PLATFORM-MEDIATED CARE-WORK IN CITIES

Platform Care as Care Fix

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It has almost become a truism in the social sciences to state that technology does not develop in a vacuum. It matters who makes those decisions, who deploys technology, and to what end; it matters who the programmers and engineers are and what assumptions they hold (Wajcman 2006; Pettinger 2019: 136ff.). Moreover, technology never merely replaces a task. Instead, the nature and even the meaning of tasks are transformed, while new tasks are also created in the process. As Larry Lohmann (2019: 46) puts it, "there is no 'thing' that stays constant through the process of 'being mechanized' any more than there are discrete objects called 'technologies' that, when sprinkled onto humanity, help it attain its desires but otherwise leaves it just as it is". It also matters what investment decisions, forms of ownership, and business models inform the development and use of technology. Consequently, the digital platforms relating to *care* and the business models they are premised on reshape the everyday social relations of care, the relationship between public provision, while they are also linked to the privatization and financialization of social infrastructures. Thus, platformization is not only a techno-social process, it is also a political-economic one.

In this contribution I discuss the political economy of the contemporary platformization of care that ranges from self-care health apps to online agencies for care services. The examples I refer to all stem from the UK context and I draw on the research I carried out for the book *The Care Crisis* and the arguments and analysis presented there (Dowling 2021). I discuss the ways in which the current platformization of care is part of a *care fix*, entailing a process whereby digital platforms insert themselves into a mounting care crisis, offering to plug the care gaps that are experienced by individuals and households in an everyday context and in the wake of the neoliberal restructuring of the British welfare state and its correspondent care regime.

Care crisis

Feminist scholarship has sought to draw attention to a growing care crisis (Rosen 2007; Rai/Hoskyns/Thomas 2013; Elias et al. 2016; Fraser 2016), which has been both exacerbated and made more visible by the coronavirus pandemic (de Henau/Himmelweit 2020; Barry/Jennings 2021: 36ff.). In its most general terms, a crisis of care means that more and more people are unable to access adequate care, while those who provide care to others are unable to do so satisfactorily and under dignified conditions. This care crisis is premised on changes to the material conditions for the provision of care – whether within households and families, in communities, by public or social services, or through the market, private corporations, and agencies – and pertains to the growing gap between care needs and the resources made available to meet them (Dowling 2021: 6). Key dynamics include the demographic changes of *ageing* societies, with the associated increase in care needs; the neoliberal dismantling and restructuring of public services; the attempted commodification of services; dual-earner models in the context of stagnating real wages, i.e., the requirement of households to spend a high proportion of time in gainful employment. These developments are occurring against the backdrop of a heightened personal responsibility for care along with the reliance on the compassion and sense of responsibility of those who care to continue to do so under adverse conditions, precisely because they care. All of this perpetuates and even deepens existing traditional relations of care and *social reproduction* together with intersectional inequalities, reinforcing the devaluation of care and worsening conditions under which care is provided, both paid and unpaid.

Care fix

A care fix entails efforts at crisis management that do not resolve one and for all, but merely displace the crisis, thereby perpetuating the structural feature of capitalist economies to off-load the cost of care and social reproduction to unpaid realms of society. This is because the dynamic of capitalism is to seek a care fix in ways that will allow for the continued pursuit of profitability. Care fixes lie at the heart of the current reorganization of the relations of production, social reproduction, and care. In the face of limits or impasses, capitalist economies reorganize to overcome crises. David Harvey (1975; 1982) and Bev-

erly Silver (2012) have respectively termed such forms of reorganization a *fix*, analyzing the ways in which capitalist production undergoes spatial, technological, organizational, or financial fixes to solve the pressures of maintaining profitability. This can very well mean is that the underlying problems that led to the crisis in the first place are not actually addressed, instead being merely displaced. The analogy of the fix can be applied to the social relations of care to understand how particular care fixes (Dowling 2018: 334-35; 2021: 14-15) reorganize care in the face of both an economic and a care crisis.

Each regime of accumulation (the way that goods are produced and consumed) has a corresponding care regime, understood as the arrangements through which care is provided and labor power is produced, e.g., within the household and kinship arrangements, through a welfare state, in neighborhoods and communities, or via the market in commodified form (Brown et al. 2012: 80). As Nancy Fraser (2016) has elaborated, historical periods have specific configurations characterized by different institutional forms, as well as norms that govern the provision of care across state, market, and society on the basis of a gendered and racialized social division of reproductive labor in ways that (re)draw the boundaries between production and reproduction.

