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Editorial

Anke Bartels and Luke Martell

On 5th May 2023, Tedros Adhanom Ghebreyesus, Director-General of the World Health Organisation, declared the end of COVID-19 as a public health emergency of international concern. While this does not mean that COVID, which has now become endemic, will not be with us for a long time to come, it definitely seems to entail a going back to pre-pandemic discussions about how health care should be organised and who will profit from it. Far from looking for new solutions to increasing problems in the health care industry or affordable medication for everybody, not even pay rises for the much clapped-for carers ever materialised in the aftermath of the pandemic.

Still, COVID-19, which was first discovered in Wuhan in November 2019, sparked a lot of interest not only in contagion, epidemics and the role of scientists in telling the story of an ill-

ness, but also highlighted a multitude of problematic issues in areas outside of medicine and medical knowledge severely affected by it. In this edition of *Hard Times*, we try to take this into account by covering literature and arts as well as society and politics. There is some focus on Britain but, in accordance with the global nature of the pandemic, it is also much more international in coverage and themes than usual.

One important theme brought about by the pandemic, in fact, is the interplay between the global and national. Since COVID, as a pandemic, spread internationally, it seemed to support globalisation theories and to ask for global answers. But the solutions were very national - vaccinations, lockdowns, border closing etc. - implemented by nation-states and varying by nation, despite the disease's global nature. So politics seems to still be very

national and non-global, in this case at least, despite globalisation theses.

The emphasis on the national was, not least, visible in the outbreak myth circulated in the Global North. It falsely claimed that Chinese people eat unhealthy food and thus cause all kinds of contagious illnesses with Corona being a case in point. This idea was further reinforced by talk of the “China virus” and fanned all kinds of xenophobia reminiscent of earlier defamations of East Asian people as “Yellow Peril”. But it did not stop there, as instead the fear of contagion led to all kinds of different forms of “othering” with regard to marginalised groups, while leading the discussion away from important issues like man-made climate change, rapid urbanisation and other effects of neoliberal capitalism.

The global nature of the pandemic exposed the vastly different experiences of Global North and Global South with regard, for instance, to vaccine distribution. Following on from this, many contributions discuss inequalities and discrimination, often along international lines, exposing further global differences and tensions. Obura discusses how the pandemic was often represented through western lenses and comes to the conclusion that it marginalised People of Colour. Pittel also discusses the western-centrism of stories from the pandemic, but argues

that it is not as simple as that and stories also covered the porous nature of what we went through and also had themes that were globalist and cosmopolitan. Raja and Choudhary discuss the discriminatory nature of death in the first wave in India, where the middle classes suffered, at least initially, much less than the poorer. Dowling, relatedly, discusses the feminised, racialised and classed workforce in the UK’s care system, showing the unequal nature of the workforces battling amidst COVID as well as of the victims.

Some of our contributors draw attention to the roles of neoliberalism and privatisation. These are seen to be at the root of many problems in care and health services. COVID laid bare the inadequate state of health services due to the neoliberalisation of medicine. At the same time the role of governments in funding and promoting vaccines seems to have been beneficial, while there is no denying that these were also used for ideological battles. While Lister charts the privatisation of the NHS, driven by neoliberal ambitions, and outlines painfully and painstakingly its failures, setbacks, and devastating effects, Pietrzak-Franger discusses how the digital empowerment of patients also pushed responsibility on to them in a neoliberal way, psychologising care and health, and away from the state and the role of social context and social structure. Dowling,

on the other hand, focuses on the under-resourced nature of the British care system and, as just mentioned, the way it rests on personal responsibility, profit and inequality. These structural underpinnings for the crisis of care need to be over-turned and, she argues, this requires agreement over the distribution of societal resources and capacities for caring.

Solutions to the crisis of health and care in the UK will need a re-thinking of ownership in these sectors. Bringing health and care back into the realm of collective ownership and need and away from private ownership and profit is required, for the sake of better resourcing, worker pay and conditions, and patient care. But Gain, focusing also on care, argues that what ownership means needs to be thought through. Ownership, he argues, should be more than abstract and psychological and must be about control, collective and participative, and not about manufacturing consent.

This issue of *Hard Times* also covers themes of openness and closure. During the pandemic there was the closure of peoples' lives, an inability to go to social events, mix and go to public spaces. This is contrasted to openness and, at one end of the debate, arguments for people to choose to live as normal, and be released from lockdowns. These are entwined with

disagreements over government control over people to impose lockdowns. Anti-lockdown movements argued against state control and for individual freedom, as did anti-vacc movements. There is also the more in-between case of places like Sweden where the state played a slighter role and favoured more voluntary isolation. In the end, this debate has been on individual freedom versus solidarity (expressed through lockdown and masks etc), where the balance should lie, with our freedom to do what we want autonomous from state or collective restrictions or, on the other hand, our responsibility to accept the latter out of solidarity with, and protection of, others. In this context, Peterson talks about life without concerts during lockdowns, and how live-streaming and invisibility replaced concerts. Nothing can replace the life of in-person concerts, but Peterson discusses how possibilities have developed for music and performance outside live performance. As we can see from these themes covering the role of the state, neoliberalisation, and openness and closure, the pandemic was heavily politicised.

This politicisation was also the case with discourses and representation and a number of contributions look at the representation of COVID. Pietrzak-Franger outlines narratives of long COVID. For her, social media, digital technologies and digital ac-

tivism helped to get recognition and legitimation of long COVID, knowledge creation about it, and community building. But there were also downsides such as the datafication of individuals and stigmatisation. Obura discusses how representations or discourses of COVID marginalised children. Children were seen in some discourses as powerless, were muted and as lacking agency. Yet, he talks of instances where children tried to find a voice and assertiveness. Pittel, on the other hand, discusses stories from the pandemic in *The Decameron Project*. These aimed to face rather than escape from the pandemic. The stories covered staying in and getting out, and recognition and solidarity. They were often sombre, portraying a thin line between life and death. Raja and Choudhary, finally, look at the poetry of the pandemic coming from India. What they discuss exposed the

role of the state, including its limits and failures, the resulting discriminatory nature of the pandemic's effect, and the parallel worlds of the middle classes and others. As with many of the contributions, contrasting experiences and themes show up, in cases such as this, of both resilience and death.

While all our contributors started their inquiries during or in the direct aftermath of the COVID pandemic, their discussions are far from obsolete. In fact, COVID made the problems inherent in global neoliberal capitalism just more visible. The futile attempts to stop a global crisis on a national level should tell us one more time that global questions need global solutions which address injustice and inequalities, not only with regard to health care systems.

The Private Sector Has No Answers to NHS Problems

John Lister

John Lister discusses how ideological pressure for privatising 'reforms' to England's National Health Service reflect the neo-liberal ambition to shrink the state (and taxation) and maximise private sector involvement. He argues that the focus has mainly been on promoting European-style 'social insurance' systems rather than the obviously flawed and costly US system. Privatisation (outsourcing) of sections of the NHS began in the 1980s with non-clinical services, but was continued in the 2000s with contracting out of clinical care and the privatisation of provision of capital – the Private Finance Initiative.

From 2010 13 years of real terms cuts in NHS spending under Conservative-led government austerity has created a growing dependence on private providers of clinical and especially mental health services. However this has been limited by workforce issues (reliance upon the same limited pool of qualified staff) and by the limited scope and ambition of priva-

te providers. Private hospitals have only sought contracts for the least complex elective patients, leaving the NHS to treat the remainder. Greater privatisation of clinical care therefore risks diverting money and staff away from emergencies and the most seriously ill patients – leading to worsening performance and rising levels of public dissatisfaction.

More than six months have now passed since the resignation of Liz Truss, the shortest serving and most ideological of British Prime Ministers. Her disastrous (and swiftly aborted) economic policies, which she still upholds (Smith 2023), flow from her long history of involvement with opaquely-funded right wing lobby groups. Such groups aim to create a profitable private sector role in both the financing and provision of health care in England (other parts of the NHS outside England are controlled by devolved governments).

However, savvier advocates of more privatised systems in Britain have distanced themselves from any kind of US-style system based on private insurance (Seekings and Wang 2021). American health care is notorious for its extravagant waste, fraud, inflated costs, and the millions of people left uninsured or under-insured, with many bankrupted by unpayable bills.

The favoured models are therefore systems that can be portrayed as relatively close to the NHS – apparently offering universal coverage, free at point of use. Liz Truss herself was one of an 8-strong Parliamentary Board of the ‘1828 Committee’, whose ‘Neoliberal Manifesto’, published jointly with the Adam Smith Institute in 2019, condemned the NHS record as “deplo-

rable” (Lesh et al 2019). It states: “We believe that the UK should emulate the social health insurance systems as exist in countries such as Switzerland, Belgium, the Netherlands, Germany and Israel, among others. ...”

Right wing newspapers and broadcasters have also consistently pushed for such a massive change. One-time Brexit secretary David Davis has called for scrapping the NHS as a tax-funded system (Davis 2022). The argument is that the NHS as launched in 1948 is ‘out of date’, and that it should be replaced by a ‘social health insurance’ system ... dating back to the 1880s. This would wind back the clock to reinstate the failed system that was in place in Britain before the NHS.



Sunak and private sector health leaders,

<https://www.opendemocracy.net/en/elective-recovery-taskforce-private-healthcare-nhs/>

Social health insurance (SHI) began in Germany as workplace insurance under authoritarian Chancellor Bismarck in 1883, covering only elite workers in the initial schemes, and only while they were working: it did not cover their families, retired workers or of course the millions of people, working or unemployed, who were left outside the scheme. By 1885, just 10% of the German population was insured – by a total of 18,776 sickness funds (Blümel et al 2020).

This model inspired the system in Britain prior to 1948, which left more than half the population without adequate access even to primary health care (Kings Fund n.d.). Nevertheless, the IEA's Dr Kristian Niemietz argues SHI could be a blueprint for 'reform' in the UK, claiming SHI systems "tend to have better healthcare outcomes" (Pym 2022).

Of course, outcomes are related to inputs, and the figures show that Germany, for example, spends a lot more than the UK on health – and has done for decades. BBC Health correspondent Hugh Pym notes: "The German system is better staffed and stocked than the UK, relative to the population. ... in 2019 the UK had around nine nurses per 1,000 people, while in Germany there were about 14. The disparity in bed numbers was wider - with Germany's eight beds per

1,000 patients more than three times higher than the UK figure." (ibid.)

What really matters in terms of resources on the ground is not the share of GDP spent on health but the amount spent per head of population. On this measure, UK spending is much lower than many of the countries cited as preferable models by the IEA and by Truss and her '1828 committee' colleagues. Germany spent 46% more per head on health than the UK in 2019, Switzerland 58% more, Belgium 22% more and the Netherlands 29% (OECD 2022).

Not only do these countries spend more, they also leave patients stuck with more of the cost of care. In Switzerland the proportion of private 'out of pocket' spending on health is exceptionally high at 26% of total health spending, so poorer households pay a higher proportion of their income for health care than the richest (Tikkanen 2020). Belgium levies higher user charges for mental health and dental care (Gerkens and Merkur 2020); and even the right wing US Heritage Foundation points out that in the Netherlands costs fall disproportionately on poorer people, who spend between 20-25% of their income on healthcare (Altenburg-van den Broek and Lynch 2010).

These ideal models aren't so ideal after all: so David Davis and ot-

hers resort to a lie, insisting, against all of the evidence, that the NHS is an insurance system. Davis argues: "...we already use a principle of insurance to fund our health service: National Insurance."

Davis knows full well that only in exceptional circumstances have governments resorted to using National Insurance contributions to fund the NHS, which has mainly been funded from general taxation – effectively sharing the risk and the costs of ill-health across the whole tax-paying population. The Truss government reversed the most recent plan to use NI funds for the NHS (Lister 2022a).

Aneurin Bevan, architect of the NHS in 1948, clearly rejected any notion that it was an insurance scheme and argued it should not be confused with National Insurance (Bevan 1952). Why, then, is David Davis so keen to suggest that the NHS is an insurance scheme? He explains: "Involving private firms in the provision of health insurance ... would simply mean sharing the burden (and the opportunity) between the state and the private sector."

However private insurance would only play a role if 'social insurance' is linked with paying for preferential access to hospitals, mental health and GPs. So, the right wing 'reformers' don't just aim to change the mecha-

nism of funding: they want to privatise and commercialise the provision of health care.

But its advocates can't explain how SHI is the answer to any of the big questions facing the NHS today, whether these are waiting lists, an exodus of staff, lack of front-line capacity, long queues of ambulances outside emergency departments and delays in emergency admissions, or the delays accessing mental health care for children and adults.

In 1948 the NHS superseded the social insurance system that had prevailed from 1911, to establish a system that was universal and more forward looking. It allowed services to be planned on the basis of local need, patients to access services regardless of ability to pay, and national training systems to be put in place for doctors and professional staff. Nobody but the right wing of the Conservative Party and neoliberal lobby groups now wants the discredited old system back.

Ideological Privatisation

The stress test of the pandemic has also underlined another important fact: private sector provision is not the answer to any of the big problems, either.

Government attempts to carve up the NHS and create contracts for private companies began 35 years after it was founded as a largely publicly owned and publicly funded service. Margaret Thatcher's government from 1979 began privatising whole publicly-owned utilities and turning them into private, shareholder-owned corporations (Centre for Public Impact 2016). However, despite Thatcher's own ambition to switch to a system of compulsory private health insurance, we now know her cabinet saw the need to tread much more carefully with the NHS (Travis 2016).

Privatisation (initially limited to competitive tendering and "contracting out" of services that previously were part of the NHS) was based from the outset on political ideology rather than on any evidence. From 1983 onwards ministers began the process by salami-slicing off low-profile but potentially profitable services – starting with non-clinical support ("ancillary") services, primarily cleaning, catering and laundry (Lister 2020a).

Thatcher's ministers claimed that their objective was "efficiency". In fact, the process ticked four boxes on their political agenda:

- it reinforced the free-market, small-state ideology later known as 'neoliberalism';

- it delivered some short-term cash savings – at the expense of quality;
- it offered contracts for the Conservative government's donors and cronies in the private sector;
- and, no less important, it undermined the power of the NHS unions.

The latter point is often ignored: but contracted out workers were no longer NHS employees. Once anti-union laws had been passed, privatisation helped ensure combined strike action by support staff (historically the most strongly organised and most combative in these sectors of the workforce) and professionals over pay and conditions (as had happened in the 1970s and 1982) would not recur for 40 years.

Belief that the power of competition ("contestability") could improve quality and increase efficiency in health care was also the main driving force in New Labour's increasingly irresponsible experiments with the use of private providers for clinical services from 2000. Ministers chose not to expand the NHS itself, but preferred instead to encourage the development of new, private providers, creating an artificial 'competitive market'. They even set targets for a growing share of NHS operations to be delivered – at higher cost – by the private sector (Lister S., 2004).

When David Cameron's coalition took office in 2010, it was

ideology, in defiance of the growing body of evidence, that drove Andrew Lansley's Health and Social Care Act. It restructured the NHS to institutionalise a competitive market in clinical and non-clinical services at considerable cost, but with no detectable benefit other than to private providers (Davis et al, 2015).

Privatisation to Fill Gaps

The years of austerity from 2010, ten years of real terms cuts in spending, have brought a chronic lack of capacity in the NHS. Ministers now argue that a depleted NHS somehow "needs" the resources of private contractors and private hospitals to fill the gaps created in services (IHPN 2017a) and address growing delays (NHS Confed 2019).

By 2017 the private sector was boasting that it was providing "capital, capacity and capability to the NHS to help meet the increasing demands it faces." (IHPN 2017b) Private firms were delivering over 22% of all NHS gastroenterology, trauma and orthopaedic services; over half a million NHS elective surgical procedures annually; almost 10% of all NHS MRI scans; and almost half of all NHS community services.

In 2019 the Institute of Fiscal Studies found that the NHS was becoming

increasingly reliant upon independent sector providers (ISPs) for some types of elective work, providing "30% of all NHS-funded hip replacements, 27% of inguinal hernia repairs and 20% of cataract procedures. [...] 82% of the growth in hip replacements between 2003–04 and 2018–19 was accounted for by ISPs." (IFS 2019). The COVID pandemic further reduced the capacity of NHS hospitals, mental health services and GPs.

Rising Share of NHS Funds Go Private

Department of Health and Social Care (DHSC) *Annual Reports* show how spending by NHS commissioners on private providers of clinical services rose each year, from close to zero in 1997 when John Major's Tory government finally fell (Timmins 2005), to just over £2 billion (2.8 %) in 2006 when separate figures were first published (Full Fact 2017), and £9.2 billion in 2018 (DHSC 2019). The most substantial jump prior to the COVID pandemic was a 24.7 % (£1.6bn) increase in 2013/14 as the 2012 Act took effect (Rowland 2019).

These commissioner figures do not include additional contracting out of services by NHS providers, so they significantly understate the scale and impact of private sector involvement. If all NHS spending on GPs and

dentistry, and all NHS spending on social care (almost all of which is privately provided) is included, the real figure could be as high as £29bn in 2018/19 (Rowland 2019).

Even without NHS primary care and dentistry, total NHS England spending on private providers rose 34% in six years: from £13.5bn (14% of budget) in 2013/14, to £18.1bn (16%) in 2018/19 (Lister 2019a). However the latest DHSC Annual Report shows NHS spending on private providers rocketed by 25.6% in 2020-21, to over £12 billion (DHSC 2022).

At the centre of this was the massive NHS England contract to block-book beds in private hospitals as the pandemic hit (Dunhill 2020). Despite the shockingly poor value of that contract to the NHS (Dunhill 2021), a further 4-year, ‘framework contract,’ worth up to £10bn, was subsequently put in place to make it easier for NHS trusts or commissioners to make use of private sector beds as ‘additional capacity’ until 2024-5. The hope was to find a way of bringing down waiting lists and waiting times (Lister 2020b).

But with thousands fewer NHS hospital beds occupied than before the pandemic, thousands of beds still occupied by COVID patients (9,600 on October 5 2022) and an average of around 12,000 patients who cannot be

discharged for lack of social care and services outside hospital, the new higher level of NHS dependence on private beds is likely to continue for some years to come.

£ 1.283 billion of the first £2.15 billion paid out by the NHS to private hospitals in 2020 was paid to three private hospital chains: Circle Health Holdings (now owned by predatory US health corporation Centene), Spire, and Australian-owned Ramsay Health Care UK (Parsley 2021). Most private hospitals were happy to accept NHS subsidies to cover their costs during the COVID lockdown, and to fill their otherwise under-used beds with NHS patients as part of the 4-year £10bn “framework” deal. But nowhere near the full 8,000 private sector acute beds were made available to the NHS, and far fewer were used (Thomas 2020).

The reason is simple: for the NHS to make full use of the beds, either the private hospitals would have to ‘poach’ more staff from the same limited pool of staff trained by the NHS – increasing the pressures on front-line NHS services – or the trusts would have to split their own clinical workforce to send teams to work off-site in small private hospitals. Any benefit from access to additional beds to speed up elective work would be offset by the greater problems maintaining adequate staffing of emergency services.



God bless the NHS, © Luke Martell

Both Spire and Ramsay subsequently bragged that delays waiting for NHS care would generate more lucrative possibilities with self-pay patients (Spire 2021): they prefer to fill beds with more profitable, self-pay and insured private patients than NHS patients at the lower NHS tariff cost.

In any case, even if it had been possible to utilise ALL 8,000 private sector acute beds on a short or medium term basis, it would still leave the NHS facing a drastic loss of capacity at the end of the contract, compared with 2019, and even more chronically dependent on the private sector.

Setbacks and Failures for Private Contracts

The private sector did not reap the expected reward from the 2012 Health and Social Care Act. In 2019 the Independent Healthcare Providers Network (IHPN) revealed that the proportion of NHS contracts awarded through competitive tendering had *fallen*, from 12% of all contracts in 2015/16 to just 6% the following year (IHPN 2019). The value of these contracts had fallen by a third (from 3% to just 2% of CCG spending on clinical services) over the same period. Competitive tendering had been largely replaced by 'framework contracts' listing approved providers or extending contracts to existing providers (NHS SBS no date).

In community health services the private sector had won many more contracts than the NHS – but most of these were small in value. While NHS trusts had just one in five community contracts, this was more than half of the contracts by value – ten times the 5% won by for-profit private companies (NHS Providers 2018).

Non-clinical service contractors had also under-performed. Despite over 25 years of pressure to contract out basic hospital support services such as cleaning and catering, researchers found only around 40% of 130 hospital trusts had contracted out their cleaning services from 2010 to 2014 (Elkomy et al 2019). Earlier figures

suggest similar numbers had opted to contract out catering (Thomas 2010).

There have been many and repeated contract failures ever since the first hospital support services were contracted out in 1984, especially where contracts turn out to be more costly or complex than the contractor expected, performance falls below specifications, and contracts are wound up years early.

One of the most bruising setbacks for the pro-privatisation lobby came in January 2015 when Circle, (then – falsely —claiming to be a ‘John Lewis-style partnership’) finally pulled out of its disastrous contract to manage Hinchingbrooke Hospital in Cambridgeshire, just three years into a 10-year £1bn franchise (Lister 2014). Circle had promised to generate more than £300m savings in 10 years, but left the Trust saddled with a £7m-plus deficit, and departed just after a Care Quality Commission report unveiled the abysmal quality of care in Hinchingbrooke (CQC 2015). Circle’s failure to retain staff led to sky-high spending on “interim staffing” – locums, bank and agency staff. In the 2013 NHS Staff Satisfaction Survey, Hinchingbrooke came out worse than the NHS average on 19 of 28 Key Findings, including incidence of bullying or abuse from colleagues. Its staff turnover rate was almost 50% higher than the NHS average.

This collapse killed off several similar plans to “franchise out” the management of NHS hospitals to private companies. Since then large-scale outsourced non-clinical service contracts have been wound up early: Interserve in Leicester 2016 (national-healthexecutive.com 2016) and Carillion in Nottingham University Hospitals (Bowden 2017). Prominent hospital trusts, especially in London, have more recently agreed to bring support services back in house (Clover 2021), or to drop plans for outsourcing (Lister 2020c).

Clinical failures include the collapse of ambitious attempts to contract out older people’s services in Cambridgeshire and Peterborough (Lister 2016), and cancer and end of life services in Staffordshire. The consistent message is that private companies want profit, and they want it guaranteed and without risk.

Doubts over the wisdom of contracting out have not been dispelled. The BMA reports doctors’ most common fear is destabilisation of NHS services; followed by fragmentation of services, and concern that independent sector provision represented worse value for money and provided care of lower quality (BMA 2019).

There have been a host of outsourcing service failures, including

diagnostics, GP surgeries, hospitals, mental health, pathology, support services, and patient transport and ambulance services (NHS For Sale 2022). Nonetheless the private sector has grown. The Health Foundation has warned that private providers were growing at the expense of NHS trusts, leaving the NHS as increasingly an ‘emergency’ service (Charlesworth 2017). The Financial Times in June 2020 estimated NHS work already accounted for “more than 80% of Ramsay’s revenues, and around 40% for BMI/ Circle and Spire” (Plimmer and Neville 2020).

Centene Doubts Future Profits

However, the apparent boom times in England’s puny private hospital sector need to be put in context. In 2021 US corporation Centene apparently put itself in pole position to cash in on the weakness of the NHS when it paid \$700m for complete control of Circle, the largest UK private hospital chain, with 54 hospitals (Parsley 2021). The company had also controversially taken a relatively large stake in GP services in England, making them the largest private player in the primary care market – albeit with just 1% of GP practices (Kollewe 2021).

The corporation established high-level influence with the Johnson government. In 2021 Samantha Jones,

then CEO of Centene’s UK subsidiary Operose, was appointed as a senior advisor to Boris Johnson himself, and then chief operating officer in Downing Street (Stewart 2022).

Nonetheless at the end of 2021 Centene revealed that they were contemplating a complete withdrawal from Britain – and from all their international operations, worth a total of around \$2 billion per year (Liss 2021) – to concentrate on their vastly larger (\$126bn per year) “core” business in the US (Minemyer 2022). Centene’s concerns underline the fact that the profitability of contracts in a chronically under-funded NHS is not necessarily as high as they (or we) might expect. It’s certainly less than can be extracted from the vastly-better funded US health care system.

More Setbacks for Private Sector

Early in 2018 privatisers suffered a seismic shock when Carillion, the multinational construction and services company abruptly collapsed after years of mismanagement (Neate and Davies 2020). Carillion had been a leading player in ‘Private Finance Initiative’ projects building hospitals and schools from 1997.

