Galea, "Population Health in an Era of Rising Income Inequality: USA, 1980–2015," *Lancet* 389 (10077) (2017): 1475, 1490.

[41] Matthew Desmond, *Poverty, by America* (Crown, 2023).

[42] Nancy Krieger, "Discrimination and Health Inequities," in *Social Epidemiology*, ed. Lisa F. Berkman, Ichiro Kawachi, and M. Maria Glymour, 2nd ed. (Oxford University Press, 2014), 63–125.

[43] Krieger, "Discrimination and Health Inequities."

[44] Ibid.

[45] George Aumoithe, "Dismantling the Safety-Net Hospital: The Construction of 'Underutilization' and Scarce Public Hospital Care," *Journal of Urban History* 49 (6) (2023): 1282–1311.

[46] George Aumoithe, "The Racist History that Explains Why Some Communities Don't Have Enough ICU Beds," *The Washington Post*, September 16, 2020, https://www.washingtonpost.com/outlook/2020/09/16/racist-history-that-explains-why-some-communities-dont-have-enough-icu-beds.

[47] Armando Lara-Millán, *Redistributing the Poor: Jails, Hospitals, and the Crisis of Law and Fiscal Austerity* (Oxford University Press, 2021).

[48] J. Tom Mueller and Stephen Gasteyer, "The Widespread and Unjust Drinking Water and Clean Water Crisis in the United States," *Nature Communications* 12 (1) (2021): 3544.

[49] Daniel Hausman, Michael McPherson, and Debra Satz, *Economic Analysis, Moral Philosophy, and Public Policy*, 3rd ed. (Cambridge University Press, 2017).

[50] Jedediah Britton-Purdy, David Singh Grewal, Amy Kapczynski, and K. Sabeel Rahman, "Building a Law and Political Economy Framework: Beyond the Twentieth Century Synthesis," *The Yale Law Journal* 129 (6) (2020): 1785–1835. For the "measuring rod of money," see Ronald H. Coase, "Economics and Contiguous Disciplines," *Journal of Legal Studies* 7 (1978): 201.

[51] David Copley, "Beyond Public and Private: Toward a Political Theory of the Corporation," *American Political Science Review* 107 (1) (2013): 139–158.

[52] Kate Andrias and Benjamin I. Sachs, "Constructing Countervailing Power: Law and Organizing in an Era of Political Inequality," *The Yale Law Journal* 130 (3) (2021): 546–635.

[53] Amna A. Akbar, "Non-Reformist Reforms and Struggles over Life, Death, and Democracy," *The Yale Law Journal* 132 (8) (2023): 2497–2577.

[54] Nancy Krieger, "Theories for Social Epidemiology in the 21st Century: An Ecosocial Perspective," *International Journal of Epidemiology* 30 (4) (2001): 668–677; and Gary Mercer and Nancy Berlinger, "Interdependent Citizens: The Ethics of Care in Pandemic Recovery," *Hastings Center Report* 50 (3) (2020): 56–58.

[55] Amy L. Fairchild, David Rosner, James Colgrove, et al., "The EXODUS of Public Health What History Can Tell Us about the Future," *American Journal of Public Health* 100 (1) (2002): 54–63; and Patrick Farard, "Public Health as a Social Movement," Working Paper (International Public Policy Association, 2015), 1.

[56] Frank Pega, et al., "Politics, Policies, and Population Health: A Commentary on Mackenbach, Hu, and Looman (2013)," *Social Science and Medicine* 93 (2013): 176–180.

[57] Mercer and Berlinger, "Interdependent Citizens," 57.

[58] Jon Zelner, Ramya Naraharisetti, and Sarah Zelner, "Invited Commentary: To Make Long-Term Gains against Infection Inequity, Infectious Disease Epidemiology Needs to Develop a More Sociological Imagination," *American Journal of Epidemiology* 192 (7) (2023): 1047–1051.

[59] John Coggon, "Is Public Health Just Science? Values, Politics and Varied but Collective Practices to Secure Better Health with Justice," *Journal of Public Health* 44 (1) (2022): i34–i39; and Jon Zelner, Nina B. Masters, Ramya Naraharisetti, et al., "There Are No Equal Opportunity Infectors: Epidemiological Modelers Must Rethink Our Approach to Inequality in Infection Risk," *PLOS Computational Biology* 18 (2) (2022): e1009795.

[60] Henry Farrell, "AI's Big Rift Is Like a Religious Schism," *The Economist*, December 12, 2023, https://www.economist.com/by-invitation/2023/12/12/ais-big-rift-is-like-a-religious-schism-says-henry-farrell.