The way that the economy and politics are governed is one realm, another is the terrain of the everyday, where social life is organized. Care fixes can be analyzed with regard to three dynamics. First, a care fix repairs, seeking to re-establish favorable conditions for the pursuit of profitability in the face of crisis. Second, a care fix displaces, postponing the underlying causes of crisis and their symptoms into future, or off-loading them elsewhere. Third, a care fix pins down certain configurations of care for a given historical period (Dowling 2018: 334). These configurations are either political-economic, socio-cultural and technological, or affective-ideological. Political-economic configurations pertain to the way the economy is governed, i.e., the relationship between states, markets, and commons. For example, questions of the public provision of care, legal regulations with regard to access to care, or the extent of commodification. By socio-cultural and technological configurations of care I mean the social relations of care, e.g., the provision of care in households or families, or the role of civil society organizations along with the extent of mechanization, automation, and digitalization. The affective-ideological configurations of care include the feelings and meanings attached to ideas about care and caring; norms, values, and responsibilities; gender, race, and class dynamics as well as relationships to the body. Of central importance here are the affective mediations through which a sense of self is

gained and subjectivities are shaped. Of importance also are the narratives, or more rather the *ideologies of caring* (Dowling 2021: 38) that justify, legitimize, and normalize unequal or exploitative care arrangements in a given society.

A brief clarification is necessary at this point regarding the terms care and social reproduction. Analytically it is useful to distinguish between the two. Social reproduction refers to the activities and spheres of society in which unpaid or underpaid work takes place to ensure the maintenance of labor power and life in a capitalist economy. These are activities that form the backbone of any society, yet they are routinely rendered invisible and devalued, not least precisely because they constitute a cost to society and to capital (Weeks 2011; Federici 2012). Care encompasses qualitative dimensions pertaining to the *modus operandi* of an activity, the correspondent affective dispositions (such as empathy, concern, or attention) as well as the correspondent ethical relations (such as interdependence) (Finch/Groves 1983: 15; Care Collective 2020). Care encompasses endeavors to meet the needs of others and assist them to live well (Himmelweit 2007: 581). Caring affects are not merely optional or a simple add-on: tending to someone with care may very well enhance their well-being and impact on their quality of life. Moreover, it is precisely the cathexis of caring that serves as a basis for its exploitation, by relying on the fact that someone *want*s to care or feels a sense of responsibility. Indeed, caring can be instrumentalized in the pursuit of profitability or to maintain social cohesion for capital accumulation to continue (Dowling 2018: 344; 2021: 20).

Consequently, we can examine the causes and manifestations of the growing care crisis and the emerging solutions to it and investigate the kinds of care fixes currently taking shape. What becomes apparent is that care inequalities are rising, while the responsibility for caring is systematically handed down a societal care chain of paid, underpaid, and unpaid caring labor based on a core structural feature of capitalist economies. This feature is the systemic imperative to expand markets in the pursuit of profitability, which goes hand in hand with a devaluation of the work of care and social reproduction, either by making this work invisible or by offloading its cost.

The platformization of care as a care fix

Current care technologies can be divided into two categories: information and communication technologies (ICT) and assistive technologies (Dowling 2021: 122). It is with regard to ICT that digital platforms are particularly relevant.

ICTs can enable a variety of functions and interactions such as remote diagnosis, consultation, and therapy. They can also facilitate information-sharing among care workers and can better integrate the wishes and needs of care recipients, saving time and enabling communication when someone cannot travel. People in need of care can stay in touch with friends and family, while digital platforms and social networks allow care and support to be provided locally, by connecting those in need of care with formal and informal carers, including volunteers, community organizations, and local services on- and offline. Such digital infrastructures do not simply enable more or better communication; they also have a political economy.

Platforms are digital intermediaries to enable two or more groups to interact, providing the digital infrastructure that enables communication and exchange, rendering user data collected in the process productive in order to develop and marketize services. They rely heavily on the so-called *network effect*, which is why they tend towards monopolization, thus exercising control over the "rules of the game" (Srnicek 2016: 46). In other words, they shape the protocols that govern interactions. Moreover, the price structures, that is to whom they charge how much for what, vary between different providers, and indeed can also vary over time within the same platform. Srnicek refers to this as "cross subsidization" (ibid.) arguing that part of the business model of platforms is "fine-tuning the balance between what is paid, what is not paid, what is subsidized, and what is not subsidized" (ibid.). The platformization of care entails the provision of paid and unpaid care services by digital intermediaries that enable the communication and exchange between multiple users. These platformized care services with their concomitant business models insert themselves into the existing political economy, offering solutions to social as well as economic problems.