Its collapse halted work on two major PFI hospitals (in Liverpool and Birmingham). In each case the public

sector had to step in, take over the contracts, and pick up a hefty additional bill for the remaining work – effectively doubling the construction cost of each hospital, neither of which has yet been completed (Construction Index 2020). This fiasco effectively marked the end of PFI – but with no extra capital this has left a constipated silence on Johnson’s promises of public funds to build up to 48 ‘new hospitals.’

Mixed Signals – But Privatisation Continues

The long-awaited publication of NHS England’s Long Term Plan sought to remove some of the most objectionable elements of the 2012 Act, notably the sections and regulations which compelled Clinical Commissioning Groups to put services out to competitive tender (NHS England 2019).

However, NHS England was even then driving through highly contentious contracting-out of services. One was a 7-year contract for PET-CT scanner services, which had just been secretly awarded in Oxfordshire by NHS England to a private company, InHealth. This led to immediate, furious opposition from consultants, campaigners, and MPs of all parties (Lister 2019b).

NHS England threatened legal action against anyone raising concerns about clinical standards and care (Lowdown NHS 2019). Nevertheless, Oxfordshire Tory MPs, along with local LibDem and Labour MPs, all wrote to question the decision and the way it had been arrived at, expressing “extreme concern” that patient care would suffer (Lister 2019c).

In the event NHS England toughed it out, but Oxfordshire was no exception. The Long Term Plan specifically called for large-scale networks to provide pathology and imaging services. With insufficient NHS capital to invest this meant even more ‘partnerships’ with private companies.

The Rise and Rise of Management Consultants

Management consultants have played a key – and lucrative – role in most of the big reorganisations of the NHS going back at least to 1974 (Begley and Sheard 2019). A major McKinsey report commissioned by New Labour after the 2008 banking crash, suggesting £20bn of ‘savings,’ shaped many cost-cutting policies of NHS trusts and commissioners from 2010 (McKinsey & Co. 2009).

McKinsey helped construct Andrew Lansley’s large and disastrous Health and Social Care Act (Rose

2012). In 2016-17 management consultants were used to support the drawing up of ‘Sustainability and Transformation Plans’ in 33 of the 44 areas (Neville 2018). In North West London firms including McKinsey were employed again and again from 2011 on the ‘Shaping a Healthier Future’ project to close two major hospitals (at a combined cost of over £80m). After that plan was scrapped McKinsey veteran Penny Dash was installed in 2020 as the chair of NW London’s “integrated care system” (Lister 2020d).

England’s NHS spent an estimated £300m on consultancy in 2018/19, despite evidence that management consultants in health care “do more harm than good” (Sturdy and Kirkpatrick 2021). But the pandemic was a massive money-spinner. By January 2021 Health Minister Helen Whately – herself a former McKinsey employee (Fleury 2020) admitted that 2,300 management consultants from 73 different companies (more than number of the civil servants in the Treasury) were working on the lamentable Test and Trace system (Bright 2021). Deloitte had 900 employees at work in test and trace.

In 2018 the Department of Health and Social Care’s own privatisation unit, Shared Business Services (itself run as a partnership with Sopra Steria) set up a 4-year “Framework

agreement” listing 107 pre-approved companies who can be hired, with no tender process, to steer the decisions of NHS commissioners and providers. A shortlist of half a dozen companies to advise on technical aspects of creating “integrated” systems’ has been massively expanded into a huge catalogue of around 200 organisations and (mainly) private companies that are all pre-approved to offer advice under the Health Systems Support Framework (HSSF). At least 30 of the firms are US-owned, offering expertise drawn from operating the notorious American health insurance market (Dropkin 2022).

Mental Health: A Stronghold of Private Provision

NHS reliance on private providers of mental health services has for many years been much greater than in acute and community services, with funding for independent sector mental health service providers “increased by 15% in real terms between 2011/12 and 2012/13 alone, while funding for NHS-provided mental health services decreased by 1%” (Lafond et al 2014).

According to the Competition and Markets Authority the market for mental health services was worth a total of £15.9 billion in 2015. The private hospital sector had grown in the previous five years, while NHS capacity had been cut by 23% (CMA 2017).

The private sector delivered 97% of a £304m market in provision of “locked ward rehabilitation” in 2015. A health minister admitted spending on private sector provision of child and adolescent mental health (CAMHS) grew by 27% over 5 years, from £122m to £156m (UK Parliament 2018); 44% of the £355m NHS spending on CAMHS care was going to private providers (Townsend 2019).

By the end of 2019 one in every eight (13%) inpatient beds – and a quarter of all mental health beds in England – were provided by American companies. Mental health patients in Manchester had a 50:50 chance of being admitted to a privately-owned hospital, and a one in four chance of the bed being provided by an American-owned company (Plimmer 2019).

The driver of mental health privatisation remains chronic lack of NHS capacity. NHS England admits 1.4 million people are on waiting lists, and an additional eight million people would benefit from care, but do not meet current criteria (Murdoch 2021).

The massive increase in need for mental health services, exacerbated during the COVID pandemic, combined with the lack of investment to leave the NHS even more reliant on the private sector.

Integrating with the NHS

The NHS England ‘Delivery Plan’ to tackle the growing backlog of waiting list treatment, announced on February 8 2022, repeatedly states the need to use the private sector (NHS England 2022). This means funnelling even more NHS cash into the same private hospitals and private sector providers that have already shown themselves during the pandemic to be dreadful value for money (Ryan 2022). The increasing reliance on private beds and services means that – despite all the rhetoric about “integration” – the NHS itself cannot run sustainably as a coherent and comprehensive public service.

Since July the Health and Care Act has reorganised England’s NHS into 42 local ‘integrated care systems’ (ICS) each run by an Integrated Care Board. And while government amendments have effectively prevented private companies from sitting on ICBs and shaping decisions, a further expansion of private sector involvement in the ICBs is inevitable, given the Long Term Plan’s heavy focus on investment in largely unproven ‘digital’ techniques and apps.

The more money that is spent on useless management consultants, questionable apps and digital quackery, the less is left to fund the core NHS business of delivering safe and high-

quality care for sick patients, millions of whom for a wide variety of reasons are ‘digitally excluded’ from fully utilising the latest ideas.

To use the private sector as additional capacity means more than paying over the odds to make it profitable. It creates a lop-sided “partnership” with companies which benefit either way from a lengthening NHS waiting list. Private hospitals are not evenly distributed across the country, but concentrated in London, the south-east and more prosperous populations. Deprived areas are excluded from this aspect of the Delivery Plan.

Where private hospitals are available as “partners”, the NHS would be increasingly confined to a role of providing emergency services, medical care and more costly, complex treatments that the private sector has always avoided, leaving private hospitals free to pick and choose the level of care they see as most profitable and wish to provide.

No Private Sector Solution

The Delivery Plan threatens to consolidate the biggest-ever expansion of spending on private providers as a permanent feature of the NHS. But if the private sector is the answer, what is the question? Four decades of failed contracts and fragmentation show pri-

vate provision is not so much a road forward as an expensive dead end.

The NHS has not been “sold off” – and there are no eager buyers, because the current situation suits the private sector, offering stability and guaranteed income. Even if a government were willing, and politically able, to deliver a fully privatised system, there seems no reason for private providers to prefer it. The new status quo allows them to accumulate profits from the NHS at minimal risk – while the government does most of the hard work of collecting in the money on their behalf.

The alternative requires increased investment to expand NHS capacity and its workforce. That is the only way to a sustainable, effective, genuinely universal and comprehensive system.

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Ownership and Care

The Challenge of Building New Sustainable Social Care Organisations after COVID Requires Us to Understand ‘Ownership’ at Work

Aaron Gain

The all too many distressing stories of deaths in older people’s residential and nursing care homes during the pandemic were vivid reminders of the inadequacies of our current system of care and have reopened older debates about the levels of funding for (and the ownership and management of) provision. Contemporary policy debates about the future of care services in England, as well as long standing scholarship about alternatives to the private and public sector, testify to the importance of ownership.

In his article, Aaron Gain (The University of Brighton Business School) seeks to discuss how understanding the heterogeneity and contested nature of ownership provides us with critical insights into how we might develop new care organisations. In contrast to conventional positivist public policy analysis, which seeks to collect and compare measurable ‘facts’, he explores how different social science disciplines have conceptualised ownership. Subse-

quently he raises awareness of recent and emerging research on the experiences of care workers and employee-owners.

Introduction

COVID-19 has resulted in unprecedented levels of both government funding and restrictions to our daily life. As governments have introduced further centralised command and control measures to limit the negative impacts of the virus, manufacturing, hospitality, retail, consumer, digital industries and health and care systems have all adapted to the new environment. However, comforting as these approaches are in a crisis, they are unlikely to be effective in delivering better care or be welcomed by the public/citizens, employees, service users, consumers, or stakeholders in the long-term. Moreover, an important characteristic of our collective response



YOUR NEW NATIONAL HEALTH SERVICE

On 5th July the new National Health Service starts

Anyone can use it—men, women and children. There are no age limits, and no fees to pay. You can use any part of it, or all of it, as you wish. Your right to use the National Health Service does not depend upon any weekly payments (the National Insurance contributions are mainly for cash benefits such as pensions, unemployment and sick pay).



CHOOSE YOUR DOCTOR NOW

The first thing is to link up with a doctor. When you have done this, your doctor can put you in touch with all other parts of the Scheme as you need them. Your relations with him will be as now, *personal and confidential*. The big difference is that the doctor will not charge you fees. He will be paid, out of public funds to which all contribute as taxpayers.

So choose your doctor now. If one doctor cannot accept you, ask another, or ask to be put in touch with one by the new "Executive Council" which

has been set up in your area (you can get its address from the Post Office). If you are already on a doctor's list under the old National Health Insurance Scheme, and do not want to change your doctor, you need *do nothing*. Your name will stay on his list under the new Scheme.

But make arrangements for your family now. Get an application form E.C.1 for each member of the family either from the doctor you choose, or from any Post Office, Executive Council Office, or Public Library; complete them and give them to the doctor.

There is a lot of work still to be done to get the Service ready. If you make your arrangements in good time, you will be helping both yourself and your doctor.

Issued by the Department of Health for Scotland

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to COVID-19 has been the widespread re-emergence of Kropotkin-like forms of mutual aid; outside and independent of national and local political authorities (Bird *et al*, 2020).

In response to these developments, news outlets, think tanks and Universities are awash with commentaries on the impact of the pandemic on new business models and the future of work. Both the normalising of ho-

me-based working and a new and an expanded role for the state have been declared (Gerrard, 2022). Although these debates encompass all industries, I wish to focus on English care services, particularly adult social care in residential and nursing homes. Firstly, it is important to clarify what we mean by care. Although medical and hospital-based care is predominately funded and provided in England by the NHS, many aspects of social care, non-clinical and emotional well-being support have always been provided by local government, charities, social enterprises, voluntary community groups as well as conventional for-profit privately-owned businesses.

Despite a wide range of different types of organisations providing these holistic interpretations of care, the residential care home market (which supports over 400,000 older people in England) is mostly privately-owned, with under 10% of providers being charities, social enterprises or state owned. For several years, this model has been challenged by a wide range of scholars and industry analysts highlighting four key concerns: 1) the lack of adequate funding for the system, 2) the unsustainable business models behind many care homes, 3) the low levels of staff retention, pay and status, and 4) the inappropriate commodification of care into measurable and definable units of time (Kotecha,

2019). For example, evidence suggests for large privately-owned businesses that significant levels of surpluses are distributed to external owners, while the sector overall is increasingly financially unstable¹.

Moreover, despite the pandemic highlighting the importance of care work and the dedication of staff caring for residents, it has also underlined the inequalities between different occupations within health and care and the lack of value society places on the lowest paid staff (Horton, 2022). Most recently, the Conservative government has produced new policy proposals to address these challenges and despite the merits (or not) of this response, it is clearly a crucial time for the sector in England². Overall, I suggest the problems of the care homes sector are not just related to levels of funding within the sector but also how we understand ownership and its resulting influence on management behaviour and staff engagement. Further, I contend that if we are to build new sustainable care organisations, we must move beyond conventional managerialism and the binary choice between the private and public sectors. We also need to supplement existing positivist approaches to public policy evaluation by asking normative questions: What is the purpose of owning? Who benefits and how do we judge achievability, practicality and realism (Lynn, Mules, and Jurse, 2002).

In this article I reconsider how ownership has been conceptualised by social scientists. Subsequently I highlight recent empirical research about alternative socially owned organisations and our response to the pandemic.

Different Forms of Ownership

Traditionally, ownership has been considered as either a:

- a. legal phenomenon (such as investors possessing company equity), or a
- b. discursive tool for management to persuade staff to accept responsibility to achieve surplus and solve problems as defined by managers, external owners, or state bureaucracies.

Jurisprudence and legal perceptions often see the study of ownership as focused on property and possessiveness; and hence the creation of exclusive unambiguous boundaries where assets can be exploited and controlled through the judicial system (Waldron, 2004). Based on the Lockean justification of acquisition by dint of labour, these perspectives claim an exclusive right to property is essential to wealth production while also reflecting our natural desire to control the number and type of 'things' that can be owned³. Furthermore, managerial forms of ownership seek to use the language asso-

ciated with ownership to manufacture employee consent to organisational goals. Ownership is re-conceptualised as a means of co-opting staff to 'buy into' corporate plans (Manz and Sims, 1995). Moreover, conventional business literature legitimizes the right of owners to seek control over *their* businesses while simultaneously demanding employees be responsible for *their* own work (Drucker, 1993).

Clearly such approaches have significant weaknesses for those disapproving of the ubiquitous nature of managerialism in both the public and private sectors. Critical organisational scholars argue management sees staff engagement as limited in scope and merely a solution for directing the workforce (Schaufeli, 2014). For example, conventional managerial and legal accounts have little to say about alternative non-hierarchical ways of working, workplace democracy and the distribution of power within the workplace. Put simply for Gunn (2011) what matters for staff is that ownership brings control over work.

More positively by reconsidering other ways of conceiving ownership, we can appreciate its collective nature and relational aspects which are central to alternative political economy and organisational forms (Lachappelle and McCool, 2007). Firstly, organisational psychologists have tended to

perceive ownership rather differently, focusing on a state in which employees 'feel' an organisation is theirs and define ownership as attachment (Van Dyne and Pierce, 2004). Ownership 'in-use' is prioritised; on a day-to-day level, how do staff feel about their job and organisation and what benefits does this bring and to whom? The experience of owning is about becoming something different from being simply an employee i.e., bringing something of their authentic themselves to work. Owning as legal possessiveness is secondary. For example, empirical studies suggest employee participation in decision-making is positively associated with psychological ownership, and in turn employees with organisational attachment participate with high degree of altruistic spirit, demonstrate more commitment, and share knowledge (Avey, Wernsing and Palanski, 2012). Put simply, for workers to experience psychological ownership having control matters (Liu *et al*, 2012).

Importantly, a distinction should be made between managerial and psychological readings. Although both forms can use similar language (such as 'taking on responsibility' and 'owning work') they differ because psychological ownership does not mean staff focus on meeting goals *pre-determined* by organisational hierarchies. Following Van Dyne and Pierce (2004), attachment is not a free good to be captured by ma-

agement. Rather psychological ownership is achieved through staff perceptions of due participative process, the just distribution of organisational benefits and a positive impact on service users/customers. Their attachment is freely given, authentic and beyond the control of management.

Social anthropologists and political scientists also challenge jurisprudence and managerial standpoints by seeing ownership as essentially about collective place-making and creating a 'polis'. Owning something involves a physical and social space which people inhabit, feel is theirs, which may or may not be their residence, home, property or contain productive means (Brightman, 2010). Ownership is essentially a relational phenomenon existing prior to, and independent of, legal institutions or markets while also being inherently political because it accounts for both temporary and permanent forms of autonomy, group identity and control. For Brightman, Fausto and Grotti (2016), different notions of ownership are wide-spread and do not conform to traditional accounts that interpret primitive societies as lands without property and therefore lacking in discussions about ownership. From this stance, the belief in the unfettered rights of owners who are physically absent from the organisation (such as is the case in the English care home sector) are nonsensical and oxymoronic.

Mirroring psychological ownership, anthropological and political perspectives share a focus not only on the benefits employees obtain due to legal ownership, but owning as a processual concept for nurturing non-instrumental values, mutuality, and public engagement. You become an owner through participating and creating with others; you are not an owner simply by possessing shares. Most famously articulated by the Nobel Prize winner for economics Ostrom (1990), this outlook sees owners becoming something different because of owning and progressively developing their capability to participate. Further, individual forms of owning do not always lead to privatised lives as some critics from the political Left claim, but is an important cognitive, emotional and existential certainty that is a pre-condition to live a collective life (Davies, 2012).

Discussion

What do these alternative readings mean for developing sustainable care providers after the pandemic? In this section I discuss two relevant aspects: empirical studies from pre-and-during pandemic employee-owned entities and emerging evidence from the experience of care workers during COVID⁴.

Ownership, Owning and Worker Participation

Clearly ownership has contested interpretations, and this is reflected in different disciplinary positions. While psychological readings challenge jurisprudence and management focus on owning as property and as a tool to meet the prescribed ends of external shareholders; relational approaches stress ownership cannot be seen as a simple binary, mine or yours issue. Despite the desire to restrict private interests from care, centralised state forms of ownership can also equally suffer from a lack of relational, local and psychological forms of owning (Allen *et al*, 2012).

Empirical studies before COVID-19 in employee-owned care providers also showed a wide range of innovative participative mechanisms, which were distinct from public and private sector organisations (Mygind and Poulsen, 2021): namely, written constitutions which defined the powers of staff to control management and the rules which governed decision-making. Further, executive boards included elected staff representatives, while owner-led staff councils scrutinised management performance and behaviour on an ongoing basis. There were also opportunities for direct employee-owner participation in allocating the yearly surplus during annual general

meetings. More imaginatively, citizens' juries (where staff were identified from a random sample of all workers) were used to tackle specific projects and collective duties. Secondly, these studies also indicated the concept of ownership was not only important to local actors but also continuously contested (Gain, 2020). Legal and managerial versions may have been ubiquitous amongst senior managers, but staff did not simply acquiesce to managerialism or disengage completely from organisational life beyond their individual work. Rather workers often contested and resisted, articulating an alternative version of managing and owning (Cathcart 2013, Mauksch, 20212).

Thirdly, increasing authentic psychological ownership in a non-exploitative way is possible through distinct stages. When asked what ownership at work should mean; many staff owners articulated attachment *to*, possession *of* and identification *with* their own work and organisation (Gain, 2020). These perceptions were more than a high degree of conscientiousness and personal pride in service quality, but a sense of collective endeavour with fellow workers, driven by perceptions of control over work. For staff what mattered was the psychological state of *being* engaged as an ongoing process. In contrast, many owners, managers and politicians saw *doing* engagement as an approach to managing the workforce

(or 'getting staff involved'). However, for Chi and Han (2008) ownership was achieved when staff perceived engagement to be genuine which was in turn shaped by:

1. Fair processes where employees have a meaningful voice in developing strategies and decision-making (referred to as procedural justice).
2. Equal distribution of organisational benefits and a positive impact on service users' outcomes (distributive justice).
3. Extensive information-sharing and dialogue (greater transparency).
4. Recognition of equal respect regardless of pay levels, specialist knowledge and job-tasks (status as a precondition for engagement).

Fourthly, staff ownership was inextricably linked with improving workplace participation because engagement had greater meaning and purpose (Gain, 2020). Rather than highlight the possessiveness of shares or the financial benefits to be gained, employee-owners gave ownership a collective relational meaning; emphasising the discovery of shared values and common endeavour and ownership as a prerequisite for ensuring the organisation operated on a more democratic and egalitarian basis. For many, ownership represented more than being emp-

loyed, it took on a democratic character through direct participation in citizen juries and one-person-one-share-one-vote processes.

Fifthly, management-initiated participation programmes often lacked authenticity and were poorly attended by staff. This phenomenon was observed in both public and privately-owned organisations. For example, during NHS Trust staff engagement programmes, Allen *et al* (2012) found senior clinicians and management were very supportive of autonomy from central government departments but obstructed new forms of accountability to local clinicians, staff and communities. Senior directors sought an intensification of managerialism through engagement, not its replacement. Being an employee was simply insufficient for genuine participation and staff required equal respect and status (as well as stable and enduring belonging) to engage.

COVID-19 and the Implications for Management and Care Organization

Building upon these long-standing scholarly debates, contemporary studies of the societal impact of COVID-19 (and other significant emergencies and crises) have highlighted several insights into management practice and alternative ways of working (Zanoni, 2020)⁵.

Firstly, although many in the sector have experienced trauma while working during COVID-19, the emotional commitment inherent in 'care' labour (and the value we give to care more generally) has become more widely appreciated. Moreover, the pandemic has revealed the inequalities and unjust nature of the pay and conditions for social care staff relative to other sectors (Horton, 2021). This revaluing of care work has not just been reflected in demands for increasing pay but also improvements in their status, autonomy, occupational standing and decision-making at work.

Secondly, awareness of the wider meaning of care beyond the provision of clinical interventions via the NHS has increased. From March 2020 onwards there have been calls for all of us to take responsibility 'for each other' as well as volunteering to provide practical acts of care giving (Howard, 2020). There is clearly greater societal engagement in science, health, social care and well-being.

Thirdly, the essential role of staff in maintaining organisational survival in crises, as well as providing care beyond their traditional job descriptions and contractual obligations, has become apparent. Workers have done whatever was required to care for residents, resulting in a blurring of the traditional separation between profes-

sional boundaries and job demarcations (Griffin *et al.*, 2020). From earlier

turns, including higher levels of job retention, satisfaction, and commitment



Thank you NHS, Brighton cereal café (© Luke Martell)

empirical studies of crisis situations, we also know the response of employees (and their willingness to strive for the organisation) is crucial to maintaining both quality services to vulnerable people and for saving the enterprise from insolvency (McDonnell and Burgess, 2013).

Fourthly, empirical studies have also concluded that employees (who have legal ownership through shares and who participate in organisational decision-making) have more positive experiences during economic down-

(Blasi and Kruse, 2021, Dickinson and Warhurst, 2019). In contrast, staff in conventional private and public organisations before (and during the pandemic) often felt disengaged with decisions made by policy hierarchies and management (Bird *et al.*, 2020) with an increased perception of a gap between frontline staff and others (Ellerman and Gonza, 2021). Building local socialized forms of ownership for care provision can also provide an important aspect of economic development post-pandemic (Bedford and Phagoora, 2020).

Fifthly, emerging evidence also suggests ownership had an impact on outcomes for residents. In their study of the relationship between nursing homes ownership and their response to the COVID-19 pandemic, Kruse *et al* (2021) concluded for-profit privately owned providers were less effective in maintaining service quality. Furthermore, scholars have always understood that employee engagement is a precondition for the engagement of users/patients in their own care (Pestoff, 2017).

Sixthly, the behaviour of owners and managers during a crisis is important not only for survival but also employee experience (Mikusova and Horvathova, 2019)⁶. In particular, absent, distant and impersonal ownership and management leads to poor staff experience and organisational performance (Hazaa, Almaqtari and Al-Swidi, 2021). More pessimistically, crisis situations can reinforce in the short-term management's control and their decision-making prerogatives, rather than lead automatically to improved working conditions and better service quality. Both McDonnell and Burgess (2013) and Zanoni (2020) suggest the impact of crises on employee experience varies considerably and can intensify existing workplace power imbalances. Where labour conditions are relevantly poor and collective forms of worker representation weak (such as in care settings) management response to

crisis is to act quickly, erratically and without staff input and consent.

Conclusion

While ownership does involve legal and abstract questions of who owns the equity of an enterprise, as I have argued, this is not the whole story. As new forms of business models emerge post-COVID, understanding how we foster mutual aid and local forms of ownership are vital (Shabi, 2022). However, this paper does not seek to make the case for employee-ownership in social care uncritically. There are several barriers to the specific applicability of the model to older people's services. For example, to change ownership in the care home market will require a solution to enable staff and local communities to gain sufficient levels of capital to buy-out existing owners (Major and Preminger, 2019).

However, by asking questions of how staff understood ownership and how they experienced their work before and during the pandemic, we can appreciate the value of alternatively owned entities in offering 'real-life' experiences of non-managerial working. In addition to calls for increasing the relative pay and conditions for care staff, we also need to develop a sense of place, equality, autonomy and self-confidence for workers. Although there is much more to be written about the im-

pact of COVID on care homes, I argue by rediscovering how different social scientists have considered ownership (as well as reflect upon recent research) we can avoid the trap of seeing the policy solutions as a simple private-versus-public battle.