Digital self-care

In the wake of the coronavirus pandemic, there has been a considerable surge in the use of all kinds of digital apps, as people have been confined to their homes and face to face meetings have not been possible under conditions of lockdown, including health and self-care (Inkster et al. 2020). Care-apps range from online therapy, i.e., a virtual meeting with an actual therapist, to apps that help track moods and offer advice on how to manage these through a combination of self-care ranging from mindfulness activities and apps that

measure and monitor physical performances. There are also apps that helps to manage depressive episodes or keep anxiety in check (Ratcliffe 2017). Often, these draw on cognitive behavioral therapy, which focuses mostly on changing existing patters of thinking and acting where they prove to be inadequate (Burns 2020). Apps for online counselling are also part of these developments.

With regard to therapeutic models in particular, there is the question of the role of embodied human connection in therapy. Where the therapeutic relationship is reduced to the virtual, it could be that the quality of the connection between therapist and client becomes more superficial without the full range of embodied communication and the qualities of co-presence. This is an aspect that requires more research and is not only pertinent to the therapeutic context but pertains more broadly to the benefits of in-person presence in a whole variety of contexts, from personal relationships to educational settings and workplaces. In this broad dimension this is an issue that has come to the fore very acutely in the wake of the pandemic where lockdowns and remote communications have heightened awareness not only of the benefits, but also the potential drawbacks of digital communications popularized as *zoom fatigue* (Bailenson 2021). If key aspects of the therapeutic process are automated, e.g., advice for particular feelings or thoughts, this raises the questions of whether computers really can deliver on the key components of the therapeutic relationship if these include not simply becoming aware of or verbalizing problems and seeking solutions but experiencing the compassion and understanding of and connection with another human being (Burns 2020). Moreover, the political question of the collection and interpretation of data from bodies and behavior and the commercial (or other) uses that this is put to is acutely relevant, as is the imposition of measure. When we count up what we do and what we achieve in ratings and measurable outcomes that can in turn be routed through financial markets for the purposes of extracting surplus value.

All in all, the promotion of this kind of sense of self puts personal responsibility center-stage and is a kind of care fix that privatizes the responsibility for care and turns self-care into a coping mechanism in the face of an inadequate and ailing care infrastructure. The question for a political economy analysis then is twofold. First, what needs are care platforms responding to and how are they shaped by or in turn shape existing and emerging ideologies of caring (such as self-care)? Second, what are the business models of these platforms and how do these in turn insert themselves into the political economy of care across the domains of state, market, and society in response to

the ongoing care crisis? In what follows I discuss some examples of new care platforms and their business models in order to ascertain the particular care fix they offer.

Online healthcare services

In recent years the National Health Service (NHS) in England has been exploring the use of a digital healthcare app in parts of London and Birmingham under the name *Babylon GP at Hand*. The private company contracted to provide the service is Babylon Health, a venture capital-backed digital health start-up with *unicorn status*.[1] It provides users with data-driven tools for the self-management of conditions that include health, mood, and activity monitoring as well as symptom checking and using artificial intelligence and machine learning to refine the interpretation of symptom descriptions by users and improve diagnostics.[2] Aside from these tools, users are able to consult a General Practitioner (GP) online 24/7. If a user needs to see a medical doctor in person, they visit a Babylon Health clinic. The aim is to increase user self-management of healthcare needs and decrease the need for interaction with medical professionals (Babylon Health 2017). Users who sign up privately pay a subscription fee, the version available via the NHS is free for users. Users who register with the Babylon GP at Hand service through the NHS are automatically de-registered from their existing GP practice and must use a Babylon clinic.

Here, the self-care fix intertwines with a fiscal fix (Dowling 2021: 180). Babylon Health offers purported cost-savings to the public sector. First, because patients can avoid long waiting lists and waiting times and have a video consultation with a doctor within two hours. Second, because the app promises to save the NHS money, by increasing the occasions when users can self-manage their health without needing to be seen by a doctor. However, critics have argued that the company takes away resources GP practices need by taking away younger and healthier patients who are more likely to use the app (Crouch 2018; Downey 2019). In the British healthcare system, GP practices are currently funded through weighted payments for each patient that consider the healthcare needs of the particular population a practice serves,