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Endnotes

1 See <https://chpi.org.uk/blog/the-hidden-profits-behind-collapsing-care-homes/>. Also see the ongoing ERSC funded University of Warwick Business School led programme 'Financial Impacts of COVID-19 on Care Homes' (<https://ficch.org.uk/>). The final programme report was published in Spring 2023.

2 People at the Heart of Care: adult social care reform white paper - GOV.UK (www.gov.uk).

3 From this perspective the essence of ownership is individual property; and this does not change when staff become employee-owners. They are still profit maximisers seeking financial benefits.

4 There are many different forms of community, local and employee-owned organisational forms.

Collectively they are often referred to multi-stakeholder governed business. We do not have sufficient space to discuss this very large scholarly field, however the Employee Ownership Association provides a useful definitional starting point. What is EO | Find Out More | Employee Ownership Association.

5 More generally it is noted that research on managing within crisis situations are fragmented across

a wide range of disciplines and prior to COVID-19 there was little critical research to challenge conventional managerial approaches (Fischbacher-Smith and Fischbacher-Smith, 2016 and Hazaa *et al*, 2021).

6 I would suggest that too much unwarranted emphasis is placed on managerial approaches to 'leadership'; perhaps it is more appropriate to say it is one of several critical factors for staff and user experience.

Britain's Care Crisis: Why Claps Don't Pay Bills and Money's Not Enough

Emma Dowling

This article examines the care crisis in Britain in the wake of the coronavirus pandemic and explains how and why Britain's care resources were already exhausted before the pandemic broke out. The article discusses how existing care systems are being upheld against the odds by a feminised, racialised and classed workforce and argues that seriously addressing the care crisis will require transforming the structural conditions for giving and receiving care and disentangling care from the premises of personal responsibility and private profit. Emma Dowling is a sociologist and political scientist and based at the University of Vienna. Prior to that, she held academic positions in Germany and the UK. Her research covers topics that include feminist political economy, social change and social justice. She is particularly interested in political economies of emotion & affect and the myriad ways that unpaid labour upholds the current economic system. Her most recent book is entitled The Care Crisis -

What Caused It and How Can We End It? (Verso, 2021).

When it comes to care, societies face a challenge. Everyone needs to be cared for and everyone needs access to care. However, not everyone has the same care needs. What's more, these care needs vary across the course of a lifetime. These are reasons why an effective care infrastructure cannot be built on personal responsibility alone and requires agreement over the distribution of societal resources and capacities for caring. At the same time, agreement on what constitutes acceptable standards of care relies on implicit and explicit social and cultural assumptions (Himmelweit, 2007: 582). Care involves reciprocity, even if that reciprocity might not be immediate, nor restricted to the same two individuals. All of this makes care a profoundly political matter (Dowling, 2021a: 3 & 26).

Caring takes place across society in homes, in neighbourhoods, in communities, in networks of friendship, in publicly funded institutions and in commercial organisations. Broadly speaking we can identify three dimensions of care (Dowling, 2021b: 9). First, there are the care relations that are constitutive of kinship, friendship and community networks in which we are embedded across our everyday lives. These are relations of care that we rely on to maintain our lives and livelihoods. Second, there are care needs that arise from particular physical, mental or cognitive conditions or at particular stages in the life cycle. These care needs have to be met for us to live well and can involve more formal assistive relations. Third, there is the notion of care as an affective disposition or even moral imperative, pertaining to the more qualitative and ethical dimensions of what is meant by the verb *to care*. Caring encompasses the physical activities of taking care, as well as affective relationships involving emotions, feelings and ethical concerns, even if these feelings can be quite complex and not limited to simply feeling 'good' about someone else. The two dimensions cannot really be separated, although in practice they often are. Indeed, their separation can be the very cause of crisis (Dowling, 2021a: 46).

Pandemic Paradox

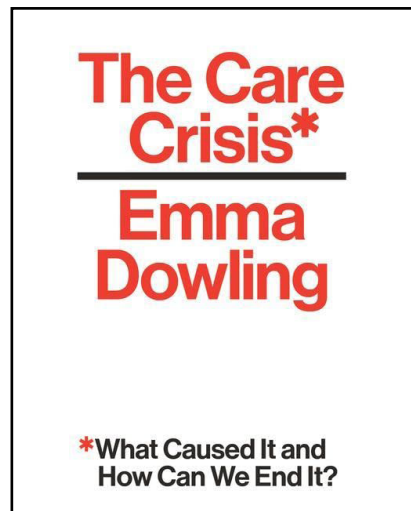
The coronavirus pandemic made Britain's care crisis evident: under-resourced and overburdened care workers in the health and social care sectors; households overwhelmed by the challenges of home-office, home-schooling and caring for loved ones; migrant domestic care workers with little economic security excluded from furlough schemes. When the pandemic broke out, Britain's care resources were already exhausted. There were not enough reserves to meet care needs, while the situation of care workers was already untenable.

On the one hand, Britain's care crisis has to do with the relentless pursuit of cost efficiency at the expense of care, both in the face of underfunding due to austerity and in the service of profit due to an increasingly privatised care system. For example, in Britain many homecare workers have been placed on zero hours contracts, do not receive occupational sick pay, are not paid for travel time, and are expected to undertake home visits of less than 15 minutes (Dowling, 2021a: 105 ff.). Care needs were heightened by the pandemic, but government preparations relied explicitly on 'just in time' contracts geared towards being able to quickly get hold of personal protective equipment (PPE) should it be necessary (National Audit Office, 2020: 18).

Moreover, the award of billion-pound contracts to the private sector, not only for PPE but also for test-and-trace systems, turned out to be inadequate (Public Accounts Committee, 2021). In addition, while the NHS quickly received extra funding to respond to the pandemic, social care received less attention. The tragic toll the pandemic took on nursing homes is symptomatic here, revealing not only how little value is afforded to those who provide care, but also to those who require it. Already prior to the pandemic, research had shown that there are at least 1.4 million older people in the UK with unmet care needs (Incisive Health, 2019). At the same time, people with disabilities have borne the brunt of austerity measures in terms of cuts to services and direct cuts to financial support (Ryan, 2019: 18). These are the conditions of crisis that the pandemic both collided with and made evident.

On the other hand, Britain's care crisis has to do with the fact that the work of caring is so often simply taken for granted and rendered invisible. The pandemic made apparent just how much the existing care system relies on informal carers – for the most part women within family contexts – who are expected to carry out caring within the home. There are two developments happening simultaneously: On the one hand neoliberal restructuring of the economy and of hearts and minds has

furthered individualism and entrenched the idea of a personal responsibility for care, pushing people towards the market to satisfy their care needs. On the other hand, there is a resurgence in the importance of family. People are thrown back onto those with whom they have familial ties, because these are individuals who are more likely to feel a moral or also an economic responsibility for their care. Especially where households cannot afford expensive commercialised care services, families end up having to shoulder extra care work where public services have been cut (Pearson and Elson, 2015; Dowling, 2021a). Sometimes, the extra care work is also shouldered by helpful neighbours or friends, or it is volunteers who pick up the tab.



Cover of Emma's new book, <<https://www.versobooks.com/en-gb/products/326-the-care-crisis>>

In fact, the nuclear family household is an arrangement that relies on a whole host of assistance from outside the home (Lewis, 2020). During the pandemic, school and nursery closures made this apparent. For many single mothers (who make up the overwhelming majority of single parents (ONS, 2020)) the pandemic resulted in their support structures often wholly breaking down. A survey among informal carers revealed that 80% of respondents caring for loved ones reported a significant intensification of the care work they were providing at home as a result of the pandemic-related closure of local services like day centres or the lack of availability of people they usually relied on for breaks (Carers UK, 2021: 23). Furthermore, there were only very small increases to means-tested welfare benefits. While in Scotland a top-up to Carer's Allowance was provided, in England this was not the case (Allen et al., 2020: 587). By the same token, many precarious nannies, elder carers and other domestic workers lost their jobs and accommodation during lockdowns. Given the fact that informal employment in domestic work is widespread, they did not always have access to government schemes (Deutsch, 2020). Yet, there are also many people for whom the nuclear household is not the main context where they receive intimacy and support. This could be because someone lives on their own or in LGBTQIA+ communities and

queer forms of kinship and support. It could also be because someone relies on extended community networks in the countries they live and work in, for example in the case of migrant communities. In addition, not everyone has a home to go to. Nor is the home always a safe place to be.

To a certain extent, the UK government's promotion of 'support bubbles' during lockdown periods could be read as a recognition of these complexities (Hester, 2021). Nonetheless, if we look at the conditions for caring across paid and unpaid work, all in all, the pandemic revealed a paradox: care is so tremendously important for wellbeing and survival, yet so little social and economic value is attributed to caring – both paid or unpaid. Furthermore, contemporary society operates on the basis of an assumption. That assumption is that someone will step in and do the caring, whether out of a sense of responsibility and good will, or due to feelings of compassion and empathy. This is the case whether it is caring for children and elders, or for anyone else who temporarily need support or required more long-term assistance. On the whole, this assumption is still very much feminised.

Thinking Across Paid and Unpaid Work

According to research, women spend more than three times the amount of time as men doing unpaid care in the form of household work, direct personal care and volunteering (ILO, 2018: 53). Time-use surveys for the UK show that today's men are increasingly involved with childcare at home (ONS, 2016: 3). However, mothers frequently retain the primary responsibility for the overall 'management' of childcare, what has come to be known as the 'mental load' (Hogenboom, 2021). Statistically, men are most active in the context of care when they are older (above the age of fifty) and caring for a partner (ONS, 2016). Ratios vary by region, but everywhere in the world without exception, women do significantly more unpaid care work than men (ILO, 2018: 53). If we were to put a figure equivalent to an hourly minimum wage on the unpaid care work provided world-wide, it would total nine per cent of the global GDP (ILO, 2018: xxix)

Across OECD countries, female labour market participation has increased by roughly 20 percent over the last thirty years (OECD, 2020). The public and expanding service sectors required skills associated with femininity, including caring were where many women entering the labour market

found work (Morini, 2007). However, without a fundamental transformation of society's sexual division of labour, the significant increase in the female labour force participation left many women facing a 'second shift' of unpaid care and housework in the home (Hochschild and Machung, 1989), or even a 'third shift' outside of the home helping neighbours and friends or volunteering for charities that provide care for those in need (Gerstel, 2000). At the same time, the primacy of waged labour in a situation of stagnant wages and declining wage shares has meant that many households really struggle to meet care needs when all efforts are geared towards working outside of the home to bring in income. All the while, inequality is rising as dividends to wealthy shareholders have increased (Mariotti, 2019: 6). Exhaustion is rife, especially among the so-called 'sandwich generation' (Williams, 2004) caring for young children and older parents at the same time. This situation is contributing to the care crisis.

Combining childcare responsibilities with paid employment is difficult, often due to the lack of affordable childcare. In Britain, 38% of employed females work part-time, while only 13% of employed males do (Irvine et al., 2022: 7). Moreover, caring brings with it considerable economic penalties, which affect women more because they are more likely to be

in caring roles. Care penalties (Folbre, 2017) can involve loss of earnings due to caring responsibilities. This can include not taking jobs that demand long or irregular hours. This has knock-on effects in terms of available income in the short-term and in the long-term leading to lower pension entitlements (ILO, 2018: xxxv). Care penalties can also involve being exposed to low earnings and low job quality due to employment in the low-paid care sector, while informal work or self-employment can mean someone is less likely to be able to pay into social security systems. Single mothers and female pensioners who live alone often face particularly high poverty risks. Such a situation becomes more acute in the context of austerity measures and cuts to welfare and social infrastructures.

Intersections of Care

When it comes to paid care work in areas such as education, health and social care, female staff are the majority. Drawing again on figures from the International Labour Organisation (2018: 168) care work makes up nearly 20 per cent of global female employment and just over six per cent of global male employment, while 70 per cent of health and social care workers worldwide are female (Boniol et al, 2019). In the UK over 80 per cent of the adult social care workforce is female (Skills for Care, 2019: 66). Ho-

wever, even within these sectors there is a gendered distribution of the workforce. There are much higher numbers of women in low-paid, assistive and front-line care and nursing work than among doctors and in the ranks of management. According to research, the average gender pay gap in the global healthcare workforce is 28% (Boniol, et al., 2019). That means that on average women earn nearly a third less and are more likely to be employed undertaking low-paid and precarious work.

Yet, it is not only gender, but intersections across gender, race and class that matter when it comes to caring. In the UK, Black, Asian and Minority Ethnic workers comprise over 20 per cent of the adult social care workforce, higher than the diversity of the overall population in Britain (Skills for Care, 2019: 66). There are also many more migrant workers in the care sector than in the overall workforce in Britain (*ibid.*). Nonetheless, the UK continues to experience significant shortages of nursing staff (Campbell, 2022). Certainly, in the wake of Brexit, employing care workers from the EU has become more difficult, while Britain continues to recruit healthcare staff from other countries, including, for example, from the Philippines (Economist, 2022). Recruiting trained nursing staff from other countries is a cost-saving mechanism, as is the exploitation of labour market vulnerability on the

basis not just of gender and class, but also ethnicity, migration background or citizenship status. Individuals with less bargaining power in the labour market are pushed into front-line care work because it is low-paid, considered unskilled, has low entry thresholds and there are lots of vacancies. Putting it all together, we can see that there is a structural logic at play in which the devaluation of caring syncs with the systemic requirement to keep the overall costs of care as low as possible.

A central pillar of the neoliberal configuration of care has been the fact that many (often white and middle-class) women have off-loaded the caring responsibilities placed on them by gendered societal expectations. These caring responsibilities fall on the shoulders of working-class and/or migrant workers from other countries in Eastern Europe, South-East Asia or the African continent. Consequently, class hierarchies between women have become further entrenched and care deficits merely displaced elsewhere, as has been analysed in the sociological research ‘global care chains’ (Hochschild, 2000) and the ‘international reproductive division of labour’ (Parreñas, 2000; 2011). However, the pressures here do not simply have to do with wealthier households off-loading their caring responsibilities. A significant issue is also austerity and the privatisation of care. The retrenchment of welfare systems

and government attempts to curb fiscal expenditure, lead to inadequate access to care for those who require it. At the same time, these people, especially pensioners with low incomes, may well be unable afford to pay the high care costs of declared home help. Therefore, they are under pressure to find ways to obtain affordable care that they pay out of their own pocket. This situation acts as a conduit to irregular and precarious work.

Care and housework are part of an expanding gig economy with the proliferation of digital platforms. These digital platforms may in part serve to formalise such work. Yet, as we know, the gig economy model is a conduit for casualisation and precarity (Woodcock and Graham, 2019). Platforms act as intermediaries rather than employers, thereby externalising labour costs. In the area of on-demand care work, it is even the case that a discourse of female empowerment is deployed to market their services, stating that such services seek to help women solve their own personal care crisis by connecting them with care workers who can look after their children or care for their parents while they pursue their careers (Hall, 2020). Not only does this promise freedom and empowerment off the backs of low-paid and precarious workers, it also corresponds to what Sara Farris (2017) has termed feminism’s ‘productivist ethics’, which stigmatises care

work in the home as something to free oneself from in favour of being economically productive in the waged labour market. Already prior to the pandemic, the personal and household services sector was the second-fastest growing sector in Europe. Demand is expected to increase due to increased care needs in the home that result from greater female labour market participation on the one hand and the demographic changes that are to be expected due to effects of ageing on the other (Decker and LeBrun, 2019: 13).

The Crux of the Problem

At the heart of Britain's current care crisis lie the evident failures of privatisation. Britain began privatising care in the 1980s and 1990s with a series of legislative reforms, including the National Health Service and Community Care Act of 1990. Local authorities were to facilitate the marketisation of care through a combination of outsourcing and commissioning of privately provided services, even as they retained the responsibility for eligibility and needs-assessment. The argument for privatisation was that it would harness competition and choice for the purposes of raising productivity. Cost-efficient services were supposed to generate savings and make money go further. Yet, the labour- and time-intensive work of caring by its very nature does not really lend itself to productiv-

ity increases through rationalisation. Any rationalisation in care work that does take place is mostly 'pseudo-rationalisation' (Dowling, 2021a: 137). These can include cost-saving mechanisms such as the reduction of pay and conditions, or not paying for uniforms or investing in training or in facilities. However, there can also be more hidden forms of pseudo-rationalisation that redraw the boundaries of work. Examples here include the redefinition of what counts as a necessary task and what does not count as a necessary task, for example when care workers are under such time pressure they routinely cannot tend to the social or emotional needs of care recipients. Another example is the redefinition of what counts as part of work time and what does not, for example in homecare when travel time is not paid for. Indeed, the sub-optimal conditions under which caring is carried out serve to redefine what caring means, often encapsulated in reductionist notions of 'actual care' as mere assistance with physical or medical tasks, as has also been pointed out by Moore and Hayes (2017: 102) in their research on the effects of electronic monitoring in homecare.

In addition, privatisation was supposed to facilitate innovation because it would make available the capital required for infrastructural improvements, creative experimentation, research and development and the

improvement of service quality (Whitfield, 2020). The problem is that this has not really happened to the extent that it was heralded. In fact, the current crisis in the care sector suggests that the situation has worsened overall. Industry representatives have blamed austerity and underfunding. However, a growing body of research discusses that not enough funding is going into ensuring adequate working conditions and pay for care workers or maintaining and improving facilities while, at the same time, much-needed financial resources are being *taken out* of the sector in the form of dividend payments, interest payments or directors' fees (Kotecha, 2019: 10). Predatory financial engineering practices and the entry of private equity companies into the sector have exacerbated these problems (Burns et al., 2016; Bayliss and Gideon, 2020; Corlet Walker, 2021). There is also research that draws attention to issues of tax avoidance (CICTAR, 2021). The structural power imbalance inscribed in this economic architecture means that when things go wrong or if there is an economic downturn, investors can protect themselves from exposure to risk through financial engineering. Yet, care workers and care recipients are left to bear the brunt of increased instability and risks of insolvency. Financial interest in care homes has been particularly developed given that the assets of care homes include real estate that is of considerable value.

While particularly pronounced in Britain and the US, these developments are not limited to these countries. In fact, in Germany the process of care home financialisation is underway (Bourgeron et al., 2021). With the expansion of care markets and the commercialisation of care, we are witnessing a situation in which financial investment in care is orientated to extracting profits at the expense of staff, facilities and service quality. Posing the question of how this has been allowed to happen, we come full circle to the interlinked issues of value and (bargaining) power. One of the reasons why these restructurings are possible is that the work force is undervalued and disrespected and does not have enough systemic power to successfully resist, as Horton (2022) has argued in her research on the financialisation of care.

Propping Up Profits

More resources are needed to address existing care deficits and the low value attributed to care and care workers - paid and unpaid. The International Labour Organisation estimates that the global employment in care jobs is expected to grow from 206 million to 358 million by 2030 due to socio-demographic changes. Investor reports currently celebrate the fact that care is 'ripe for investment' and that there are multiple opportunities to make money by investing in care. However, if the

profit motive is kept in place and there is no stringent regulation against inappropriate business models and predatory financial engineering practices, any new funds made available for care will simply go towards propping up profits. This problem was exemplified in the pandemic. In May 2020, the UK government made an extra £600 million available to care homes providers to help with the extra costs of dealing with pandemic, such as paying for PPE or continuing to pay staff wages even if they had to self-isolate and couldn't come into work. According to the *Financial Times* one major care home provider received financial assistance while still making millions of pounds in payments to owners. In response to such criticism, the care home provider insisted they were not paying dividends, but asset management fees and interest on loans.¹ Yet, this is precisely the point: The apparatus that has been built around care homes hardwires financial wealth extraction into its architecture and renders it a necessary part of the business.

Exploiting Caring Affects

All the while, this situation relies on the commitment, compassion and sense of responsibility of those (under-)paid and unpaid workers who continue to care, even in conditions that are increasingly difficult and unacceptable. This can be the case where health

and social care workers go beyond the call of duty or work overtime to ensure someone is properly cared for. This can also be the case where volunteers step in to pick up the tab for staff shortages or cuts to welfare services. This routinely happens in contexts where those who care worry about what will happen to the people they care for if they don't care for them. Short-term 'care fixes' are sought that do very little to end the care crisis long-term and often rely on off-loading caring along a chain of underpaid and unpaid labour. Analogous to the feminist critique of naturalised feminine caring labours rendered invisible as the 'labours of love' of a devoted housewife and mother, we can see how caring affects are often mobilised to enlist free or low-cost labour. Especially in times of crisis, this mechanism serves as a way of not making more material resources available for care. This is a mechanism that also relies on a constant separation of the immaterial and material dimensions of caring, often playing one off against the other. The constant separation between caring affects and material resources is an important and often overlooked point that helps us understand why simply calling for more empathy and care as a solution to the care crisis is insufficient. This constant separation may very well explain some of the mixed feelings that nurses and care workers experienced when they were celebrated as heroes and people took to their doorsteps to

‘clap for our carers’ during the pandemic (Manthorpe et al., 2021). Caring for carers means not merely sending appreciative affects their way. It means improving the material conditions for caring by ensuring that their working conditions are safe and conducive to providing good quality care, while their livelihoods can be secured with the pay that they receive.

What Future for Care?

Currently, we have an economy that continues to draw from so-

cial care resources without much concern for replenishing or even expanding them. Moreover, existing care systems are being upheld against the odds by a feminised, racialised and classed workforce. In 2021 a new Health and Social Care Levy was introduced to make more funds available for health and social care. A closer look at the specifics of the levy shows that the bulk of the money will go towards addressing the deficits in the NHS, with much less of the money raised going towards social care (Ogden et al., 2021). Importantly, there are next to no funds made available for improving wages and working conditions in the sector. Critics have pointed out that all in all the reforms are geared towards helping a small number of wealthier households protect their assets, while raising the revenue for doing so from all working people. In fact, these working people include the many underpaid and unpaid carers for whom the levy will not bring much of a change for the better (Dowling, 2021c). In fact, government rhetoric in the UK seems set to further privatise and individualise the responsibility for caring. Health Minister Sajid Javid has stated that “care begins at home” and that people should not turn to the state but rely on their families (Atkinson, 2021). However, seriously addressing the care crisis will require transforming the structural conditions for giving and receiving care and disentangling care from the premises of personal respon-



Nurse, © Luke Jones,

<<https://unsplash.com/de/fotos/CEFYNiM9xLk>>

sibility and private profit.

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Endnotes

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Standing Together at the Edge of the World

The Decameron Project: 29 New Stories from the Pandemic

Harald Pittel

The Covid-19 pandemic, though less prominent in the headlines than in 2020 and 2021, is still with us today and has become part of our cultural memory. While in Hard Times 105 Sarah Heinz discussed Peter May's novel Lockdown (2020), it is for Harald Pittel (Leipzig) to examine a more international approach to what may be called 'lockdown fiction' from The New York Times Magazine with its loftily titled Decameron Project (2020). In the following, special attention will be given to the British contributions to this Boccaccio-inspired collection, and its death-defying outlook will be related to the critical discourse around world literature.

The New York Times Magazine, a Sunday supplement to the famous bastion of American liberalism, has a reputation for attracting notable writers to contribute essays and stories. Responding to the worldwide outbreak of the Covid-19 pandemic in spring 2020,

the editors drew on their vast network of contacts to invite the submission of (very) short stories engaging with the crisis. The outcome is a collection of twenty-nine stories that was first published as an all-fiction special issue of the magazine. The project evolved into a beautifully designed website; it was also made available in book form.¹ The list of authors in what came to be called *The Decameron Project: 29 New Stories from the Pandemic* is impressive, including leading literary figures such as Margaret Atwood, Edwidge Danticat, Colm Tóibín, David Mitchell and Kamila Shamsie, to name but a few. What else is remarkable about the collection and its stories? How did the contributors react to the pandemic?

To begin with, the project draws its name from Giovanni Boccaccio's classic *The Decameron*, a seminal 14th-century compilation of tales written in the Florentine vernacular in re-

sponse to the Black Death, the most fatal pandemic ever recorded in human history. In Boccaccio's original, a group of young men and (mostly) women have successfully fled plague-ridden Florence for a nearby countryside villa, spending ten days entertaining each other in successive rounds of storytelling. *The Decameron* famously celebrates the importance of love, wit and will to cope with unforeseeable turns of fortune. What the *New York Times* collection has in common with its influential precursor is a general aspiration of fiction to offer hope and comfort in times of distress. This vitalising outlook was once an inspiration for Chaucer's *Canterbury Tales* and relies on a multiplicity of voices and perspectives. However, unlike the escapist tendency prevalent in *The Decameron*, most of the stories included in *The Decameron Project*

aim to face the present crisis. As stated in a big headline at the top of the website and on the book's front cover flap: "WHEN REALITY IS SURREAL, ONLY FICTION CAN MAKE SENSE OF IT" (original emphasis).

Lockdowns around the World: 'Staying in' vs 'Getting out'

More specifically, the *29 New Stories from the Pandemic* focus on lockdown experiences, the manifold effects of having to (and/or: being able to) 'stay in' – often desperate and coupled with sickness, but also allowing space for self-reflection, sometimes enabling decisions to change lives. Furthermore, the multiple implications of 'staying in' – which means different things for different (groups of) people – are paired with the likewise unclear prospects of



Lockdown. © Hervé Simon,

<<https://flickr.com/photos/125601701@N03/51269501083>>

‘getting out’. On the lighter side, this tension makes for amusing episodes, such as “The Perfect Travel Buddy” by Italian writer Paolo Giordano, told by a first-person narrator whose flat is raided by his twenty-two-year-old stepson, a real nuisance with loud music, constant zoom parties and generally antisocial behaviour, thus effectively ruining his parents’ sex life. However, when the numbers of infections fall, the narrator does not want his stepson to leave: realising that they have similar problems, the two of them eventually bond over a tub of salted caramel ice cream. There is also John Wray’s “Barcelona: Open City”, in which a young slacker called Xavi rents his dogs to other people during isolation. This becomes a lucrative source of income, as leaving your flat for walking your dog is not prohibited by, and thus helps sidestep, the local pandemic regulations. Xavi even starts a love affair with one of his dog-walking customers, which, alas, does not survive the end of the quarantine, making Xavi long for yet another Covid wave.

‘Getting out’ is thus seen in an ambiguous light: on the one hand, some of the authors share the optimism of Kamila Shamsie’s “The Walk”, which celebrates the unexpected post-quarantine joy of flocking to the streets of populous Karachi, Pakistan’s former capital: “In that moment, the world felt like a better place than it had ever been – generous,

safe” (DP 27). Yet there is also the other, often more realistic, extreme, when leaving your flat is perceived as synonymous with re-entering a hopelessly conflicted society, as in Israeli author Etgar Keret’s “Outside”, whose focal character (identified with the reader in second-person narrative voice) stumbles out into a street filled with soldiers, stone-throwing youths and homeless people, making him or her realise that “[...] the heart that softened while you were alone will harden back up in no time” (DP 87).

Despite all these ambivalences, some of the stories also register unprecedented moments of solidarity: in Tommy Orange’s “The Team”, isolation, requiring individuals “to watch and wait, to stay put”, is regarded as teamwork and a marathon, “the only way the Team could make it, humans, the whole damn race” (DP 158). And in Karen Russell’s “Line 19 Woodstock/Glisan”, a public bus, half-empty during the pandemic, is strangely stuck in time, requiring a “muscular, united effort” (DP 155) from the passengers, who, by singing and pushing, eventually manage to get out of the “invisible putty” of “cosmic mud” (DP 148, 154).

Spotlight: From Irish Cosmopolitanism to Brit Grit

Many readers of *Hard Times* will be particularly interested in further contributions (alongside Shamsie's) from British and Irish authors. Colm Tóibín's "Tales from the L.A. River" is a charming piece about a Los Angeles-based gay narrator (with ties to 'Old Europe') who learns to accept the fact that his literary and cultural interests are far removed from his beloved partner – "He read Harry Dodge; I read David Lodge" (DP 32). The self-introspective narrator also manages to cope with their relationship being so unlike all these congenial homosexual couples that have left their traces on intellectual history: "Why were we the only ones like us?" (DP 34). Tóibín's story thus offers a positive take on 'staying in' during lockdown as an opportunity to learn how to live with difference and to eventually reconnect with the world. In a more sinister light, David Mitchell's and Andrew O'Hagan's contributions, both centred around white working-class males, add a note of Brit Grit to the collection. Mitchell's "If Wishes Was Horses" amplifies the psychological effects of 'staying in', portraying the condition of Luke Wilcox, an unreliable first-person narrator who has been imprisoned during the pandemic for homicide. Luke makes friends with a cellmate called Zam, "an Arab, Indian, Asian, something" (DP 161),

and a potential terrorist on top of that, who turns out surprisingly sociable and supportive. It never becomes quite clear whether Luke's imprisonment is real or merely the result of a lockdown delirium. Dreams and reality become indistinguishable when Luke imagines himself at a school reunion in the future, asked by the headmaster what the Covid-19 crisis was like, thirty years ago. Suddenly, the man Luke killed appears at the back of the classroom, and Luke wakes up. In the end, it turns out that Zam – a name suggesting magic – only existed in Luke's imagination, perhaps signalling the other in the self in a burgeoning inner dialogue, an emerging process of self-recognition which no longer attempts to repress its opaquer sides. While there is thus a glimmer of hope for Luke, "Keepsakes" by the Scottish novelist Andrew O'Hagan (who is also editor at large of the *London Review of Books*) is more direct in depicting the mental health effects of social isolation. "Keepsakes" reports the hardship faced by Alexander 'Lofty' Brogan, a Glasgow-based fishmonger who seems unable to find a place for himself in today's stratified Britain. Gradually distancing himself from his upwardly mobile family, Lofty's detachment becomes ever more uncompromising during the pandemic. Described by his brother as "toxic and self-righteous, unreachable, angry" (DP 94), handsome-yet-uncommunicative Lofty is caught in a schizoid web

of contradictions. On the one hand, he condemns the money-centredness of his socially advanced brother who now lives in London's fashionable Notting Hill district. However, Lofty is likewise determined to eradicate from his memory each and every trace of his working-class lineage. Triggered by the virus-related death of his mother, he comes to give away or burn all the remaining furniture and possessions still contained in the now empty five-generations-old family home – originally, we learn, Lofty's family was Irish and migrated to Scotland during the Great Famine. Forlorn and unsympathetic with other Glaswegians, Lofty dreams instead of beautifully unfrequented "European" (DP 92) cities like "Malmö in the spring" (DP 98). There is a way of reading the inscrutable profundity of Lofty's alienation as a difficulty to adapt to a specifically English-centred liberal individualism, making the story appear like an allegory of Britain's neglected margins in post-Brexit times, with a distant and displaced yearning for an idealised Europe revealing an unarticulated desire for greater social cohesion on the British Isles.

Recognising the Larger Story

Reading the collection as a whole, its indebtedness to *The Decameron* turns out less pronounced than expected, and it is only for a few authors to adapt some of the Florentine *novel-*

le. Most conspicuous in this regard is Margaret Atwood's "Impatient Griselda". The author of *The Handmaid's Tale* takes issue with Boccaccio's notorious "Griselda" episode, about a 'patient' woman enduring any burden imposed by her husband-and-ruler; this is transformed by Atwood into an Angela Carter-style feminist rewriting that lets the husband have it. Overall, though, the *New York Times* collection has a more sombre outlook than its Renaissance model. Its dominant theme, providing a level of cohesion between the stories, is the thin line dividing life from death in times of Coronavirus-related health issues, an existential line whose haunting presence cannot be quite as easily kept at bay as in Boccaccio with his stronger note of joyful escapism and "bawdy" playfulness.² It is in this sense that the *New York Times* collection is aptly framed by Victor Lavalle's "Recognition" and Edwidge Danticat's "One Thing", the former told by an intradiegetic narrator facing the sudden death of an old, sick woman in a near-empty apartment house, the latter tracing the longer process of a Haitian-born focaliser accompanying her dying and hospitalised husband over the phone during the last days of his life, with a zoom funeral to be expected when he has passed away. In both stories, the dead are mirrored in the living, and the living in the dead.

Following the cue from Lavallo's opening piece, most of the collection would indeed centre around 'recognition' – not only among lovers, friends and relatives, but also more surprising kinds of recognition in which strangers turn out to be closer than expected, with a shared awareness of "past lives" (DP 3, 9) allowing for uncanny, yet often beneficial, encounters. It is this deeper connectedness that offers a comforting outlook by challenging overly 'atomised' conceptions of the self, which one might see unluckily verified in lockdown situations. Many of the characters in *The Decameron Project* are haunted by memories, complicating simplistic definitions of identity as restricted to their immediate cultural embeddings. For example, non-white western city dwellers reveal migration histories as they recollect their former lives under the oppressive regime in Iran (as in "The Cellar" by Dina Nayeri) or yearn for an Ethiopian "home" (as in Dinaw Mengestu's "How We Used to Play", DP 142). Such biographic 'blasts from the past' interrupt the monotony of the everyday; they make room for intercultural experience and allow revisions of, and reconciliations with, repressed layers of identity – new self-recognitions, as it were. The terms of recognition – both intra- and inter-subjective – are never settled; rather, their instability relies on an unchained play of perspectives, which are not only multiple but sometimes offer comple-

tely unheard-of points of view. It is thus that Atwood's revised Griselda tale is told by a not-quite-anthropomorphic alien who has been sent to earth "as part of an intergalactical-crises aid package" (DP 70) assuming that "storytelling does help us understand one another across our social and historical and evolutionary chasms" (DP 76), whereas Charles Yu's "Systems" is narrated by none other than the virus itself, ironically merged with the Google search algorithm. There is thus always more to see and more to tell than anybody might have anticipated – 'Living with Difference' writ large, so to speak.

Is New York Everywhere?

It is interesting that the title reference to *The Decameron* has been erased in the 2022 paperback edition of the book, which is now simply – and arguably, more accurately – called *Stories from Quarantine*. In fact, as we have seen, the relationship with Boccaccio is rather loose, making the original name appear somewhat generic at times.³ Moreover, in the introduction, "Lifesaving Tales" by Rivka Galchen, who is said to have initiated the project, *The Decameron* is accompanied by two further references, the Arabic compilation *One Thousand and One Nights*, featuring death-defying storyteller Sheherazade, and the ancient Indian series of animal fables *Panchatantra*, both relativising the exclusive

status of the name-giving collection. It would be too simple to dismiss the exposure of these further compilations as a mere 'disclaimer' against potential allegations of Eurocentrism. Rather, these additional titles would frame the *New York Times* project very much in the context of world literature, and if asked to specify on the understanding of 'world' motivating the collection at hand, its conspicuous affiliation with New York comes into focus: a city epitomising multicultural integration and urban cosmopolitanism as a model for modern life more generally – a 'project' resisting attempts to be cancelled albeit being threatened and undermined by various perils, among them virulent racism, a widening class gap, religious fundamentalism, right-wing authoritarianism, economic collapse and, of course, the lingering pandemic. In collected form, the *Stories from Quarantine*, reflecting relatable experiences across a variety of places and cultures, would suggest that a positive perception of 'New York' in terms of an ever-inclusive model of freedom can manifest, in principle, everywhere.

Cosmopolitan World Literature

'New York', then, as a difference-based ideal of urban modernity, seems to have inspired the collection as a project of world literature, and we should carefully consider the nuances of meaning evoked by the expression 'world' in

this literary context. In a traditional understanding commonly attributed to Johann Wolfgang von Goethe (2014 [1827]) and further developed by Rabindranath Tagore (2014 [1907]), 'world literature' implies an orientation towards 'world' as inherently pacifying and cosmopolitan, conceived of as an open-ended dialogic and intercultural process of mutual 'correcting'. A complementary and more political understanding of 'world' related to literature can be derived from Hannah Arendt, seeing the world as 'in-between' animated by a web of stories forming and formed by human actions, a common and constantly updated space that is simultaneously connecting and separating, socialising and individuating (2005, 128-129). The world is here understood as a joint context of empowerment and responsibility that is equally shared by all its inhabitants. 'Cosmopolitan world literature' in this sense would express an investment in frames of meaning that go beyond the restrictions of any particular society, culture, region or language, whilst simultaneously stressing a common sense of belonging to the as yet under-instituted planetary whole called 'world'.

To critical readers this might reek of Western centrism, as such a 'worldly' ideal of literature might be difficult to realise without privileging some points of view over others, poten-

tially even succumbing to the danger of a single (meta)story to keep the multiplicity of tales together. One might argue, however, that the collection is aware of this peril, as the offerings included therein are from different regions and fields of experience, their authors and characters highly diverse in terms of gender, social background and (albeit filtered by translation) language, thus allowing for various configurations of time and space thoroughly complicating the monolithic idea of a ‘global grid’ normalising subjectivities and senses of reality. In particular, “The Time of Death, the Death of Time” by Brazilian writer Julián Fuks resists the concept of time as chrono-

logically homogenous; rather, the pandemic has taught the inhabitants of the planet a lesson on the contingency of temporalities, and the “certainty of time” (DP 237) is now little more than a childhood memory, though still a highly significant one. It is precisely this experience of the relativity of time – often enough endured as pseudo-synchronised “Screen Time” (Alejandro Zambra) – that paradoxically allows for universalisation. And just as there are no fixed temporal structures mastering the present, there is no reason to accept a standard model of self-containment usurping planetary space in the name of possessive individualism. Rather, identities reveal themselves as porous in



Greece - Meteora - Monastery of the Holy Trinity, © Harshil Shah,
<<https://flickr.com/photos/85903370@N00/32947802168>>

their constant fixing and unfixing, implying shifts of key coordinates such as the separation between the public and the private, which, rather than being simply postulated as a global norm, is thoroughly spatialised and temporalised – or, in other words, unfolded in and as multiple stories, allowing insights into, and potential revisions of, constitutions of self and community at fundamental psychological, phenomenological and political levels. Thus standing ‘at the edge’ of ourselves is no reason for despair; on the contrary, such an outlook allows for new modes and energies of solidarity beyond habitual ways of seeing us and others: Standing together at the edge of the world.

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Endnotes

- 1 Each story comes with a linocut by British artist and illustrator Sophy Hollington, and further artists have contributed colour paintings. The latter can be seen on the website but are not included in the book.
- 2 The element of “bawdy” eroticism, often subversively directed by Boccaccio against the moral authority of the Church, is virtually absent from the stories contained in the *New York Times* collection, albeit being highlighted on the book’s front cover flap. By contrast, one of the most widely known 20th-century adaptations of

Boccaccio's tales, Pier Paolo Pasolini's *Il Decameron* (1971), takes their sexual content seriously, deploying it critically against the bourgeois moral hegemony of postwar Italy.

3 It should be noted that 'The Decameron Project' was also the name

of another Covid-related initiative, partnered by The New York Public Library and The New School, which from 2020 to 2022 encouraged American school students to write stories. A rich catalogue of submissions is still online at <<https://decameronproject.org>> [last accessed 31 May 2023].

Safely Dead?: Pandemic Poetry and the Limits of Power

Ira Raja and Somya Choudhary

This essay by Ira Raja (University of Delhi, India) and Somya Choudhary (MRM College, Lalit Narayan Mithila University, Darbhanga, India) examines a series of poems about the Covid-19 pandemic, published on the internet, all except one of which were written originally in Hindi. The first set of poems analysed here recount how in the Indian middle-class experience, social distancing, isolation and ennui of the first lockdown was constantly breached by disturbing sounds and visuals of the masses of migrant workers as they fled the cities shortly after the first lockdown was imposed, presenting a study in contrast to the experience of the middle-classes from advanced industrial nations, for whom the lockdown frequently meant long periods of complete isolation from other people. More critically, the pandemic exposed how what Achille Mbembe calls necropolitics, did not just present itself in the Indian state's failure to "guarantee or even administer life" but worse, in its partisan policies aimed at

securing some lives at the expense of others who were also its own citizens, albeit without the rights and entitlements of citizens. The second set of poems discussed here are set in the context of the horrific Delta wave, as it swept through the country, leaving a trail of death and immense suffering in its wake. But as the authors observe in the concluding part of the essay, pandemic poetry ditches the abjection that characterizes so much of the media reporting on the pandemic, in search of the hope that ordinary people's sense of betrayal and abandonment by the state may pave the way for a demand for accountability. Indeed, many of the poems enlist the agency of corpses, alongside that of natural elements, questioning the state for its many failures. Death, that is to say, fails to bring closure, presented instead as an occasion to refuse have the trauma of the nation swept into oblivion.

In his essay “Necropolitics” (2003) Achille Mbembe argued for ‘the emergence of a new form of politics centered on the power over death’, a contention he developed subsequently over the course of a monograph by the same title (Mbembe 2019). More recently, Christopher J. Lee extended Mbembe’s claims, which had drawn primarily on ‘the spectacle of war machines and suicide bombing, among other features’, to argue for another form of necropolitics, evident in some states’ handling of the Covid-19 pandemic. Lee’s analysis focused on the long-term policies of neo-liberalisation that have led many states to cede key arenas of public health to private players (Lee 2020). Less readily recognisable than the more spectacular forms of violence, such commitment to a neoliberal agenda in matters of state welfare has nonetheless resulted in massive loss of life during the pandemic (Lee 2020). As Lee explains, “decades of reduced infrastructure for medical care in many countries,” has meant that national governments when faced with the emergent conditions of the pandemic could not really “guarantee or even administer life, except through the crudest forms of non-medical state control and cold violence against non-citizens.” Ordinary people’s chances of surviving the pandemic, in other words, depended in the first instance on whether they could actually afford the cost of survival, and then on “the goodwill, ability, and ex-

pertise of medical workers and others directly engaged with the situation”, rather than the power and resources made available by the state for managing the crisis. In Lee’s refurbishing of Mbembe’s thesis, Covid-19 exposed a form of necropolitics instantiated not by war and terrorism but neoliberal economics.

In this essay, we draw selectively on a wide range of poetry, mostly in Hindi, published on the internet, to point towards another dynamic of necropolitics that became visible during the pandemic in India. While the Indian state’s commitment to public health has never been adequate, what the pandemic went on to show, for the first time, is how necropolitics could also take the form of the state’s active intervention *on behalf of* certain sections of the population while pushing others in the line of harm. In the face of a public health emergency, the national government in India failed not only in its ability to “guarantee or even administer life” but worse, in its partisan policies aimed at securing some lives at the expense of others who were also its *own* citizens, albeit without the rights and entitlements of citizens. It is another matter of course, that notwithstanding the differential levels of risk to which the various strata of society were subjected because of considered sectarian politics on the part of the state, the many people who died in the second

wave, did so irrespective of class, caste, gender and other variables. Some observers and commentators have even ventured to suggest that it was the state's handling of the first wave in which the discriminatory policies of the state were most visible that was directly responsible for the indiscriminate virulence of the second which spared none (Rai 2020).

The Sovereign Injunction

On 24 March 2020, relatively early in the Indian trajectory of Covid-19, the Government of India ordered a 21-day nationwide lockdown to contain the spread of the virus. The lockdown, amongst the most strin-

gent in the world, had to be extended thrice, with the country starting to re-open only in early June. A week into the lockdown, shocking visuals of large crowds scrambling to flee the cities started to flood social media (Raja 2020). As Chinmay Tumble explains, these internal migrants make for the sub-continental phenomenon of regional migration, accounting for some 200 million people. Part of one of the largest and longest streams of mobile workers in recorded history, it is a phenomenon that has sadly remained obscured by the better documented fact of transnational flows (Tumble 2018: 40). With the economy abruptly grinding to a halt, this mass of people whose cheap labour had fuelled it



Stranded migrant workers during fourth phase of the lockdown, © Sumita Roy Dutta, <https://commons.wikimedia.org/wiki/File:Stranded_migrant_workers_during_fourth_phase_of_the_lockdown_IMG_20200523_125500.jpg>

in the first place suddenly found itself with no means of survival. The unplanned lockdown, introduced at four hours' notice, now forced them, in the absence of all public transport, to walk hundreds of kilometres home. The fact that some six hundred people died in the process shows that necropolitics of Covid-19 in India entailed active decisions on the part of the state, including not just the sudden imposition of the lockdown, but also the deployment of state machinery to enforce disciplinary measures and restrict movement in ways that wilfully put particular lives at risk (Thomas 2020).

The online poems examined in this essay foreground a uniquely Indian experience of the pandemic. While many of the poems dwell on the state's infringement of the people's most basic rights, frequently they also point to the limits of state power, showing its sovereignty to be less than absolute. This was evident in the large number of people who chose to defy the state's injunction against mobility to in fact take to the roads in unprecedented numbers (Nair 2020). These were desperate choices but they were still choices and entailed considerable exercise of agency, volition, and resistance. Defying the diktat of the state to walk home in ways that their presence could no longer be invisibilised, was to refuse to die in the manner decreed by the state. In the words of Krishna Kalpit:

Refused life,
Are we to be denied death as well?
We are leaving,
in a steady stream,
onwards and away.
Trudging
Past train tracks
Past highways
To our villages
Where our homes lie.
One step at a time.

Blisters on feet
Are better than
Blisters on hands. (Kalpit, n.d.)¹

Of the over six hundred deaths recorded in the first wave, of people trying to make their way home, many had been etched on the nation's conscience. Consider Vishnu Nagar's sardonic commemoration of the sixteen migrant workers from Madhya Pradesh who were run over by a freight train as they lay asleep on the tracks, during an overnight halt in their journey home from Mumbai, after being laid off in the lockdown, "Siesta on Train Tracks" (cf. Niazi 2020):

Does sleep need a pillow?
Then what are headstones for?
When others can sleep amid such hue
and cry,

Why can't we, on an empty stomach?

Which place is flatter and safer
than the piece of earth
between two tracks?

Why can't one snooze there?

Is being run over by a freight train
so unusual as to interrupt sleep?

(Nagar, n.d.)

But while the roads made for good reporters in the first outbreak (“When else were roads such good reporters?”) (Singh, A. n.d.), innumerable others who died in the second remained unnamed, unaccounted for in official records which cited ‘co-morbidities’ as the reason for refusing to list Covid as the cause of death (Varma 2021). In the words of Nityanand Gayen:

The Government of India

In its new avatar

No longer counts its dead.

That is to say,

There is no official account or database

With any record

of just how many

have died. (Gayen n.d.)

What did it mean for the widespread failure to fix accountability for Covid-related deaths in India? Did it transform the poor of the third

world into what the Italian political philosopher, Giorgio Agamben, has called ‘bare life’? It is in this context that this dossier of poems on the internet about Covid-19 becomes crucial: while it cannot stand in for an official account, it performs the very important twin roles of mourning the lives lost and bearing witness to the collective trauma of a whole generation on a national scale.

This essay examines two sets of poems: the first is focused on the Indian middle-class experience of social distancing, isolation and ennui which stands in stark contrast to not just the army of daily wages workers milling around in the hope of catching that last bus home, but also middle-class people from advanced industrial nations, where the experience of isolation was not constantly breached by disturbing sounds and visuals from the world outside (Bharucha 2022: 32).

The second set of poems draws on the Indian experience of the horrific Delta wave, the actual death toll for which has been notoriously difficult to determine, with the government response lurching between denying the numbers on the one hand and refusing responsibility for the deaths that occurred on the other.² In Pankaj Chaturvedi's bitter words:

Don't be confused later.

No one is responsible for these deaths.

Neither society nor state.

The ones to fear

Are safely dead. (Chaturvedi n.d. 1)

Bitterness however is hardly the last word on the pandemic in the poetry examined in this essay. As our discussion in the third section below will show, the notion of ‘safely dead’ is barely tenable in the case of Covid mortality. Indeed, many poems enlist the agency of corpses alongside that of natural elements to demand accountability from the state for its failure to protect lives, while contesting the abjection that characterizes so much of the realistic reporting on the pandemic.

The Parallel Worlds of COVID-19

A large number of poems refer to the ways in which the pandemic changed existing definitions of love, intimacy and care. The sociability characteristic of human existence, they suggest, has given way to compulsory distancing between people. The following poem for instance acknowledges the complicity of the good citizen, who dutifully follows the rules laid down by the state, in triggering a crisis of empathy and compassion:

Stay home.

Stay safe.

Maintain social distancing.

Refuse handshakes

When namaskar will do.

What was once counted

As cold and distant

is the new shape of

love. (Chaturvedi n.d. 2)

Ordinary expressions of love and affection are rendered risky by the new forms of behaviour introduced in the name of controlling the virus. The sense of grief at the loss of loved ones is overtaken by a feeling of dread, preventing the living from saying their final goodbyes to the dear departed:

Social distancing

Is the new mantra of life.

Think twice

before approaching the body

of someone who has

just died. (Chaturvedi n.d. 1)

By all accounts, the Indian middle-class experience of the pandemic was overwhelmingly characterized by fear and paranoia about its own safety. Pankaj Chaturvedi’s “I had never thought” bemoans the loss of innocence that is entailed in this newly stipulated terror of spontaneous affection and intimacy:



Cheerful young Indian spouses during self-isolation at home, © Ketut Subyanto, <<https://www.pexels.com/photo/cheerful-young-indian-spouses-during-self-isolation-at-home-4308200/>>

Some days ago
A friend grabbed my hand
in affection.
For a long time after
I remained fearful.
I had never thought
Staying safe would entail
A fear of innocence.
(Chaturvedi n.d. 3)

These poems speak to a milieu in which social distancing was indeed more or less the norm. The radical altering of interpersonal relations, now regulated by the new regime of hygiene

and suspicion of the stranger, is viewed in here as a source of both agony and disbelief.