1 This means the privately held start-up is valued over $1 billion.

2 See babylonhealth.com/ai.

including factors such as age or socio-economic situation. Risk is pooled, because those who are younger and fitter require less attention and therefore fewer resources. The basic principle of risk-pooling is that a population's health needs vary over the course of a lifetime. Babylon's business model actively undermines both the principle and the material base of the collective solidarity and risk-pooling that are fundamental to a public healthcare system. Emphasizing individual freedom and the right to choice, this is a tech-driven mode of accumulation fueled by the privatization of public cost savings. More and better self-care aided by digital technology (at a fee to the public purse) is supposed to save Britain's public health service money and mitigate the crisis of public healthcare funding through reduced visits to the doctor. However, a first evaluation of the service revealed that the use of the symptom checker reduced over time, as patients – especially those above the age of 30 – preferred to speak to someone in person (Ipsos Mori 2019: 31). Moreover, at least in the present model continuity of care is not given because usually there is no longer-term link between particular doctor and the patient (Ipsos Mori 2019: 51). Overall, digital divides are deepened where older persons and persons with more complex needs are less likely to use such apps and find them accessible. Finally, Babylon Health draws on a medical workforce of younger, part-time, and locum (temporarily employed) doctors working from home (ibid.: iii), which follows the trend towards precarious work.

Helping people with disabilities

Yet, platform care is not just about self-care, but also about caring for others. Be My Eyes is a platform that enables volunteers to assist visually impaired people over the internet. The platform is free to users and volunteers, but charges corporations to access its ecosystem and offer support to visually impaired users as a way of optimizing its products and services.[3] In the longer term, the company envisages using the data collected from each interaction between user and volunteer to help with machine learning for the development artificial intelligence (AI) products (Singularity University 2018). This means that the interactions between users (those who provide and receive help) are a learning ground to which corporations pay to gain access in order

3 See bemyeyes.com.

to optimize their services to visually impaired users. But also, these interactions serve in the long-run as raw data to optimize machine learning for AI products that the developers of the platform seek to monetize in the long-run. The point here is certainly not to criticize assistive technologies nor the people who offer their time to help visually impaired persons. The concern here is to reflect on the business model of the platform and understand its political economy. We can identify here how there is an affective-ideological dimension at play in enlisting the online (micro-)volunteer labor of individuals wishing to help. This fits with analysis of platforms as spaces where unpaid labor is performed to produce products that are sold by those who control the platforms (Altenried 2020).

Online care agencies

The broader need for care within the household has also facilitated the development of new platforms. One of the most well-known platforms so far is Care.com, a transnationally operating platform that charges private households a subscription fee to connect with care workers offering childcare or eldercare services on an hourly basis. Hired as independent contractors, the workers offering their services are part of a growing precarious workforce in the gig economy. As Ursula Huws (2019: 21) argues, here it is particularly the combination of public service retrenchment and time pressures that push people towards platform services in the area of care. Sybille Bauriedl and Anke Strüver (2020: 274) emphasize that this does little to reshape existing intersectional inequalities with regard to care and social reproduction. Functioning similarly to a temp agency, the platform charges those seeking care services (i.e., the buyers), it does not charge those offering care services (i.e., the sellers), although it offers help with writing a resumé and promoting one's services.[4] The business model relies on the network effect.[5] While one path of analysis is to *follow the money* and understand how care platforms generate profitability, another line of analysis is the affective-ideological dimension. In her survey of a number of different care work platforms, Miranda Hall (2020)

4 See care.com.

5 See https://digital.hbs.edu/platform-digit/submission/care-com-a-two-sided-marketplace-for-all-your-care-needs/.

poignantly observes that "these childcare platforms explicitly promote themselves as a silver bullet for the crisis of social reproduction". Hall highlights how the platform also markets its services to companies who have employees with caring responsibilities and explains that "the pitch to these companies is that unexpected caring responsibilities damage productivity and therefore damage profit" (ibid.). In offering a quick and effective crisis management in the face of a lack of time for care as other calls beckon, this kind of empowerment follows what Sara Farris (2017: 131) has termed a "productivist ethics", rendering female empowerment synonymous with labor market participation and freedom from subordination through the chores of care and domestic work. All the while the tab is picked up by precarious gig economy workers brought in to plug the care gaps in a labor market that continues to be stratified by the intersections of gender, race, and class.