An interesting contrast to this focus on how the pandemic had changed everyday organization of social life, is offered in Vinod Vitthal's poem "In the Time of Corona" (Vitthal n.d.). Vitthal is more interested in the continuities between the new regime of the pandemic and the one it has displaced. He begins disarmingly by talking about love:

It's hard to tell
when it happened
How it happened,

by which touch,
with what breath.
How similar is catching Covid to
Love!

In the very next stanza though the poem moves to a more contested terrain:

So many people lag in
quarantine
for eons on end

waiting
to be touched.
waiting
at long last,
for a hug and a kiss

Waiting
for an equally shared world!

For Vitthal, the pandemic has made visible the abiding faultlines of a caste society where some people are perpetually in quarantine, as it were. The manner in which the pandemic forces everybody to be viewed with suspicion as a potential carrier of the deadly virus is not unlike, in Vitthal's account, the suspicion that a caste society harbours towards those lower down the hierarchy. The funereal silence in which the city of Delhi lies wrapped in many

of the poems, Vitthal suggests, is not unrelated to a longer history of silence around forms of othering and prejudice to which the pandemic has given free rein.

Madan Kashyap's poem, discussed below, offers a closer view of this other world suddenly made visible to the poet from the window of the apartment in which he is imprisoned. While the lockdown stalled the ordinary rhythms of life around the world, its lived experience differed radically from region to region. As many of the European writers who took part in a panel discussion on "Reconsidering Europe in India in 2022" at the University of Delhi on 22 September 2022, mentioned, their experience of the lockdown was overwhelmingly one of silence and social distancing. This was in stark contrast to their Indian counterparts, represented at this forum by the writers Teji Grover and Rustom Singh,³ who began their lockdown on a relatively peaceful note but one they were unable to sustain given the human drama unfolding around them. As mentioned before, the announcement of the lockdown in India led to what can only be described as hypermobility, where thousands upon thousands of people, placed on the lowest rungs of the wage hierarchy, took to the roads in a bid to reach homes in the remote hinterlands. As Kashyap writes:

While we were imprisoned in our

homes,
Not a soul in sight on our streets and
alleys,
thousands came from nowhere
onto the highways.
Only if
you peeled your eyes
could you tell
the fully human shapes
that comprised this swarm.
(Kashyap n.d.)

Clearly, it wasn't just the migrant workers whose experience was distinctly different to that of their more middle-class counterparts. As Teji Grover, Madan Kashyap, and Mridula Garg's short poem below, bear out, even for the privileged few the lockdown was never defined by silence and stasis alone. Garg speaks of her awareness of the turmoil on the highways piercing her isolation, her guilt at the silent screams of people left homeless by the lockdown, shredding her solitude to pieces:

There hasn't been a quiet moment
since Corona.
Imprisoned at home,
my ears pierced
by the cries
of starving men, women
hungry children

sobbing babble of the homeless
unemployed hordes,
oddly separated from each other by
two meters
like a detachment
the threat of whose boots
brings bridges down. (Garg n.d.)

The seamless, even startling transition in the above poem from images the abjection and helplessness of migrants marching to the drumbeat of hunger to something altogether more fearsome in the subsequent image of a platoon whose boots bring bridges down, alerts us to the hope, even possibility, of the disorganized hordes fleeing the cities to be similarly morphed into an organized army that in its march for justice shakes the very ground on which we stand, clamouring for change. Both indicate a crisis within a polity. While the first image is of people who have been left to their own devices by the state in a time of crisis, the second image is about channelizing that anger and helplessness towards something more considered. The poet's refusal to stop at images of despair also delivers us neatly to the key themes of the second wave poetry in which the fact of death is refused as offering closure. Instead, poem after poem frames death as a form of unfinished business. Not the last rite of passage as it is cast in the scriptures but the beginning of a calling

to account of the powers responsible for the loss of lives.

Return of the Dead

While the ‘first phase’ of Covid in India between March and September 2020 is remembered for words and visuals of impossible resilience, the ‘second phase’ is associated with searing accounts of disease and death (cf. Bharucha 2022: 13; Gettleman et al., 2021; Barnagawala 2021; Pandey 2021). One particular poem from this phase, Parul Khakhar’s “The Hearse is now the Ganga”, may be singled out for its powerful indictment of the necropolitics of the state. Originally written in Gujarati but rapidly translated into several Indian languages, this is the only non-Hindi poem we have included in our discussion primarily because its Hindi translation quickly went viral as they say (Khakhar 2021). While others remained mostly confined to their location on the web, Khakhar’s poem was extensively circulated on social media in translation as well as in recordings set to music, with several versions also accompanied by photographic accounts of this traumatic time.

The immediate context for the poem was the staggering number of deaths taking place all over the country to the point where cremation grounds ran out of both wood and space. The long wait for one’s turn to

cremate a deceased family member, the expense involved in performing the last rites in the manner prescribed, as well as what Rustam Bharucha calls the double stigmatization of bodies – “first as corpses in their own right and additionally as corpses in which the virus still lurked”, not to mention the dominant realities of poverty, lack of education and fear, meant that quickly committing the dead bodies to the river was the most convenient way of preventing the virus from spreading (Bharucha 2022: 22). This was in stark contrast to past norms when only the remains of the body after the cremation would have been consigned to the river. As Bharucha writes:

Acute shortage of wood meant that several bodies had to be placed on the same pyre. Given the pressure of those waiting for their turn, bodies were sometimes not completely burnt before the remains had to be retrieved by kin. When thousands of people were dying of Covid 19 in India, not just in the cities but in rural areas as well, the Ganga became the only affordable dumping site for poor families unable to afford a regular cremation (Bharucha 2022: 22).

Khakhar’s poem begins with a chorus of corpses eagerly assuring “the Lord” that everything was in fact just fine (“changa”), a claim quickly followed by an account of how the mighty Ganga was now entrusted with the lowly task of ferrying the dead. But the eagerness

of this multitude to assure the Lord that everything was fine, flies in the face of the tragedy which the poem sets out to commemorate. What could 'fine' mean given the enormity of death and the absence of emotional and material resources to deal with it? What could fine possibly mean in light of the gross violation of all of the Hindu funerary rituals aimed at ensuring the dead were "free from pain and suffering"? What could it mean for the dead to be consigned to the river without having been cremated, if collecting and immersing the ashes after cremation signifies the liberation of the soul from the coils of materiality? What kind of peace in the hereafter could the dead expect, seeing how their mortal remains were dealt with? The reference to 'fine' ("changa") then really points to the inability to make sense of Covid-related deaths within existing structures of meaning.

Meanwhile bodies continue to pile up. Every house is morphed into a place of mourning, while funeral pyres rage without respite. The poet attempts to comprehend the suffering of the people through images of widowhood, allocating to the masses a gendered identity: "our bangles are shattered". At the same time, and in a corresponding move, she then pits the grieving masses against Billa and Ranga -- a pair of notorious criminals convicted for rape and murder of two children in the 1980s, whose names

are frequently used on social media as a way of bypassing the censors when referring to the two men currently at the helm of political power in the country:

Lord, our bangles are shattered,
shattered are our hearts

The fiddle plays while the towns are
ablaze, "Wah, Billa-Ranga"

Lord, in your ideal realm the hearse is
now the Ganga

[*Translated by Rita and Abhijit Kothari*]

While the reference to Billa and Ranga playing the fiddle even as the flames from the pyres are burning brightly is a clear reference to the Roman Emperor Nero, known to have infamously fiddled while Rome burned, also detectable here, in our view, is a reference to the political leadership fiddling away precious time in numerous initiatives that achieved little by way of preparing for the virus -- lighting candles, chanting, clapping and banging of pots and pans, to name a few. The state was clearly not missing from Covid-related action in India. On the contrary it was everywhere, enjoying a kind of performative centrality, if you will, in egging people on to take up the most trivial pursuits in place of effective measures to actually counter the virus.

The gendered allocation of roles between the feminization of the

grieving masses on the one hand and the toxic masculinity of the political leadership presiding over the pandemic maps rather neatly onto the devotee-deity binary in the well-known and longstanding pan-Indian devotional tradition of Sagun Bhakti in which the deity is always imagined as masculine while the devotees, both men and women, are cast as female. That the Hindi term for devotee, i.e. 'bhakta', is also used quite commonly to refer to the supporters of the ruling party in the country today only strengthens the connections we are seeking to make here (Gajaria 2019).

The poem, however, invokes the bhakti idiom only to demonstrate just how untenable it is. In the poem's Hindustani translation by Ilyas Sheikh, the Lord's luminosity ("*Sahab, tumhare divya vastral daidipya tumhari jyoti*") offers a striking contrast to the blank eyes of the grieving populace ("*Tha-ke hamare kandhe saarel aankhein reh gayi kori*"). If the root word for Bhakti suggests a relationship of equality between the deity and the devotee, then something is clearly amiss here: In the zero-sum-game that the poem suggests is characteristic of the relationship between the leader and his adoring followers, the latter's loss is the former's gain, there being nothing shared between them. Once the truth of this relationship is exposed, the conventions that inscribe the devotee and the deity

in their respective roles no longer hold. Released from the obligation to adhere to the gendered stereotype of the silent suffering woman, the devotee can now emerge from the place of grief and speak truth to power:

Lord, the town entire sees you

in your true form

If there be a real man here,

come forward and say

"The emperor has no clothes".

While Khakhar's poem indicts the state for its necropolitical agenda, deploying irony as her choice of literary weapon, other poems take a more oblique approach, while simultaneously shrugging the note of abjection that was characteristic of most realistic accounts of the pandemic.⁴ Consider the following reflection on Covid patients in Shubhankar's "Hospital/Tree":

Lives ripen on the hospital-tree,

fearing the injunction against

ripening.

Ripened, fruit falls.

This season,

there are no relatives

to collect the fallen fruit.

This season
to ripen is to rot.

The touch
of rotting fruit
Spoils the entire crop.

(Shubhankar, n.d.)

The trope of ripening has been used productively to understand the process of growing old in literature – *reifungsroman* or the fiction of ripening, which seeks to resist the understanding of ageing as decline in favour of the more enabling image of growing old as a maturing of one's natural essence. A disruption of regular existence, however, appears to have also led to an irregularity of meaning in the realm of language so that ripening no longer means what one thought it did. Wrenched from its pastoral context, the image of ripened fruit gathered from beneath the tree where it's fallen, is transformed into something altogether more sinister. Covid-19 was associated overwhelmingly with sudden death – media was awash with images of people alive and singing one day and gone the next (cf. "Woman" 2021) – rather than death that came slowly, as insinuated by the word 'ripening'. Ripen in the context of the poem "Hospital/Tree" is less about the slow and natural maturing of one's essence than it is about the proverbial 'hopping

the twig'. To ripen here is to die. Worse still, to ripen is to rot. Death here is indelibly associated with the fear of contagion, which needs to be handled carefully, lest it spoil the entire crop.

But rotting also brings up other less obvious associations. The sight of the ghost of Hamlet's father prompts Marcellus in Shakespeare's famous play to announce that 'Something's rotten in the state of Denmark'. Fruit that has fallen before its time, rotting before it's ripened, cannot be collected for fear of disease. The bodies of loved ones rendered untouchable by Corona are not gathered up in the arms of their kin to be laid gently to rest. Consider *Hamlet*, where unnatural death causes the dead to return to the land of the living. Fruit that has ripened prematurely on hospital beds out of the fear of ripening similarly points to something unnatural at stake. As carriers of contagion the corpses in this poem remain as potent as the ghost in *Hamlet*.

If this poem speaks of the agency of the dead who continue to threaten the social order, and who need to be buried quickly so they cannot spread the disease, others suggest that burial is no guarantee that the threat posed by the dead has ceased, albeit this time the threat is more inchoate than contagion:

The river bank on which
Grew melons and gourds

Are now sprouting the dead,

crimes.

Bodies exposed to view after

The season's first rain. (Kumar n.d.)

Dead bodies that were buried by the river side in shallow graves are exposed by the first rain of the season as it washes away the thin layer of soil beneath which the dead had been hastily laid to rest. In place of melons and gourds, writes the poet, the river banks are now sprouting the dead. This vision of hell replaces the bounty of nature on which life is nourished with death and despair. And yet, there is also something ominous about the dead peeping through from inside their shallow graves, which transforms these poems from being expressions of unmitigated despair to poems that point to the limits of power. Locating these deaths in the cycle of nature as against the political economy of an apathetic and often incompetent state is not the depoliticizing gesture that it seems at first glance. The dead seem to speak from beyond the grave, their silence ringing louder than the cacophony of '*thaalis and taalís*' (literally plates and claps; a reference to the Indian political leadership's call for people to bang plates and clap as a means of making Corona go) celebrating the state's handling of the crisis. In the poet's updating of the lyric form, nature aligns itself with the victims of the state's apathy, literally exhuming the bodies to uncover state

Siddheshwar Singh's poem "Calcutta Returned" notes how under Covid-19 'returning' rather than 'going away' has become the deadliest verb in the Hindi language (Singh, S. n.d.). While the immediate context of Singh's poem was the migrant workers' desperate journey home during the first lockdown, as our discussion above has tried to show, the fear of return also operated at other levels, most notably the fear of the dead who had been denied their due in death could still make claims upon the living as spirits. Death, that is to say, remains an unfinished business here, its lack of closure offered as an opportunity to prise open the possibility for hope, for accountability and the refusal to have the trauma of the nation swept into oblivion.

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Endnotes

1 *All English translations of Hindi poems included in this essay are by Ira Raja, unless otherwise stated.*

2 The total COVID-19 death toll for India was put at 4.7 million by WHO which was ten times the India government's tally (Reuters, 4 May 2022), cf. also Mallapaty 2021; Cunningham 2021; Chakraborty 2022.

3 Long Night of LiteratureS 2022, University of Delhi.

4 Even with Rustam Bharucha's flair for the literary, his account of the pandemic reserves a very grim note for the death on display: "One should keep in mind that the dead bodies themselves in all their disintegrating corporeality are not likely to remain embedded in the riverbanks. At

some point, they are bound to putrefy and decay. Rarely has death been more massively demeaned in the Indian sub-continent as it has during the pandemic". (Bharucha 2022: 23) Bharucha's account of the "multitude of shallow graves of Covid-19 victims...scattered all along the upper banks of the river" is deeply insightful on many levels. As he explains, the corpses embedded in wet mud are loosely covered with saffron cloth, its dignity at the mercy of wind and rain: "Buried in haste, these bodies are exposed from their graves and remain unnamed, anonymous, in their pitiful absence of dignity, naked and decomposed." (Bharucha 2022: 20-21). While abjection seems like the right word to describe the state of the dead in Bharucha's realistic account of the second wave, literary accounts reserve a rather different tone to describe the same event.

Concerts After COVID-19

Dylan James Peterson

Socially and economically disrupted by COVID-19, the U.K. music scene had to consider alternative forms of concert-going that could be more conducive to the shifting standards of public and mental health in a (post-)pandemic world. Dylan James Peterson, who holds a Master of Arts with distinction in Anglophone Modernities in Literature and Culture from the University of Potsdam and teaches English at community colleges in the Chicago metropolitan area, suggests that Burial's experimental dubstep might offer possibilities outside of live performance.

Not dissimilar to the drive-in movies of the 20th century, some popular musicians experimented with “drive-in concerts” in 2020, allowing performers to play to a group of on-lookers who sat stationary and isolated in their parked cars in front of large outdoor stages. This was one way to go to a concert during the onset of the COVID-19 pandemic, but an even

more popular means of maintaining social distance was the digital format of live-streaming, which allows a performer to play songs from their bedroom, garage, kitchen, wherever they like, and then likewise the audience can watch the online event from their respective homes as well (given a decent Internet connection). In the years that follow the peak of COVID, will these new forms of performance be discarded as placeholders for the loss of physical concerts during a global pandemic, or did they become emblems of a new normality?

Health is a social issue. To allay symptoms of anxiety or loneliness, a positive communal interaction is a non-artificial antidote to the harmful stresses of solitude. While the NHS cannot prescribe a live music concert, the effects of such an experience were once upon a time a means towards increased endorphins and energizing sen-

sations via sonic vibrations. Concerts were good for our health, they made us feel the vitality of life. I can attest, because before the COVID-19 pandemic I worked in the music industry as a DJ, a booking agency marketing associate, a radio producer, and a music journalist. My chosen vocation was exciting and full of possibilities until 2020, but during lockdown I could only look back at these career experiences as relics of a bygone era as I have watched colleagues put down their guitars to pursue commercial driver's licenses or return to grad school to pursue a degree in another field. Even as venues reopen and artists perform live concerts again, the nascent reality emerging after COVID is that the ways in which performers and audiences experience music has been altered, permanently.

Pausing the Music Industry

The COVID-19 pandemic necessitated that the global music industry come to a sudden standstill, shutting down concert venues and postponing any organized gatherings around live performances on a massive scale for the sake of public health. Since COVID-19 is highly contagious and health organizations advised to maintain strict social distancing guidelines within indoor spaces to help deter the spread of the disease, concerts around the world had to cease immediately and entirely, since by their

nature live music events could not be carried out safely according to widely accepted social distancing guidelines. Annual festivals which drew thousands of attendees were either postponed or cancelled, and even smaller-scale concerts which would have drawn no more than a few dozen ticket holders became non-existent in some cities. As mentioned, many musicians and fans of music opted to still participate in live performance, albeit in forms contrary to the nature of concerts as they existed prior to the pandemic, but forms which do not provide adequate psychological support to groups of individuals for whom gathering *en masse* exists as a central component to their social lifestyles and consequent mental health upkeep, leading to the dilemma of everyone suddenly becoming a digital Robinson Crusoe.

As concerts remained paused beyond 2020 and through 2021, with prominent UK concert promoter Live Nation even cancelling its planned drive-in tours of popular artists like Dizzee Rascal and The Streets, not only did this produce unforeseen effects on the mental health of popular music fans who regularly attend large music events, but also the subcultures and underground scenes that form in solidarity over shared connections to fringe music interests, subsequently resulting in creative atrophy due to stagnation of collective elevation. In this article I will

lay out the theoretical framework for the cultural importance of this global adjustment to the group experience of live performance, show how the resultant placeholders are inadequate as long-term solutions to maintain cultural identities through shared music interests, and explain why engagement with unsatisfactory social activities will lead to a delusional embrace of deficiency, jeopardizing an otherwise healthy paradigm of shared grief and mourning in collective loss.

The lens that construes this thesis was written over a decade before COVID-19 in Priscilla Wald's 2008 book, *Contagious: Cultures, Carriers, and the Outbreak Narrative*. Wald writes in her Introduction: "Specific diseases blur together as emerging infections map the changing spaces, relationships, practices, and temporalities of a globalizing world" (6-7). COVID-19 directly changed the cultural space of the music world by closing down live performance venues, which shifted the relationships formerly found in these spaces, driving the communal practices into a physically distanced or non-physical/digital space, irrevocably demonstrating how precarious music culture can be in the global present. Wald notes, "...the experience of a communicable-disease epidemic could evoke a profound sense of social inter-connection: communicability configuring community" (6). This explains why a "drive-in concert"

or live-stream performance would even be considered during a quarantine. Live concerts are meaningful to groups of people and not something so easily given up when infections emerge and mandate a re-mapping of the music scenery.

In his introduction to *Pandemic! COVID-19 Shakes the World*, Slavoj Žižek further expounds on the meaningfulness that is found amidst shared corporeal experiences: "It is only now, when I have to avoid many of those who are close to me, that I fully experience their presence, their importance to me" (2). He later wonders, "Maybe only virtual reality will be considered safe, and moving freely in an open space will be reserved for the islands owned by the super-rich" (30) which may recall the now notorious Fyre Festival, the disastrously fraudulent VIP music festival experience which was to take place on a secluded Bahamian island, catering exclusively to only those who could afford to spend thousands of dollars on a single ticket. Now an infamous scam of the century, Fyre Fest proved to be nothing but a fever dream of what a concert experience might look like when exclusivity rules. With concert venue capacities ranging from anywhere between 100 and 10,000 persons, ticket prices have thus far been reflective of how many persons can fit into a room when standing a few inches away from one another. The questions

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of cost were obvious: if what was once a £20 ticket for a concert in a 100-capacity room, how will a reopened venue be able to continue operating if only a fraction of the capacity is allowed in? Would the ticket be increased to £40 to make up for lost occupancy? Social distancing demanded venues either operate at a loss, pay artists or their own staff significantly less, or charge exorbitant ticket prices - none of these options are sustainable. Even in 2022 after multiple waves of new variants spiking cases in the UK, musicians and concert promoters struggled to survive the economic instability caused by the pandemic, with M&B Promotions “going bust” and citing COVID-19 as the reason, resulting in major summer tours by Craig David and UB40 cancelled.

Going forward, now with ensuing ups and downs in the music industry, the pandemic has already changed the nature of what concerts are going to be. If assemblages of musical performers now demonstrate what were formerly unrestricted expressions during COVID-19 as if nothing has changed, it comes now with a sense of disdain. This was first apparent when mask-less gospel choirs sang at former US Vice President Mike Pence’s speech, suddenly seen as a potentially dangerous “super-spreader” group, rather than the former embodiment of communal hope in song. Zizek offers astute insight here as well: “The catch is that, even if life does eventually return to some semblance of normality, it will not be the same normal as the one we experienced before the outbreak. Things we



Empty Hall (© Dylan Peterson)

were used to as part of our daily life will no longer be taken for granted, we will have to learn to live a much more fragile life, to our existence as living beings among other forms of life” (49).

The New Normal?

Permanent change has already taken place, but rather than pretending that concerts can be recreated virtually or simply returned to as they were in their pre-pandemic form, the least delusional option that remains for music fans is a collective mourning for what has been lost (at least, that was the impression at the time). Zizek points to Elisabeth Kübler-Ross and her seminal 1969 book, *On Death and Dying*, to suggest that her suggested five stages of grief and acceptance of the death of a human life also applies to the death of a meaningful facet of societal life. The five stages are as follows:

1. Denial and Isolation
2. Anger
3. Bargaining
4. Depression
5. Acceptance

The third stage, Bargaining, is where concessions like “drive-in concerts” and livestream concerts come from. It is certainly hard to believe (and easy to deny) that the isolation thrust upon music fans and performers who once experienced such a meaningful re-

lationship with each other through this cultural artform was not meant to last forever, and consequently this inspires rightful anger towards the uncontrollable situation. But after the bargaining has passed and it becomes clear that there is no replacing what has been lost as a result of the pandemic, it makes for a sobering stage four, certainly nothing short of depressing. The bargaining does not replace the fifth stage though, because real acceptance is never delusional.

Antithetical to the comradery that is found in close-quartered concert spaces, which often result in physical displays such as group dancing and singing in unison, a spacelessness of live music produces a void in the creative culture which cannot be substituted with aberrations for too extended a period of time without eventually resulting in cultural inertia. Even now with vaccines, which were at one time the solitary hope for salvation from the pandemic, leftover stand-ins for the edification inherent in the ritualistic and communal activity of live music culture remains endangered by the spectre of isolation which will always be the foregone supposition when it comes to the overall health and safety of society. Concerts, these distinct public forums where call-and-response interaction between performer and audience (thus consistently inspiring new and emergent forms of art and culture) will not

be sufficiently replicated in more isolated forms, are therefore in danger of suffering not only in economic terms, but culturally, artistically, and psychically as well. To keep concerts alive but on a digital respirator is to continue seeing them through the traumatic event which triggered them; it constructs a Freudian screen memory to stand in place of the unpleasant reality that lies just beyond. The memory of what existed before the pandemic may not be vanquished, but if replaced by a psychic imitation of the past it can weaken the cultural strength of the memories, as UCLA professor of English and Comparative Literature Michael Rothberg explains in his 2009 book, *Multidirectional Memory*, “The [...] difference between screen memory and multidirectional memory concerns the question of the affective charge of the memories at issue. For Freud, screen memories stand in for and distract from something disturbing - either a traumatic event or an illicit, unacknowledged desire” (16).

Zizek considers this a time not to restore *what was*, but to accept that *what was* is now gone and has thereby created a space for something new that is yet to come: “Dead time—moments of withdrawal, of what old mystics called *Gelassenheit*, release—ment—are crucial for the revitalization of our life experience” (38). Recalling Wald’s framework again, COVID-19

has proven live music concerts to be a temporality of the global world, a once seemingly free and accepted practice rendered suddenly illicit according to the injunctions of the outbreak. It is not a silver lining moment, but one to be acknowledged through grieving, which is indeed made all the more difficult by the fact that even this too must be done in isolation. Resurging case numbers in the UK showed that the coronavirus can spread quickly and unpredictably if restrictions are not kept in place, and even with the World Health Organization declaring the end of the public health emergency, endemicity of the virus is still uncertain. In the meantime, a rich creative culture has become as shipwrecked as Crusoe. Live music performances afforded meaning-making, identity-building, social accountability, and aesthetic appreciation, all of which are now necessarily marred by the deformation of concerts and cannot be resurrected through any sort of bargaining with apparitions. Other paths to meaning are possible, although taking them requires forging new ways, for what was once a clear road is now at an impasse. Hegel’s words may be remembered well in such a moment as this: “The human being is this night, this empty nothing, that contains everything in its simplicity—an unending wealth of many representations, images, of which none belongs to him—or which are not present. One catches sight of this night when one

looks human beings in the eye” (204).

The stage curtain comes up, the band steps out and picks up their instruments, but there is no sound of applause, only the loud and clear ding of an incoming iPhone message. There is no exhilarating eye-contact made with an attractive stranger at the front of the stage, because it is not possible to see who is inside the window tint of each car. There is no meeting up with friends at the back bar, no crowd-surfing, no mosh pits, no waving of hundreds or thousands of hands in the air because they just don't care. These memories of concerts will remain, and they ought to be remembered fondly, but alas, they were but another one of the many trag-

ic casualties of COVID-19. But this is not the end—there is still a future for music.

Burial and a Possible Future for Music

In the final moment before the outro of Burial's 2021 song, “Dark Gethsemane,” a voice dramatically proclaims, “We must discover the power of love. For love... it is strong as death.” This hybridity of the dark and the beautiful as a paradoxical force is a familiar theme in the music of the UK-based electronic artist, William Emmanuel Bevan, aka Burial, and though many other audible vocal clips



Spectral Concert (© Dylan Peterson)

are scattered throughout this track, this particular byte acts as the climactic statement which commences a rollicking finish, propelled by a preacher repeatedly shouting, “We must shock this nation with the power of love!” as a final punctuation to the 10-minute journey from the ethereal dub techno pulsations through the dark garden of Gethsemane into a euphoric trance of transcendent possibility. However, these audibly recognizable English phrases are subsidiary key sounds in a vast sonic world of invisibility as Burial becomes more political in an unseen/un-speakable sense than a straightforwardly temporal or declarative one.

Situated on the surface as an electronic dance music post-dubstep production, “Dark Gethsemane” initially suggests the mood of an underground club atmosphere where DJs perform in a booth for a crowd, with deep bass lines and a steadily pulsing dub techno rhythm. But as a music production released under the context of COVID-19, this suggestion towards the dance club came with a nostalgia for a lost time. Most major dance clubs were still not open at full capacity in the UK, after many had to shut down completely for health and safety measures during the pandemic, causing many musicians to struggle both economically and artistically due to a main part of their career, live performance, having suddenly disappeared.

This trauma inflicted upon musicians did not apply to Burial in the same way though, because Burial has *never* performed, and does not ever intend to. A decade and a half since his full-length debut album stretched the limits of the dance music genre, “Dark Gethsemane” re-establishes Burial as a radical outsider in the music world not due to a particularly unique style of dance music which is solely claimed or owned by him, but because of the reinvigorating sonic agency that listeners are afforded upon hearing and relating to the distinguishing terms of his music, namely that of being unmoved by the capitalist enterprise of the music industry at large which incentivizes the performative aspect for anyone pursuing music as a profession. Because Burial resists not only live performance, but press interviews, album cycles, and various other visualizing formalities imposed by the music industry, this subversion of dependency on mass market dictations is commensurable with his music itself and implies an attunement that does not conform to the confines of mainstream performance, but of somewhere darker and more uncertain, thus requiring a different kind of listening which is not compatible with ubiquitous consumerism.

In his 2018 book, *Sonic Agency*, Brandon LaBelle says, “[...] a black art is a craft aligned with magic and a logic of ambiguities and liminali-

ties, of transactions that communicate through oblique messages, temporary meanings, and truths defined by spectral force” (88). One example of this “logic of ambiguities” can be heard in Burial’s regular use of “crackles” which may be interpreted as noisy, perhaps reminiscent of ambient sounds like city environments or the incidental pops and clicks of a vinyl record. Burial sometimes amplifies these noises to the point of distortion, even to a degree where the noise might be interpreted as a damaged or compromised recording—number stations or pirate radio frequencies may also be considered in effect, or some other type of mysteriously invasive and undesirable disruption in a broadcast. Of course, these sounds are desired by Burial and are prominent features of the production, suggestively unsettling the ontological meaning of performance.

My professional experience as a DJ occurred either as a service-worker (weddings, bars, and corporate events) or an entertainer (parties, festivals). Burial’s music never felt appropriate to me in either of these venues, as his tracks always sounded out of place in a mix due to the static “crackles” or the melancholic quality of the songs themselves. Even in clubs where experimental noise was more acceptable, a standard of pre-established restrictions on outputs maintained expectations through the EQ knobs of

the house system’s soundboard. In other words, speakers should not sound like they are blown out, but in nearly all Burial tracks this is a built-in feature of his production. This hesitation to include Burial’s music in a performance setting, even by someone other than Burial himself, is a manifestation of “black art” and the “spectral force” that empowers its sonic agency. In a 2015 essay for the journal *Dancecult*, Alessio Kolioulis referenced the critical authority on Burial, the late Mark Fisher (one of the very few people to have ever interviewed Burial), to draw out this distinctive quality in Burial’s music as something which he calls *hauntological*: Drawing from Derrida’s *Spectres of Marx* (1994), Fisher defines hauntology “as the agency of the virtual, with the spectre understood not as anything supernatural, but as that which acts without (physically) existing” (67).

With “Dark Gethsemane” being released in 2021, in the not-yet aftermath of the COVID-19 pandemic which shut down clubs and music venues everywhere in the world, the hauntological nature of Burial’s music takes on an even more remarkable dimension: Burial persists, unharmed, and in a sense untouched by the crisis that (physically) struck the music industry. The virtual presence of “Dark Gethsemane” never needs to be heard live on Burial’s hypothetically postponed or cancelled tour, because he

was never going to tour anyway. While many professional musicians were hampered by their once vital visibility being forced to adapt on livestreaming online platforms or uncomfortably masked and socially distanced live events which restricted ticket sales and crowd sizes for the sake of following health and safety guidelines, Burial was never visible in the first place, and so his perpetual invisibility emerged with immunity to the precarious whims of the capitalist system that determines the success or failure of musicians who depend on live performance (be it in-person or online in livestreaming formats) as the dominant means of commodifying artistic production. Kolioulis noted this characteristic of Burial as well, saying, “His approach to space, in line with dance floor DJs, clearly stands at the opposite end of festivals’ “Spectacle DJ” (Rietveld 2013)” (68) which could be understood in reference to Guy Debord’s seminal work, *Society of the Spectacle*, in which Debord states, “[...] the spectacle is the affirmation of appearance and the affirmation of all human, namely social life, as mere appearance. But the critique which reaches the truth of the spectacle uncovers it as the visible negation of life; as a negation of life which has become visible” (11). For Burial, the music itself, be it the listening to or the production of it, is resistant to visibility (mere appearance), and hence resistant to the spectacle. But what’s more, Burial flips this “negation of life”

on its head (“For love... it is strong as death”) and embraces the life that is of the invisible; the hauntological.

Challenging Music’s Spatiotemporalities

Burial’s other track released in 2021 which follows “Dark Gethsemane” on the *Shock Power of Love EP* is a continuation of futurist ebullition, with a notable acceleration of BPM on “Space Cadet.” Arguably Burial’s most uplifting work to date in tone and atmosphere, twinkling with arpeggiated synths that could be straight out of a 1970s sci-fi adventure film, the track repeats a sample of “take me higher” and contains all the proper ingredients for a headlining DJ set at a music festival. But the song will undoubtedly still frustrate traditional DJs with its extra-prominent “crackle” during the track’s most straightforward stretches of melody and crescendo, yet again preserving the invisibility of Burial and his listeners.

Historically, viewed as post-COVID texts, Burial’s two tracks on this EP look to the present as the future - the future as here, as it always was, because the listener of the future also listens in the present. This sentiment was hinted at by LaBelle when he correlated the late David Graeber’s thought to the power of the invisible in sound: “It’s precisely from these in-

visible spaces – invisible, most of all, to power – when the potential for insurrection, and the extraordinary social creativity that seems to emerge out of nowhere in revolutionary moments, actually comes” (52). Indeed, the *moment* which came in COVID exposed many weaknesses in modern societies, creative communities, and sub-cultures, but as the invisibility of Burial proved resilient as a sort of (non)resurrection of defiance of hegemonic subjugations regardless of displaced resonance.

In a curious irony to the real virus which acted as the emergent setting for Burial’s (non)resurrection in 2021, the 2005 song, “The Spaceape,” utilized a metaphorical virus to show an early inversion of Burial’s sonic resistance to Empire, as analyzed by Bartels, Eckstein, Waller and Wiemann in their book, *Postcolonial Literatures in English: The collaborative sonic fiction of Burial and The Spaceape* thus opens up new ways of communication, new ways of social relation and ultimately envisages new sonic communities to come: viral communities beyond Empire in which “chaotic cultural dissemination in more and more elaborate circuits [...] dispatched in provisional and unfinished forms [...] is the regulative norm” (Gilroy 2001, 252; see also Eckstein 2015). (180)

Referring here to a “virus” in the lyrics of the track which drama-

tically altered the lives of the fictional spaceapes, this futurist sensibility saw a sort of fulfilment of prophecy in 2020 with the real virus that altered the stability of the world, thus compelling a re-listening of Burial as an untrue non-performer—a creator who is not visible but creates affective material anyway. With this ability to subvert the virus through invisibility, Burial’s darkness proved that it was always ideal terrain for confronting the political beyond.

The invisible hand of the market is the foil to Burial’s counter-hierarchical invisibility, as other sound art like Christina Kubisch’s *Electrical Walks* (which offered listeners an opportunity to hear the frequencies of the city environments around them which would otherwise have remained invisible to the public) already revealed. Works like Kubisch’s point to those intentionally hidden and invisible factors playing clandestine roles in a person’s everyday life which may not always be to the benefit of the unaware person. For example, surveillance tools in a cell phone will not alert someone when an algorithmic marketing calculation designed to increase the likelihood of selling a product to an unwitting consumer has taken place within the phone, this always occurs invisibly. The generative art of Burial, however, contrasts with the manipulative and exploitative unseen forces evocative of Chomskian manufacturing of consent—never bla-

tantly obvious but always effective as propaganda in a neoliberal state. That this toxic invisibility is not the only invisibility is the political challenge brought by Burial, which, rather than stripping the agency of a person as an advertising algorithm does, empowers the agency of the marginalized through a sensory act (listening) which need not be dependent on a means to predetermined, rational end.

Back to the jubilant ending of “Dark Gethsemane” then, which is an affirmation of a different future, a *shock*. It is positive, rising out of a dark time in history which does not deny its darkness. The suggestion is not exactly a religious one, even if this is Burial’s appropriation, but the political implications are palpable regardless. Who is to be *shocked*? “This nation.” And who is doing the *shocking*? Those with the power of love; the invisible. With the sound clip removed from its original context, altered in a new form, this repetition in the track intersects blasphemy with revolution, which is precisely what happened in the Garden of Gethsemane when Judas betrayed Jesus, sealing the fate of his demise but also the salvation of the rest of the world. Love itself is the radical idea posited here, but not necessarily a love that shows itself as another spectacle. Love, too, may be considered an invisible power, an uncertain, creative force which compels people towards a propagation

of something new. Another clip in the middle of the song even whispers “the power to create a new world” as if it’s a secret that lives right here in the music, hidden, invisible, but heard and understood if only listened to closely.

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Navigating Marginal Familial and Globalised Childhoods in Kenya during COVID-19

Oduor Obura

Oduor Obura, who is affiliated with the Technical University of Kenya and obtained his PhD from the University of Potsdam in Germany, looks at ways in which the concept of childhood is constructed as a marginal factor in narratives surrounding the COVID-19 pandemic in Kenya. He posits that there are two layers of looking at the Kenyan child, from local experiences and from global interactions and depictions. Loosely benefitting from decolonial conversations, he looks at how children in Kenya respond to the two stimuli from an agential perspective and how they disavow positions that insinuate control over them as children. Additionally, he samples some global and national experiences to find out how children navigate the complexity of adult attempts at controlling their world.

Introduction

I travelled with my two children (aged seven and three) from Berlin to Nairobi, Kenya in the midst of the COVID-19 outbreak in August 2020. At the outbreak, face masks were hard to come by and I had to give my children adult-size masks. The absent masks were a reminder to me, and also a harbinger, of what befalls the place and idea of the child in COVID-19 narratives, experiences and containment measures. On the other hand, children were an auxiliary audience of the COVID-19 containment measures. The pandemic risked affirming an auxiliary role of childhood in social spheres.

Immigration controls made it much easier for flights from Berlin to Nairobi than to travel from Nairobi to Berlin. Intriguingly, COVID-19 mortality and infection rates were significantly

higher in Germany than in Kenya. The prevailing scientific data did not restrict the already nervous European bio-state. The flights themselves had an unusually restricted food service, so I had to watch out for my children.

The status quo was relatively similar from the beginning of the COVID-19 outbreak to the end of the pandemic. While the restrictions for adults to travel from the global north were hard, it was even harder for children who had to travel through various hurdles during the pandemic. The uses and abuses of childhood as a demographic and cultural category caught my attention. In this article I use childhood to discuss uneven power structures that COVID-19 brought about and also revealed, as well as the marginalisation of childhood in Kenya as a representation of a local black or African space. I consider childhood in both global and local spaces. There is an increasing deagential portrayal and [re]presentation of children in the Kenyan public sphere. This has been heightened particularly during the COVID-19 pandemic in a way that mirrors power anxieties in the global sphere while simultaneously creating hierarchies in local Kenyan encounters between adults and children.

Using purposefully selected texts based on their popularity and global reach at the height of the COVID-19 pandemic, I argue that child-

hood is both marginalised in Kenyan discourses while it simultaneously reflects global hierarchies of marginalisation in narratives that accompany the COVID-19 wave in the world.

Presidential Patronage: Deprotecting the Minor in Protecting the Nation

Having settled back in Kenya and spent some time observing the treatment of children during the viral outbreak, I was struck by uses of childhood during the annual Independence Day public holiday on 1st of June 2022. This year the holiday came up while COVID-19 was subsiding. However, it was still a requirement (but not strictly enforced) for all the attendants to show up masked up. In his speech during the event, president Uhuru Kenyatta said, “Equally important to highlight is the threat to our traditional values and the family as the basic unit of our Society. The evolving face of the Kenyan family is characterized in the 2019 national census where families headed by single parents rose from 25.1% in 2009 to 38.2% in 2019. If unchecked, this trend shall destroy the fundamental character of Kenya and reap untold harm onto our most vulnerable and precious members of society; our Children.” In this statement, Kenyatta invoked nationalist statements to appeal to the citizens to step up the war on protection of the child in familial spaces. The implied powerlessness of



School Kids washing hands during COVID-19 pandemic,
<[https://commons.wikimedia.org/wiki/Category:COVID-19_pandemic_in_Kenya#/media/
File:Washing_hands_kids.jpg](https://commons.wikimedia.org/wiki/Category:COVID-19_pandemic_in_Kenya#/media/File:Washing_hands_kids.jpg)>

the child is a subtraction from both the need and push for an empowered perception of the child in Kenya.

While Kenyatta navigates the tensions between family building, types and conventions in Kenya and nation building in the country, he makes references to threats against Kenya, whether biological or political. He goes ahead to say, “I urge our media houses, our religious leaders, our community elders, and the concerned government agencies to step up to the plate and make sure that the Kenyan Family remains the strong and respected institution that it has historically been.” In this case the Kenyan family becomes

both a social unit and a political unit that has come under attack.

In preparation for this particular Madaraka day, *The Star* newspaper reported the Interior Permanent Secretary as saying, “We have not also been having the participation of children because of the pandemic, but this time we shall bring them on board...” (Ombati 2022). The anxieties surrounding children in public spaces is revealed in the fact of children’s exclusion from previous Madaraka Day celebrations. This, however, contradicts infection rates that were disproportionately affecting adult victims. According to UNICEF,

from sample data of 3.7 million global COVID deaths by December of 2021, child deaths accounted for 0.4 percent, that is about 13,400 deaths. This signifies the absence of utility of medical data in informing the age of allowed participants in Madaraka Day during the pandemic. Rather it is more plausible to argue that the child's voice is muted, and visibility is unconsciously and subtly minimised, in order to elevate the visibility of the adult in the COVID-19 containment spaces and effort. This is paradoxical since it would be expected that the population segment least infected by the virus would be allowed to congregate in public spaces. While the president on one hand claims protection of the child, on the other hand a section of his cabinet de-agentialises the children by taking them out of public participation in the celebrations, allegedly to protect them. The children are ostensibly marginalised, in pursuit of the children's own interest!

Engaging the (African/Kenyan) Child in Global COVID-19 Campaigns

Whereas the rise of single families is a contributory factor in presenting the marginalised perception of children in Kenya, the rise of COVID-19 is a factor in revealing the marginalisation of Kenya by global powers. This is symbolised and realised by

narratives surrounding the representation of local childhoods in international platforms. As an illustration I travel through a section of global bodies or multinational corporations and their depictions and experiences of Kenyan, or generally global south childhoods, in their health campaigns against and during the pandemic.

The World Health Organisation (WHO) is the official body within the United Nations system mandated to direct and coordinate international health. Its uses and abuses of black childhoods would thus stand out. I visited their campaign advertisement published on *YouTube* in April 2020, two months after COVID-19 was declared a global disaster. This video, with over 170,000 views at this time, marked 100 days since the first case of what we now call COVID-19 was notified to WHO. One of the opening shots foregrounds the Eiffel tower as the voice-over speaks about all of humanity. This is a thematic announcement of the western-centric theme of the visual campaign. Interestingly the short video chooses a grey scale that brings to mind a white against black contrast even as it points to the multiracial composition of all the other characters in the short film.

The *YouTube* video foregrounds the west's urban scape in reference to all the world's humanity. This proble-

matic equation of the world's humanity through architectural presentation of mostly non-black built environments of the west strips away the humanity of the black population that is also part of the population affected by the pandemic. The nuances involved unpack a focalising of humanity through western lenses, in terms of the visualisation of the pandemic in the media. The Kenyan children are thus embedded in this matrix of erasure from the story of the humanity affected by the viral outbreak of Corona.

In addition, out of the six children in the one-minute video, none are black. The geo-cultural setting of the video is located outside Africa. Effectively, black childhood is silenced, marginalised and thus deemed insignificant regardless of the dominant demographic size of black children among the countries that are signatory to the United Nations Charter on the rights of the child. The UN COVID-19 *You-Tube* video helps to reify the image of a multiple conceptualisation of plural childhoods as non-consequential in favour of a singularised and insular idea of childhood.

Indeed, most of the campaigns were aimed at adults, for the reason that they hold rights of legal consent on behalf of children. However, campaigns that feature the voice of the black child have been proven to also be ineffecti-

ve in driving agential construction of multiple childhoods in public spaces. Cohen-Eliya and Hammer (2004) argue that stereotypical images in ads, by reinforcing negative racial stereotypes, deter people from breaking a bad habit: holding racially biased beliefs. Cohen-Eliya and Hammer note that the typical uncritical viewing of ads allows such stereotypes to be “transmitted in a way that prevents people from internalizing their belief in equality... [by failing to] neutralize the influence of their... deep-rooted acquaintance with stereotype norms” (170).

I move to the “Nike Playing for the World” campaign which features a video that is pegged on a representation of various communities in the world. Like the UN video discussed above, it is also done with a grey scale. The grey scale effect attempts to flatten out a lot of colour nuances and cultural differences. However, the colour effect is only a technological tool and not a cognitive enough tool to erase the subtle pointers of cultural differences and hierarchies. Therefore, the two videos end up reproducing colonialist trope in the manner they side-line multiple childhoods in favour of a childhood modelled along Eurocentric benchmarks.

This Nike video features many adults from different race backgrounds. It is much more representative of world cultures than the UN

video discussed above. Yet in its ambitious cosmopolitan aim, it features only one child. The last shot features a child jumping on a trampoline. The demographic absence of the child centres the narrative of adults wielding power in the world and being affected by the pandemic more than the child characters therein. However, it also falls in the category of constructing a world in which the role of the child is severely diminished and underrepresented, given that children are more demographically dominant than any other group.

It is quite intriguing to note that the Nike video has only one child and she is white. The exclusion of black and other children is problematised on two levels. First, that the child is not important to messaging on the pandemic and, secondly, that if a child has to be included then it has to be a white child. The consequence of this is an imbalanced presentation of various childhoods and the subsequent construction of a pigmented hierarchy that insinuates that western ideas and experiences of childhood are emblematic of all other childhoods. The western idea of childhood is recreated as the benchmark childhood as opposed to an affirmation of the presence of world childhoods.

Children in Their Own Voices

If the foregoing arguments portray children in less than autonomous situations, then it becomes interesting to sample comic calibrations of childhood in the COVID-19 situation. A group of children went viral in Kenyan social media when they imitated the accent of Mutahi Kagwe, who was the Kenyan Health Minister during the COVID-19 pandemic (Kenya Digital News 2020). Whereas most narratives seemed to silence the children, the three children supply a counternarrative. Their imitation of Mutahi Kagwe went viral in Kenya, and it also serves as a reminder that children can claim their own agency in various ways.

In the short video clip shared on Twitter and *YouTube*, the three children are seen mimicking the daily pressers on statistics about the contagion, given by the minister. The children hilariously order Kenya's deputy president to also stay at home and quarantine himself. The children not only reclaim their autonomy but also assert their authority to speak truth to power, through a jocular medium.

The Kenyan national TV channel NTV held an interview with two children on a "children's view of the Coronavirus pandemic" in April 2020. One of the children, Mina Anna Chebet is eleven years old. The other girl

is Hope Jahale who is thirteen years old. During the interview Mina says that she *knows* “Coronavirus is a respiratory disease that infects both young and old” and she feels “sorry for those who have been affected and those whose loved ones have passed away”. Mina is clearly aware of the impacts of the Coronavirus and she is conscious of the consequence of contracting the virus. However, when asked how she handles the pandemic, Mina responds that she cannot go outside because her mum will not let her. Despite her intimate knowledge of the virus, she is not allowed to go out simply because her mum said so. The relationship between mother and daughter, from the interview, is one of power projection on behalf of the child. At the same time, Mina is deprived of the chance to make decisions based on her own judgement. When asked whether she is scared of the virus, her response is quite telling, “I am not scared because I like thinking about the positive side of life and I know one day all these will go away and we will have our freedom back.” The freedom that she speaks of is freedom from Coronavirus-related restrictions. In the presentation of Kenyan childhood, from this media interview, the freedom for the child to make independent choices is also sought.

Interestingly the last part of the interview shifts to a conversation between the adult news anchor and

Mina’s mother. Mina’s mother speaks longer than Hope in the entire interview. This does not do justice to the host’s welcoming remark that he would be speaking to the “two kids.” The two children become effectively locked out of the interview before Mina is cued into the conversation for her brief final remarks. The other 13-year-old is not given a chance for final remarks. The NTV interview is a local structural reflection of the devoicing of children and the children’s desire for freedom. Additionally, this shows how the children express their assertiveness in Kenya.