Electronic monitoring in homecare services

In Britain, zero hours contracts, which do not guarantee hours for work and often circumvent holiday and sick pay, have come to complement the expansion of the gig economy, because they function on the principle of limiting what is considered to be the time that workers are productive, and hence paid. In the homecare sector, zero hours contracts are particularly prevalent (Bessa et al. 2013: 21) and syncs all too conveniently with electronic monitoring. Electronic monitoring can mean that homecare workers sign in and out by phone of a monitoring system when they arrive at and leave someone's home, scan a tag on the person's file with their smartphone or are tracked via smartphone using Global Positioning System (GPS) technology. Sian Moore and legal scholar Lydia Hayes have researched the introduction of electronic monitoring by local authorities in the UK (Hayes/Moore 2016; Moore/Hayes 2017). They have shown how electronic monitoring facilitates a distinction between time spent working and time not spent working during a shift through the precise monitoring of *contact time* – the duration of a visit in someone's home. In the context of what is known as *time-and-task commissioning*, contact time becomes the metric for commissioning homecare services, as opposed to a set price for a visit. For local authorities on extremely tight budgets due to austerity (Local Government Association 2018: 3), this can be a way to make money go further, with several councils publicly stating the benefits of electronic monitoring for saving money. The consequences for homecare workers

are a reduction in wages and a deterioration of working conditions, while service users also suffer the repercussions of care workers being pushed for time. When under severe time pressure, homecare workers routinely have to cut out anything that is not absolutely necessary to getting the job done. This routinely includes the emotional and affective dimensions of caring. Yet, the research that Moore and Hayes conducted showed that care workers may very well log out of the electronic monitoring system to stay beyond the allotted time if something unexpected happens, to offer company to someone who might otherwise be alone or help someone with a task they needed, precisely because they cared (Moore/Hayes 2017: 111). The fact that they would not be paid for this is an example of the ways in which unpaid work motivated by compassion and sense of responsibility is enlisted to prop up an underfunded system.

Care in the community

Paid care workers doing overtime is one aspect of a care fix, another is the reliance on volunteering. Casserole Club is a UK platform currently used by a small number of local authorities in England in the Southeast, North, and Midlands. It involves tools to allow neighbors to coordinate to bring round a meal for someone who might in the past have been eligible for *meals on wheels*. These members of the local community step in voluntarily where local councils have cut such services due to austerity, with the added benefit of conversation and social interaction as a way of combatting social isolation among elderly residents. Local councils pay an annual fee to use the platform (FutureGov n.d.). This is an example of the shift away from local authorities providing inhouse services or commissioning them to renting software for such services to be provided by the community, where the unpaid work of volunteers is enlisted, while digital companies charge local councils high sums on a rolling basis in order to provide the digital infrastructure.

The limits of platform care

There are three ways in which new care platforms offer solutions to the care crisis. First of all, they respond to the crisis of the neoliberal subject and the imperative for permanent productivity and optimization. Self-care apps of-

fer solutions for time-management, but also for managing stress, burnout, and the psychological and physical pressures of managing a healthy work-life balance. This individualizes the problem, offering solutions that are a mix of self-help and self-governance that in turn feeds quantified data about mind and body to the private corporations developing such apps. Second, new care platforms intervene in the crisis of social reproduction within the family and household, or society more generally. Especially where women are no longer available in the household as a resource for care, other, for the most part highly precarious, workers step in to take care of children and pets, or care for elderly relatives. This is even construed as conducive to female empowerment within the confines of financialized capitalism, while externalizing the responsibility for and cost of care and social reproduction further to the individual household. Concurrently, inequality between those who can afford such services and those who cannot increases, not to mention to the precarious employment conditions that prevail in the gig economy, as has been well-documented (Woodcock 2021). Third, in the face of a crisis of public services and the welfare state, digital technologies used to help councils cut costs for staff and services, as well as promising to help curtail health and social care costs. This risks not only acting as a conduit for new kinds of public-private partnerships that facilitate the privatization of public funds, but again, the work and the costs of care and social reproduction are offloaded to individuals and households, as well as to communities and volunteers. In sum, the dominant mode of platform care at present is one of privatization in two senses of the term, namely personal responsibility and marketisation.

In Europe the personal and household services sector is the second-fastest growing sector behind ICT (Decker/Lebrun 2018: 13) and in fact with the platformization of care these two sectors are becoming more intertwined. Critical questions pertain to the extent that these platforms exacerbate the further casualization of labor and pose new challenges with regard to the privatization of public funds, the extraction of profits and the commercial use of data. Further questions pertain to the working conditions are of the digital workers employed as data analysists, software developers, blog and website managers, and so forth and what their relationship is with those gig workers or volunteers providing services, along with the political decisions are automated through algorithms in the provision of care. Moreover, the problem is not always necessarily the technology itself, but the particular ways that technologies are orientated towards or premised upon capitalist valorization and accumulation. And while critical research on the societal (and ecological)

consequences of new technologies is crucial (e.g., the dramatic expansion of virtual communication in the wake of coronavirus), making sense of the current platformization of care requires a consideration of the broader political economy of care under conditions of financialized capitalism.

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