On the global front, there was a joint multinational and multi-agency task force that produced a children’s story book to highlight the efforts of children in mitigating the spread of the virus. The book was:

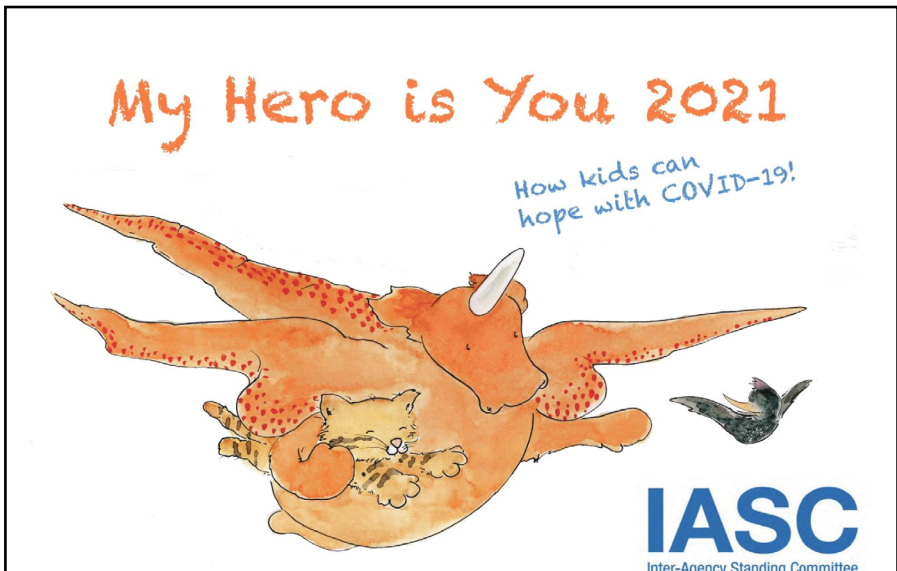
developed by the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS RG). The project was supported by global, regional and country-based experts from Member Agencies of the IASC MHPSS RG, in addition to parents, caregivers, teachers and children from all over the world. At the onset of the COVID-19 pandemic, more than 1700 children from 104 countries helped to create a children’s storybook on COVID-19 that reached hundreds of thousands of children worldwide... with more than 140 translations and an extensive list of multimedia adaptations,

including Braille. The storybook is titled, “My Hero is You 2021: How Kids Can Hope with COVID-19!” It was “developed for and by children around the world.” The story centres on the journey of Sara around the world as she educatively spreads hope to other children during the pandemic.

The short story book, first published in March 2020 and widely circulated in a PDF format, involved children from a wide geographical reach across the world. The story involves a collective effort of children characters making friends all over the world during the pandemic. As they do so, tips on how to avoid contracting the Coronavirus are narrated. Through the

heroic journey of spreading awareness on the pandemic, Sara becomes a hero. She travels around the world advising other children on what they should do to fight the coronavirus. The perspective of the child is highlighted and the child participatorily claims space in the efforts. Unlike the other already-mentioned campaigns, this child-centred narrative does not privilege any hierarchy but acknowledges the inter-connected experiences of children from different socio-geographical spaces in the world.

In the introduction to the 2021 version of the book series, IASC indicates:



My Hero Is You,

<<https://interagencystandingcommittee.org/my-hero-is-you>>

To ensure that this book addresses the hopes and concerns of children during the current phase of the pandemic, we asked children and their parents, caregivers and teachers to share their thoughts, fears and experiences of how their lives have changed... Children worldwide read and corrected multiple versions of the story, and their feedback was then used to update the version of the book you currently have.

The seriousness with which the children think of their own condition in the pandemic deserves mention, especially how they feel affected by the pandemic. They are equally affected but often have limited access and roles in discourses on pandemic prevention and containment. When asked what most affects them, the characters in the story book note:

So the children started to write and draw what gave them hope as the earth turned beneath them. "My mum making the vaccine," said Sara. "Our school opening!" cried Juan. "Flowers growing on my friend the tree," said Zoozie. "Realising I am brave," said Tiger. "Singing songs," said Sasha. "My grandfather telling me a story," said Salem (IASC 2021).

The children are equally affected by the quarantines and the lockdowns that accompanied the responses to the rising Coronavirus infection rates. They show the need to be allowed to physically socialise, like many other adults during the pandemic, as seen in the need to have schools opened.

Conclusion

Unlike the UN campaign and the Nike Campaign geared at adult audiences, the COVID-19 campaign story developed from a children's perspective is quite inclusive and broadly consultative. The child-centred efforts eschew the nationalist and essentialist undertones that are common in the adult-centred versions.

In Kenyan spaces, childhood is intertwined in nationalist discourses that are arguably patronising. There is a statutory protection of the child by state apparatuses such as the executive arm of the government. Yet in doing so, the state invokes fundamentalist discourses that imply a binary distinction of Kenya from other powers. Simultaneously, there is also a dichotomous separation of children from adults. The distinction of childhood from adulthood is a relative process that cannot be easily and neatly done. This limits the project of nationhood to a competitive matter. At the same time, it implies that Kenya is defined by its relationship to the west and not by its own autonomous sovereign potentials and parameters.

The use of childhood in global COVID-19 advertisements serves medical awareness functions within familial spaces. However, in so doing childhood is also caught and mixed up

in political campaign subtexts which implicate and evoke racialised ideologies and notions as by-products. This abuse of childhood nods to campaigns for racist hierarchies that in turn serve to limit the desired awareness effects and impacts.

The pandemic highlights dis-ease with the idea of a monodirectional notion of childhood. That is childhood as constructed in a western form and for a Eurocentric purpose. This endemic portrayal is rooted in historical antecedents (Obura 2022). Simultaneously, it strives for a replication of childhood hierarchies that divert the COVID-19 messaging underlying them. If the messages are geared towards humanity's collective control of the viral infection and situation, then it emerges how this cosmopolitan ambition is undermined by subtle forms of nationalist manipulation and pervasive marginalisation and a devoicing of the child in the process.

In the familial realm, the adult is constructed as the sole purveyor of power. The child becomes an auxiliary tool in the service of both the nation and adult-centred spaces. In conclusion, as I landed back in Kenya, Germany also experienced an initial shortage in the supply of face masks for children and I realised that children in both Germany and Kenya generally experience similar marginalisation at the hand of

adults. Childhood in Kenya experienced double weights, both marginalised by a globalised monodirectional idea of childhood and at the same time denigrated by local state instruments. In the redemptive words of Mina Chebet, "I am not scared because I like thinking about the positive side of life and I know one day all these will go away and we will have our freedom back."

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Long Covid: Digital Health Technologies, Patient Activism, and Illness Narratives

Monika Pietrzak-Franger¹

There are over sixty-five million people worldwide suffering from Long Covid. The condition, though largely accepted as a diagnosis, does not yet have a legitimate status. Patient organizations have used analogue means and digital technologies to raise awareness and draw attention to Long Covid's long-term effects. In this article, Monika Pietrzak-Franger (University of Vienna) takes a quick glance at the ways in which digital health technologies may be used in the fight for recognition and legitimation, knowledge creation, and community building. She pays particular attention to the downsides of online illness narratives and iconographies that have appeared in this context.

Disease has always been a matter of politics. While it is, for most of us, a personal event, it rarely impacts only one body: when our phenomenological relationship with the world changes, so do our interpersonal relations, with family members and

smaller or bigger communities. Our salient bodies become a disturbance: in everyday practice, on the economic market, within the larger imagined community that is a nation, or the world. This is all the more the case with long-term diseases and with the contested ones which have yet to be legitimized by the medical establishment and society. Diseases as events and everyday practices are political, and so are the stories we tell about them and the images we associate with them: illness narratives and iconographies. Medical and sociopolitical histories are testimonies to their rhetorical power.

When new health conditions, such as Long Covid, appear on the horizon, they become inscribed in the traditions of treatment and representation, activating particular behavioural and representational scripts that may be empowering as well as oppressive, or – at times – both. When the ap-

pearance of such an illness goes hand in hand with a proliferation of expressive means, enabled, as in the case of Long Covid, by digital environments, the impact of such representational practices may be profound. As the first illness ‘made on social media’ (Callard and Perego 2021), Long Covid exemplarily demonstrates how digital health technologies may be used in the fight for recognition and legitimation, knowledge creation, and community building. At the same time, Long Covid narratives and iconographies show the shadow side of this struggle, highlighting the stigmatizing power of extant representational traditions and spotlighting the difficulties in coming to terms with the unknown condition, which become manifest in various problems in their narrativization and visualization.

Patient-made: From Contested Illness to Acknowledged Multisystemic Condition

Long Covid has been a contested illness. As the pandemic progressed, though still in its early stages, the so-called ‘long-haulers’ drew attention to the persistence of a number of multiorgan symptoms months after the infection with SARS-CoV-2. Similarly, a survey conducted by the UK Government’s Office for National Statistics in November 2020 showed that one in five infected exhibited symptoms that lasted more than five weeks (Venkate-

san 2021). Over 200 symptoms have been collected and reported by patients, ranging from recurring coughs and persistent brain fog to breathing problems and fatigue.

In the meantime, the existence of Long Covid has been acknowledged by (inter)national bodies, albeit with varying terminology. Under the entry “Post COVID-19 Condition (Long COVID)”, the World Health Organization defines it as “the continuation or development of new symptoms 3 months after the initial [...] infection” (WHO). While the organization has also developed a more elaborate clinical case definition of Long Covid, even this very general one testifies to the fact that the condition has been officially recognized. Many countries have also issued plans regarding its treatment. In the UK, in cooperation with Healthcare Improvement Scotland, and the Royal College of General Practitioners, the National Institute for Health and Care Excellence (NICE) published a ‘rapid guideline’ in December 2020 (last updated in November 2021), which offers recommendations as to how to identify, assess, and manage the long-term effects of COVID-19. Irrespective of these developments, it must be remembered that such an ‘official’ acknowledgement does not necessarily mean a full-fledged, cross-societal acceptance. Long Covid does not have the same ‘legitimate’ position as can-

cer or measles, in fact, for many, it still does not exist.

The speedy official acknowledgement of Long Covid may be partly due to the apparent prevalence of cases. According to latest estimates, at least 10% of those infected are subject to suffering from Covid-19 sequelae; this amounts to no less than sixty-five million individuals around the world (Davis et al. 2023). Considering the vast number of people affected, the (often) inadequate extant health provision infrastructures and the impact the condition has on work uptake, it is to be expected that both the economies and health care systems (e.g., insurance companies) will have to deal with the issue sooner or later. The way they will deal with the condition will, of course, impact the everyday lives of many; still, when handled with care, it may also serve as an impulse to change the way we think about chronic and contested illnesses, and offer a model of how to deal with them in a sustainable manner. Whatever the outcome, though, it is clear that vast resources will be needed to understand the long-term effects of Long Covid and develop necessary (healthcare) infrastructures to address these.

Be that as it may, it also transpires that the institutional (official) acknowledgement of Long Covid would not have happened, nor would

it have happened so quickly, were it not for a number of patient (activist) groups who drew attention to its existence. In fact, the NICE guidelines acknowledge their work in discussing the choice of nomenclature, when they say that “[t]he panel recognized the significant progress made by patient groups using the term ‘long COVID’” (NICE 6). Likewise, the first version of WHO’s clinical case definition of Post-COVID-19 Condition is said to have been “developed by patients, researchers, and others, representative of all WHO regions” (WHO 2022). Likewise, researchers across disciplines have highlighted the importance of including patient experience in the processes of knowledge creation as well as policy making.

Indeed, patient-researchers have made claims to playing the key role in making the illness visible. Felicity Callard and Elisa Perego (2021) suggest that “[p]atients collectively made Long Covid”. It is, they continue, “the first illness created through patients finding one another on Twitter: it moved from patients, through various media, to formal clinical and policy channels in just a few months” (Callard and Perego 2021). Undeniably, social media channels, as part of larger digital health technologies, have proved central both in patient activism and in the processes of knowledge creation in this context.

Digital Health Technologies and Patient Activism

Digital technologies have transformed the ways we perceive and practice health. The evolution of the Internet – from Web 1.0 that enabled storing, sharing and viewing of information to Web 4.0 that has become a highly networked, regulatory ‘Internet of Things’ – went hand in hand with the evolution of digital health technologies. Today, e-health, also known as electronic health or digital health, and referring to the use of technology and digital communication tools to manage and improve healthcare delivery and outcomes, has become part of the essential health provision infrastructure in many countries. While still in its infancy at the turn of the century, e-health has continually developed further, gaining added impetus with the onset of the pandemic.

The “e” in e-health does not simply imply “electronic” but also refers to a number of expectations that Gunther Eysenbach aptly lists under “The 10 e’s in ‘e-health’”: “efficiency”, “enhancing quality”, “evidence-based”, “empowerment”, “encouragement”, “education”, “enabling”, “extending” (2001). What this list irrefutably demonstrates is the fervent hopes that researchers drew from and associated

with those transformations in their early stages. Indeed, Eysenbach considers the concept of e-health not only as signalling a technological revolution but also as a term that characterizes “a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve health care locally, regionally, and worldwide by using information and communication technology” (2001). And indeed, a lot has changed when it comes to healthcare provision systems around the world, although, to be fair, the pandemic has revealed the in-built problems and inequalities within such systems as well as laying bare the fault lines of such ‘globalized’, ‘networked’ thinking. Merrill Singer’s concept of a “syndemic” (2009) has rightfully been revived to draw attention to the intertwined epidemics and crises that we are experiencing at the moment.

Still, in dystopian times, utopian visions are necessary to fathom any kind of future. It is therefore not surprising that digital health technologies have been used to pursue activist goals, irrespective of the dangers they may harbour. Digital health technologies span a broad range of practices and products ranging from telemedicine, mobile health apps, wearable devices, to health information exchange platforms, and social media. Amongst these, online environments (especially social media) have been seen as partic-

ularly expedient and enabling not only when it comes to information-seeking but also as concerns the generation of knowledge, fundraising for research, and advocacy for changes in health practices and policies (Petersen 2020).

Still, what cannot be neglected is the exploitative potential of said environments: the emergence of the ‘quantified self’ (self-tracking and self-monitoring), ‘datafication’ (transformation of various aspects of everyday lives into analyzable data), ‘dataveillance’ (monitoring of people’s behaviour through digital data), misinformation or commercialization of evidence. The resultant “digital patient experience economy” has been seen as valorising “big data, the discourse of sharing and commercialization of affective labour” (Lupton 2014, 856). Digital environments have also been associated with gross infringements of privacy and civil rights and high potential for discrimination and stigmatization. This notwithstanding, they have been regarded as crucial to the generation and circulation of counter-knowledge, recontextualization and problematization of professional positions, re-evaluation of extant healthcare pathways, and the growth of research-relevant digital repositories of (experiential) data and evidence (Whooley and Barker 2021; Lindén 2021; Callard and Perego 2021).

Patients have made ample use of online environments and digital media. Patient activism (or advocacy) broadly refers to any endeavour (individual or collective) that aims at making visible and legitimating an illness (or condition), addressing the necessity of its proper treatment, or exposing inequalities of health provision infrastructures and improving standards of care. Ranging from grassroots actions to formal participation in policy making processes, patient activism has long been in existence. While the work of the ACT UP collective (HIV/AIDS activism) or breast cancer groups has been well documented and researched, the history of medicine is full of various actions directed against particular modes of treatment or medical establishment; take for instance, late nineteenth-century patients’ self-publication and distribution of leaflets against internment in psychiatric asylums in Germany.

While the ‘Long COVID movement’ displays characteristics of older types of patient activism, it also draws on newer tendencies in digital advocacy. Social media and the internet have changed the way patient movements operate (Petersen et al. 2019; Schermuly et al. 2021). While few in number, studies of patients’ digital activism draw attention to the new opportunities that digital technologies offer (e.g., co-production of knowledge, enactment of chronic diseases;

cf. Gonzalez-Polledo and Tarr 2016). Various proponents of digital media and mobile application technologies (policy makers, technology specialists, and clinicians) see such environments as enabling and empowering to individuals and communities alike, because they provide, for instance, better access to information and, with that, can help patients make more informed choices.

Hence, recent years have seen an intensification of critical discourses about patient engagement and empowerment, and about the so-called “bio-digital citizenship” (cf. Lupton 2018), where the latter is characterized by “the entwining of biologically based identities and digital-based practices” (Petersen et al. 2019, 481). As ‘prosumers’ or ‘producers’ (cf. Bruns 2008), patients have been viewed as empowered by digital health technologies, which allegedly offer them “choice and control” when it comes to self-management and decision making (Lupton 2018, 40). At the same time, various scholars of digital media have signalled the problematic character of such language. For Lupton, for instance, the notion of a “digitally engaged patient” is part of a neoliberal orientation to patient care, which sees individuals as “ideally willing to seek relevant health and medical information actively, engage in their own healthcare and take up behaviours that preserve and maintain good health, in the attempt

to shift the burden of such responsibilities from the state to the individual” (2017, 41). Such discourses “reduce health problems to the micro, individual level” and therefore fail to “identify the broader social, cultural and political dimensions of ill health” (Lupton 2017, 43). They also ignore the downsides of the datafication of human lives. This notwithstanding, the ‘Long Covid Movement’ has made ample use of on-line environments to raise their cause.

Long Covid Activism and Initiatives: Recognition, Research, Rehabilitation

As early as in May 2020, the #LongCovid hashtag appeared on Twitter (Perego and Callard 2021). In Great Britain, LongCovidSOS and LongCovidScotland – now both registered charities – began their work; the former in July 2020. In the USA, Fiona Lowenstein, journalist and founder of the health justice organization Body Politic, formed a support group after experiencing prolonged health problems following her COVID-19 infection. In Austria, the Long Covid Austria initiative gained ground in January 2021 and, in September of the same year, Long Covid Europe (LCE) brought together partner patient organizations from across the continent.

“Recognition, research, and rehabilitation” are the three

goals that have become the focus of these and similar groups (LCE, LongCovidSOS). Apart from the official recognition of the condition, its definition, and incorporation into the CDC (Centers for Disease Control and Prevention) register, 'recognition' also refers to the debates around the condition's naming, its acceptance as a legitimate illness by individual medical practitioners, insurance companies, the general public, and by employers. It also denotes an acknowledgement of the importance of patients' perspectives in decision and policy making. Amongst the many problems pointed out by patient organizations, the currently major one remains their concern with the psychologization of the condition on many levels: be it by individual doctors, across media reports, or in the public opinion.

If, as a goal, recognition has many dimensions, so does research and rehabilitation. Writing in May 2020, Lowenstein explains the rationale behind the collective action of the rapidly growing international group:

[...] it became clear that others were desperate for information to understand their experience. In the absence of comprehensive, up-to-date information from health authorities, the support group has allowed people living with or recovering from the disease to discuss lesser-known symptoms, crowdsource best practices from health authorities around the world,

and arm against medical bias that affects marginalized populations. (Lowenstein 2020)

The lack of information about the condition and about its mid- and long-term effects was one of the reasons behind the creation of many such groups and the communication between them.

In the UK, government and funding bodies have allocated ample resources for Long Covid research. The Department of Health and Social Care reported in July 2021 that another fifteen Long Covid research projects would receive government funding (amounting to almost twenty million pounds) through the National Health Institute for Health and Care Research. Next to focusing on a better understanding of the condition and its long-term effects on individuals and communities, the funded projects aim at evaluating the efficiency of available services, identifying effective treatments, improving self-management and monitoring of patients, and "better integrating specialist, hospital and community services for those suffering with Long Covid" (Government Digital Service 2021). In Austria, to my knowledge, there are only about a dozen small-scale initiatives that deal with the issue, be it our interdisciplinary Post- COVID-19 Care project, or the search for particular biomarkers that could be associated

with Long Covid (Kovarik et al. 2023). In many of such projects, Long Covid patients are mere ‘study objects’ as part of a traditional research design. In the meantime, and on many fronts, Long Covid patients demand that research be made *with* and not only *on* them. Such voices are very much in line with the spirit of citizen science, which involves members of the general public in the execution, and in fewer cases, in the co-creation of research designs.

Just like in the case of research, when it comes to rehabilitation, the major problem initially was lack of knowledge about the condition itself and, as a consequence, the resort to, for instance in Austria, rehabilitation programmes that were intended for other diseases (e.g., cardiovascular or pneumological problems). Whilst the importance of ‘pacing’ is recognized today, rehabilitants’ refusal, mostly due to fatigue, to pursue certain activities led, time and again, to accusation of non-compliance and had impact on future prescriptions (Alexa Stephanou, personal communication, 2nd November 2022). In the UK, the NHS has published a 10-step action plan, supported by ninety million pounds in 2022/23, to improve Long Covid services (NHS England n.d.). “Your Covid Recovery” is one element of the package aiming to “boost” NHS support for patients. It is a rehabilitation programme that is “digital, interactive, and tailored” (ibid.). Its

aim is to complement the services of specialized post-Covid centres, ninety in number, which provide access to diagnosis, treatment, and rehabilitation (ibid.). This NHS plan includes patient-involvement and reliance on their lived experience as it also directly addresses patients and provides guidelines about how to get involved in research (NHS England 2022, 30-31).

While relatively swift, the evolution of these services still took time. This said, a number of bottom-up initiatives for and by patients began to sprout early in the pandemic. In the UK, the “ENO Breathe” programme was called to life by the English National Opera in cooperation with clinicians at Imperial Healthcare NHS Trust. This online programme uses singing techniques to improve wellbeing and quality of life for people with respiratory problems after COVID-19 infection. Up to April 2022, around 1000 people participated in the programme, and a clinical trial of 150 participants found an over 10-point reduction in breathlessness (Imperial College Healthcare NHS Trust 2022). The website of ENO Breathe also amasses participant testimonies (English National Opera n.d.). Currently, they are working directly with many Long Covid Service Centres across UK in which doctors prescribe their singing- and breathing-based programme directly to Long Covid patients (Jennifer Davison, per-

sonal communication, 10th February 2023).

Not everywhere have such co-operations been implementable. In Austria, although a similar pilot project was initiated in 2021 (29th September – 10th November) under the name “Aufatmen”, its expansion has not been possible. In the pilot project, 49 Long Covid sufferers met for six weeks (four online and one onsite group). At the same time, they had access to a website with music videos, teaching instructions, a forum and a weekly programme. Project participants have reported a noticeable improvement of their fitness and their well-being (Edith Wolf Perez, personal communication, 21st February 2023). The pilot project was sponsored by and developed in

cooperation with the Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz, City of Vienna, the Porticus charity, the Theater an der Wien and Wiener Konzerthaus. In order to expand the project, its initiators have contacted Austrian private insurance companies and social insurance agencies. The reactions have been varied but never positive: either the organizations claimed to have their own rehabilitation programmes, or the decision processes have been long-lasting and brought no outcomes. As other endeavours to fund such an extension of the pilot programme have also proved unsuccessful, any large-scale development has been out of the question. This said, the Aufatmen programme has not stopped. As I write, in February 2023, the fifth edition of the programme is



Aufatmen - Ensemble, © Gabriele Schacherl

about to begin with roughly 120 participants who pay for their participation. After the end of the pilot-phase of the Aufatmen project, the group also launched a “Weiteratmen” sing-initiative. Many early participants continue to be part of it (Edith Wolf Perez, personal communication, 21st February 2023; Arts for Health Austria n.d.).

The mobilization of Long Covid patients in the fight for recognition, research, and rehabilitation has been extraordinary. With the press popularizing the discussion, their voices have been heard across media channels. Still, patients continue to call for more attention and involvement. The updated website of Long Covid Scotland bears the slogan “See us. Treat us. Study us.” This demand is both direct and aggressive. Fifty-five thousand patients (members of Long Covid Scotland) want the medical gaze to be actively turned on them and guided by them. The patient-position empowers them to demand attention, cooperation, and further research. Long Covid Scotland has established partnerships with universities, the government, and Social Care Alliance Scotland (Long Covid Scotland n.d.). While, in Austria, patients have contributed to the work of some Long Covid Centres (AKH Post-Covid-Ambulanz), and participated in discussions with insurance companies regarding the future workplace, they have, at the same time, been excluded

from the governmental task force (Alexa Stephanou, personal communication, 2nd November 2022). This said, in Austria and elsewhere, Long Haulers have been enabled, by social media and their advocacy work, to shape the narrative of Long Covid.

Long Covid Illness Narratives and Iconographies

Long Covid narratives have become increasingly visible in online environments. Social media channels have been filled with illness narratives; established platforms, like the *Guardian*, have also reacted to this proliferation of stories by launching the “Living with Long Covid” section; universities have opened digital spaces for patient stories. Whilst Twitter has been regarded as the social media channel that helped made Long Covid, Facebook served as a space for the formation and communication of Long Covid groups, and Instagram and TikTok made visible the particular iconography of the condition. Long Covid charities, support groups as well as influencers and celebrities have used social media to report on their everyday struggle, give advice, and inform about the latest developments but also to vent their frustration.

An early study of Long Covid patient narratives (employing narrative interviews and focus groups as a method) has shown that, in contrast



Long Covid Care Discussion with Prof. Dr. Mariann Gyöngyösi (AKH Post-Covid-Ambulanz), Sarah Wolf, MSc (AIHTA), Edith Wolf Perez (Projekt “Aufatmen”), Alexa Stephanou and Alexandra Marton-Krenek (Long Covid Austria), 16 Jan. 2023, University of Vienna, ©Tamara Radak

to the official biomedical narrative, patients depicted the condition neither as short-lived nor as limited to the respiratory system. Further inconsistencies emerged: in patient narratives, the protean character of the illness was stressed and the dichotomous perception (severe vs. mild) of the initial infection and its effects was called into question. The patients emphasized the “strangeness” and “weirdness” of their state (Rushforth et al. 2021, 4). They described the condition in terms of the disruption of their lives, using before-after constructions to emphasize the stark contrast between what they were able to do before and after being infected.

Recognizing the narrative construction of the patient experience, the study identified common traits of the stories as: a “disrupted chronology”, frustrated trajectory (of recovery), and a common plot twist (bettering of one’s condition followed by a relapse or new, unexpected symptoms). The frustration with such a course found vent in immobility rhetorics, with metaphors of going back and forth and being stuck used to describe the confusion and helplessness of the interlocutors (Rushforth et al. 2021, 5). The stark contrast between the medical and the collective, bottom-up narrativization of the condition as experienced, demonstrated the mutabi-

lity of the illness and challenged its biomedically established pathology (Rushforth et al. 2021, 7). Soon, a number of stories appeared across media channels that highlighted ‘medical gaslighting’ as well as stigmatization and discrimination practices, and a general lack of understanding from the public (cf. Au et al. 2022).

It seems as though, in the meantime, a much broader public has become interested in such stories. Were it not the case, established news venues would hardly decide to publish them. With a particular audience and aim in mind, they have contributed to the visibility and proliferation of Long Covid narratives. These considerations precisely have also impacted the selection and type of narrators. Whilst the patient experience is given centre stage in these accounts, they are in line with the overall political agenda of the platforms. In the early *Guardian* accounts, for instance, a notable predominance of female, white, middle-class heterosexual narrators goes hand-in-hand with an underrepresentation of stories of people with lower socio-economic status, ethnic minorities, migrants and asylum seekers as well as the elderly and disabled (Lange in press). Although the first or third person accounts take pride of place, they are flanked and legitimated by ‘expert’ opinions. Told from an *in-medias-res* position, the narratives are suspended between what Arthur

Frank called the “chaos” and “restitution” narrative types (Lange in press). Almost infallibly, they dramatize the rupture that the infection constituted for the narrators; they offer a dualistic chronology of life before and after COVID-19. By setting off with the moment of COVID-19 infection, they also invariably biologize the condition. This biologization also acts as a legitimating factor. Other such factors include, but are not restricted to, the emphasis on the Long Haulers’ almost superhuman productivity in their pre-COVID-19 lives (hyperbolization), their discipline, their healthy lifestyles, i.e., their willing participation in the neoliberal economy. The minute detail of the course of the illness, attention to the variety of symptoms, their intensity and their temporality emphasize not only the struggle that they have endured but also, through this focus, gives them the moral high ground to talk about it, and, ultimately, legitimate their stories (Lange in press). Rhythmic, sinusoid-like, open-ended with non-linear emplotments, they testify to the difficulties that patients have in finding an adequate vehicle for their experience.

Social media are ‘better-suited’ in this respect in that they help evade, even discourage, the logic of narrative linearity. With their affordances and their inbuilt relational architecture (hashtags, inter-platform connectivity)

as well as with the practices they encourage (frequency of posts, reactions to other posts, re-posting, etc.), they, in fact, emphasize fragmentation, serialization, and open-endedness. Rhythms, recurrences, and revisitations become the grammar of such stories. These ‘flash’, mini-expressions allow a conceptualization of the condition in its complex connectivity and layered temporality. In this way, they appear more adequate for registering the *in-medias-res* position of the narrators, and their anchoring in the here-and-now. Irrespective of the formal differences, many of these attempts at giving expression to the experience of Long Covid show a tendency towards temporal dichotomization of the condition and hyperbolization of the able-bodiedness before COVID-19 as a legitimization strategy along with the propensity to identify with the exigencies of neoliberalism, and notions of ‘good citizen’ and ‘good patient’.

These validation strategies are, time and again, undermined by the visuals that ‘illustrate’ them. Whilst the *Guardian* narratives do their best to legitimate Long Covid, over and over, the accompanying visualizations call them into question by activating long-standing traditions of illness iconographies. What emerges is a pattern of swooning women, with historical links to hysteria, feminization of disease, and, with that, to the possible overreaction to or

performance of illness (Lange in press). While, clearly, there exist other tendencies as well, the frequent retweeting and hyperlinking of such (often stock) images creates a particular representational pattern, which inadvertently links Long Covid accounts to practices of malingering and simulation.

Similarly, Instagram accounts such as ‘@NotRecovered’ or ‘@nicht-gelesen’, perpetuate this association. With its aim to give a face to #LongCovid and related conditions (Wir geben #LongCovid, #ME/CFS und #PostVac ein Gesicht!, Nichtgelesen n.d.), they consist of a series of black-and-white portraits, mostly selfies, with the name, age, place of residence, occupation and information about the onset of illness/the person’s inability to work. Front close-ups of their faces show them either resting on pillows, or placed against barely distinguishable backgrounds, earnestly looking into the camera. The schematic information, uniformity of representation, and the black-and-white – mourning – aesthetic communicate the sheer numbers of the affected, while, at the same time, purposefully or not, reductively defining them through their inability to work – their loss of productivity. By reducing Long Covid sufferers to this one characteristic, such representation positions them within the ‘swooning’ tradition and frames them – inadvertently so – as malingerers who do not

conform to neo-liberalist ideals of productivity.

The Politics of Digital Health Practices

The online existence of Long Covid is symptomatic of the mixed blessing that digital health technologies have been for our understanding and practices of health and illness. Whilst such spaces offer an unprecedented access to information and mobilization possibilities, they also activate various traditions of stigmatization. As they rely on persistent representational scripts, they, often inadvertently, also subscribe to oppressive histories. Long Covid patients justify their hyperbolized narratives and their dichotomic temporalities by their attempt to counteract reactions of incredulity they have met with. Whilst entirely legitimate, these strategies are also fraught with many problems as they adhere to the binary logic of explanation. Still, what else can they do, if they are constantly confronted with disbelief? Here, like in many other contexts, narratives are a matter of life and death – or, at least, of a proper treatment.

We have certainly gained a lot with the advance of digital health technologies. Still, if nuance and detail disappear, we shall remain trapped in ostracizing narrative and representational regimes that are tightly in-

terwoven with digital health practices. Like diseases, illness narratives and iconographies are a matter of politics. This should be enabling to us all. Next time we retweet or like anything, we may consider the impact of such a practice. Or, we may begin to spin a new story or paint a different picture: as clumsy as such scribbles may seem at the start, they may turn into full-fledged, visionary landscapes one day.

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Endnotes

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Sexual Health and the British (High) School Experience in Netflix's *Sex Education*

Aileen Behrendt

When Netflix's Sex Education (2019-2023) was first released, it became an instant critical and commercial success, lauded for its comedic tone and its portrayal of diverse sexualities. Though filmed and set in Britain, many critics have pointed out that the series seems to be heavily influenced by US-American high school dramas. In this column, Aileen Behrendt (University of Potsdam) explores the role of Britain as the series' ambiguous spatial anchor in its message and promotion of sexual health.

Free from the constraints of traditional broadcasting and their courtship of a presumably white and heterosexual mainstream audience, Netflix programming has long been committed to depicting racial and sexual diversity in its shows, ranging from the Wachowski's celebration of queerness in *Sense8* (2015-2018) to a reimagining of an Austen-esque landed gentry in the costume drama *Bridger-*

ton (2020-). With their own self-assessed and incorporated ratings and content warnings (Masterson and Messina 162), Netflix can operate more freely in its depiction of sexuality. Perhaps no show has made this more obvious than Laurie Nunn's comedy-drama series *Sex Education*, which released its final season in September 2023. At the same time, Netflix, more than traditional television networks, caters to a broad, international audience and this awareness plays a crucial role in their regionally based, and yet ambiguously located settings.

Sex Education's spatial ambivalence has been criticised, as it is set in rural Britain and filmed in England and Wales, but still seems modelled after US American high schools. It is certainly not surprising to learn that John Hughes iconic teen comedies of the 1980s, TV shows like *Freaks and Geeks* (1999-2000) and other US

American teen comedies served as inspiration for the show (Dalton qtd. in Horeck 2021). As a viewer versed in these teen canon texts, one might simply shrug off that American football rather than football is played in the background of *Sex Education's* school setting or that the teenagers drink alcohol from iconic red solo cups at the stereotypical teenage house party. However, rather than reading it as lazy television writing at best and cultural imperialism at worst, I propose that these nods towards US American high school narratives haunt *Sex Education* to underline the political urgency of its central message about sexual health. Or, in other words, if Britain is por-

trayed as a sexual health utopia, the US is its implicit dystopian mirror.

Sex Education has been a televisual sexual health revolution since it first aired in 2019 and not only facilitated conversations about sex but also delivered on its promise to educate. The show focuses on the (mis)adventures of Otis Milburn, a teenager who sets up a sex clinic for his fellow students who seek advice on their sexual and relationship problems – for a fee. Otis draws from the advice and learnings of his single mother, Jean, a licensed sex therapist. Otis's clandestine sex clinic is contrasted by his own sexual and emotional immaturity as he only reluctant-



The former campus of the University of South Wales in Caerleon, Newport, serves as the setting of the fictional Moordale Secondary School,

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ly embarks on this venture to impress his crush, fellow student and punk feminist, Maeve Riley. Meanwhile, Otis's relationship to his best friend, Eric E-fiong, also undergoes ups and downs throughout their school days and Eric, a queer, black boy of Nigerian descent, serves as an important story anchor for the shows' negotiation of gender and sexuality. The show largely revolves around these three teenagers and Otis's mother Jean Milburn, but features a vast ensemble cast as it episodically dives into various questions around sexuality. Despite these case studies, the comic tone saves the show from becoming too pedantically didactic, striking a careful balance between education and entertainment. The comedy is centrally based on the bluntness and immaturity of its teenage characters, who all try to negotiate their relationships at the fictional Moordale Secondary School (for the first three seasons), set somewhere in rural Britain.

Next to its spatial ambivalence, the show's vibrant costumes and occasional sepia tones render it temporarily ambivalent as well, despite its easily identifiable foundation in current sexuality discourses. Certainly, the show's sexual health message needs to be understood in its historical moment. At a time when large parts of the Western world have grappled with the resurgence of regressive sexual politics as well as rampant homo-and transphobia, *Sex*

Education in its 1970s aesthetics pays tribute to a time of sexual liberation and counterculture. It offers audiences an escape from real-world politics while countries like the US seem to return to moralising mid-century sexual policies in their severe attack on trans rights, gay rights, and woman's rights, revoking the federal right to legal abortion as the most prominent example of this backwards trend. Tanya Horeck therefore reads the programme's spatial and temporal ambivalence as part and parcel of its larger project to "decenter heteronormativity" and to create a queer utopia.

The broad spectrum of sexual health serves as the programme's overarching theme and its single episodes range from discovering one's own body to STDs. Thus, the text crucially shifts the narrative of sexual health beyond the reproductive frame to more general aspects of sexual pleasure to normalise diverse sexualities (Dudek et al. 504, Horeck 2019, Aruah 51). But this does not come at the cost of talking about reproductive health, framing it as a shared responsibility rather than using unwanted pregnancy stories as cautionary tales, with their inscribed behavioural codes mostly addressed to girls and young women. These scenes concerning reproductive health stand out as an intervention into stigmas perpetuated by previous teen texts.

Fully aware of the current political climate where any reference to abortion sparks public controversy, *Sex Education* sympathetically depicts the abortion of its central character, Maeve, as early as its third episode. The series has little patience for pro-life campaigners, which are satirically portrayed as neurotic adversaries. In an almost clichéd scene, Maeve, with her punk-rock, feminist style, coolly confronts the campaigners outside the sexual health clinic, who try to shame her and discourage her from obtaining an abortion. This confrontation recalls a pivotal moment of the widely received teen pregnancy comedy-drama *Juno* (2007), in which the protagonist's decision to abort is dissuaded by campaigners who tell the eponymous Juno that her 'baby' already has fingernails. The teenager cannot rid herself of that image which humanises the foetus and decides to carry her pregnancy to term and give the baby up for adoption afterwards. In *Sex Education*, however, the two campaigners stand in contrast to the support of fellow patients, the professionalism of the health clinic medical staff, and Otis's non-judgmental support as emergency contact, who picks her up after the procedure. Accordingly, the campaigners are relegated to a satirical sub-plot, presented as comically misguided as Otis is in his mistaken assumption that Maeve asked him out on a date.

Despite its mainstream romcom frame of Otis's and Maeve's will-they-won't-they relationship that is in line with the show's overall comic tone, Maeve's experience at the clinic and throughout the procedure is told with tonal sensitivity and a marked absence of affective music; and it is flanked by crucial moments of female solidarity. One of the most striking scenes of solidarity and support plays out between Maeve and an older patient, who has had abortions before and who establishes an honest conversation with her. Maeve, previously shown as only reluctantly engaging with this patient, reciprocates and timidly offers up her chocolate pudding when the other patient, who has only received vanilla pudding, is snubbed at by an exasperated nurse, who snaps that she might get one next time, shaming her for her repeated visit to the clinic. The patient is visibly shaken by this encounter and grateful for Maeve's offer, which symbolically acknowledges their shared emotional vulnerability after the procedure. Importantly, the abortion story features medical advice, for instance when Maeve is informed about the expected effects of abortion, such as nausea and strong bleeding and is provided with heavy pads by the clinic staff, which she accepts with some age-appropriate embarrassment as this exchange is witnessed by Otis, whom she instructs not to comment.

Though only ambivalently located in the UK, British laws and policies around reproductive health are important for the realistic portrayal and the series' basis on factual sexual advice. They allow the programme to focus on this medically rather than morally, speaking back to an array of earlier, more sensationalist texts of teenage pregnancy. Due to the US American filmic influences, the political climate is evoked in its absence, which emphasises its British setting, where Maeve, a poor and abandoned teenager living on her own in a caravan park (a residential park home), can obtain an abortion without parental consent or money as the NHS covers most abortion cases. She can also access a clinic in a rural area easily. This normalisation of health clinics and the services they provide, at a time when they have become a contested cultural battleground in the US and other Western countries, resonates strongly with feminist sexual health advocacies and epitomises the British-American cultural tension that inform the programme's sexual health message.

In another story of shared sexual responsibility and reproductive health, the series' unlikely couple, Ruby and Otis, require emergency contraception after a drunken sexual encounter. Rather aptly, they both get drunk at a clichéd teenage house party, which prominently featured the iconic red solo cups that clearly mark

alcoholic debauchery, ill-advised behaviour and teenage drama as a narrative staple of every US American teen text. To prevent an unwanted pregnancy, Ruby instructs Otis to purchase the morning after pill for her, for fear of being stigmatised as promiscuous. Due to medical policy, however, Ruby needs to get it herself and defensively (and comically) answers the pharmacist's questions, before finally receiving it for a low price she has Otis pay, dismissively shrugging that it was his penis after all. The pharmacist remains professional and patient throughout this encounter with flippant and awkward teenagers, ensuring that this scene never dips into any moralising tales in favour of showing sexual responsibility of both parties. Ruby's and Otis's quest for the morning after pill is filled with comic teenage antics that emphasise their age and, paradoxically, their innocence, which is also staged when they toast with their cans of soft drink while Ruby takes the morning after pill, after having carefully read the medical leaflet. The easy accessibility and the carefully established absence of judgement and moralising frames evokes and responds to restrictive US politics and narratives and once more establishes Britain as a (presumed) sexual health haven, where teenagers are working towards a fairer and better understanding of sexual practices.

The high school set design and the school's social dynamics anchor this show firmly within the context of US American teen texts, with its prominence of locker rows in the school hallways as a key space for social negotiations and its (initial) absence of school uniforms. Yet, the regular school assembly re-attaches these stories to Britain. The assembly becomes a crucial site for the negotiation of sexual health between the students, the faculty, and the parents. For instance, Jean Milburn is installed as a sex therapist on the school grounds to rework the Sex Ed class syllabus following a parent-teacher meeting in the assembly hall. Moreover, the assembly also becomes a contested public forum, in which the students disrupt narratives of

individualised, normative codes of gender appropriate behaviour in collective actions of solidarity.

One example of this is the show's de-stigmatisation of and education about female genitalia. Aside from singular reproductive health topics, the series is largely focused on stories of sexual pleasure and social stigmata that stand in the way of it. Targeted at younger audiences, one of its key messages is therefore to feel comfortable in and with one's own body and the show explicitly works towards undoing repressive, moralist norms and myths around bodies and sexuality. There are several instances of this established via the character of Maeve's friend Aimee. While Aimee is introduced in the show's very



The school hallway set of *Sex Education*, with kind permission © Thomas Duke

first scene, having sex with her then-boyfriend Adam, her journey explicitly revolves around her exploration of her own body. This involves her realisation that she has previously only engaged in performative pleasure catering to her male partners and discovering masturbation to learn about her own physical needs, which she has trouble acknowledging and articulating.

Her struggles to embrace her own body as hers also plays a role in her initial dismissal of being sexually assaulted on the bus when a passenger masturbates behind her and ejaculates on her jeans. Encouraged by Maeve to report this, the show then subtly establishes how Aimee is impacted by this encounter over the course of several episodes. She changes her wardrobe to bland turtlenecks, is distracted and withdrawn and crucially, walks the long distance to school, unable to take the bus anymore. She reaches her breaking point during a detention she serves with her fellow female classmates, who are all falsely suspected of having slut-shamed their teacher. According to Horeck, their detention in the library is a nod to John Hughes's classic US-American coming-of-age film *The Breakfast Club* (1985), in which students eventually bond over their similarities. Prompted by Aimee's confession that she struggles with the psychological fallout of the assault, the girls all share their own stories of sexual harass-

ment and assault and the impacts it has had on their lives. In the episode's final scene, they surprise Aimee by meeting her at the bus stop and together they board the bus and protectively flank her, squeezing into the last row together in solidarity. The scene is stepped in warm and bright colours with upbeat music before the end credits roll. Thus encouraged, Aimee then seeks professional help in subsequent episodes, talking about her assault in therapy with Otis's mother, which helps her reclaim her body and sense of self. This, in turn, leads her to comically embrace facts of female genitalia and start a bake sale with cupcakes that depict the different shapes of vulvas.

An earlier episode has featured *Vavas* in its portrayal that everyone has fears of sexual or bodily inadequacy, no matter how confident they seem. With this, *Sex Education* taps into the well-established story trope of a high school social hierarchy based on obscure social and beauty privileges to explore the insecurities of the most popular group. Keeping the case study in line with these social dynamics, however, this group is involved in a case of bullying and harassment as the photo of a vagina is anonymously posted online with a countdown threat to reveal the owner's identity. Realising that it is her vagina, popular bully Ruby, ashamed of her vulva's shape and panicked over the looming threat of having her identity

revealed, enlists Otis's and Maeve's help to find out who has posted it online. Deciding that helping her is the ethical thing to do despite their dislike for the antagonistic Ruby, they eventually discover that Ruby's close friend Olivia has posted the image to humiliate and humble Ruby. At school assembly, Olivia tries to redeem herself when the students are lectured about online harassment and start speculating, correctly, whose vagina it is. Olivia then stands up and claims that it is hers. In an act of support and solidarity, disrupting the headmaster's lecture, who is rapidly losing control of the situation, several other students chorus that it is their vagina until Ruby finally stands up too, smiling and proudly proclaiming that it is hers. What resonates here is not only the solidarity but also the show's central message to stop being ashamed of your body and own your narrative, as Debra Dudek et. all, have shown in their exploration of *Sex Education's* treatment of pornography. The careful constructions of complex characters and situations are a building block of the show's affective labour. This has audiences root for the characters as they solve their respective problems so that Ruby's proclamation coupled with the close-up of her smiling face, the scene's upbeat, roaring music and the immediate end of the episode, rolling credits on a black screen evoke a curtain falling at the end of the play and invite the audience to applaud not only the

performance, but more importantly the sexual health message.

Another key scene that concludes the third season of *Sex Education* and features an actual play revolves around the seasonal arc of implementing regressive school policies and using the assembly to pillory students for non-normative gender or sexual behaviour. The school's ambivalent location has until season three mostly presented a microcosm, largely removed from space and time. However, fear of an outbreak of STDs among students in the second season brings sex therapist Jean Milburn to the school's premises, who campaigns for a better sex education and thus aligns the school space to the outside world. When Jean publicly talks about her experiences and consultations with students, she puts the school on the map. The consequence of their subsequent fame as the 'sex school' prompts an attempt from the outside world to regulate and repress, installing a neoliberal, post-feminist headteacher, Hope Haddon, who at first subtly and then overtly dismantles any moves towards racial and sexual diversity. This marks the school as an outlier even within a presumably British liberal environment. The introduction of abstinence-only classes in this setting evokes the US once more as a nightmarish spectre that haunts the text. The cultural clash seems pronounced, especially considering that

these programmes are firmly rooted in US American Christian doctrines, which propagate abstinence beyond its national borders and have already prompted an unease in Britain of how to deal with this in their sexual health education programmes almost 20 years ago (Liz Ford, *The Guardian*, 2004).

The new mandate to wear school uniforms, tethering it firmly to conservative British school norms, takes away the spatial ambivalence, demonstrating that Britain has so far only been lauded as a sexually liberal place when compared to the yet more conservative US. The school uniforms add to the show's negotiation of representation politics, especially with the introduction of a new non-binary student who rebels against the school uniform policy based on binary gender norms. But it is not only the spatial ambivalence that is shattered; the school also seems to be lifted out of its time capsule. The introduction of school uniforms serves as an aesthetic shock to the show, which so far heavily leaned on colour, especially via the students' bright and colourful costumes and soft yellow-brown lighting to frame them. The students' clothing stood out for its temporal ambivalence as it vaguely recalls a modernised version of 1970s fashion, undoubtedly to make the show appear as timeless and spaceless as possible but with a nod to 1970s counterculture. But in this

season, space interferes, and the grey school uniforms drain the show of its colour. The aesthetic shock supports the plot when school policy now dictates uniformity and submission to normative behaviour and aesthetics coded as white, male, and middle-class. The newly installed headteacher also employs public shaming, making students walk around with signs around their necks spelling out their presumed perversions as she herself perverts the public forum and uses the assembly hall as a stage for viciously regressive shaming tactics. The students break out of this forced uniformity in an act of rebellion that has the final episode of that series explode in colour and celebrate sex-positivity and sexual and gender diversity, sexual enlightenment, responsibility, and health when they stage an overtly sexual musical in the main hall of the school assembly.

Especially season three shows how regressive sex politics need to be defied. Abstinence messages show a step further back than where the school started from, which was an inadequate sex ed class that was at least factual, but that did little to dispel students' ignorance while the plot worked out a clear demand for information that focuses on various sexual practices, shared responsibility and consent, and a de-stigmatisation of pleasure in sex education. The programme has used Britain as its ambiguous location for

its key messages of sexual health, made more pertinent and politically urgent by the filmic traces of US American texts which tie this show to a particular social discourse, in which sexuality has become a controversial cultural battleground. The series' aesthetics rooted in rural Britain and tethered to a modernised 1970s fashion and colour frame are therefore not nostalgic or revisionist, unlike its commercially successful Netflix siblings like *Stranger Things* or *Bridgerton*, but carefully negotiate an ambivalent space and time where sexual health can be explored in full and embraced as a vital part of general discourses on health.

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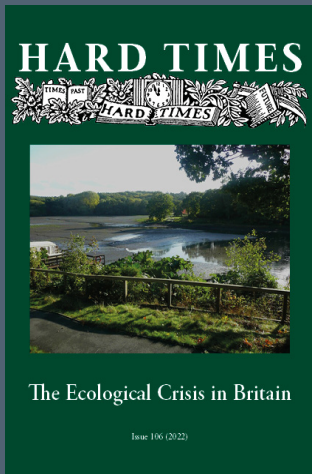
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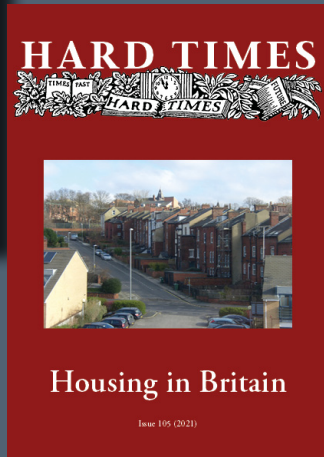


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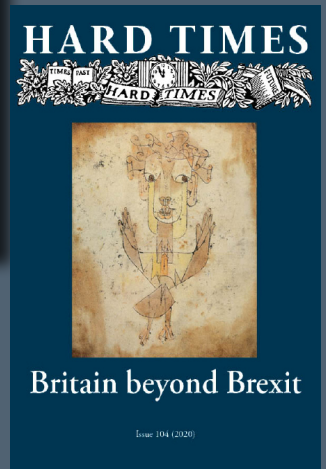
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