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Reimagining care discourses through a feminist ethics of care: analysing Ireland's Citizens' Assembly on Gender Equality

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Abstract

The COVID-19 pandemic brought to the fore stark gendered care inequalities and the inadequacy of care provision across states. This article presents a feminist-ethics-of-care-informed discourse analysis of the representation of care that emerged at the Irish Citizens' Assembly on Gender Equality – an innovative government-created citizen deliberation process. It identifies how care was represented as a 'problem' of both gender inequality and the market, and uncovers key silences, which ignored care as a universal need of all citizens and the significance of care networks to sustaining caring. We propose the necessity of ethics-of-care-based understandings to address post-pandemic care challenges.

Key words care policy; citizen deliberation; feminist ethics of care; problematisation

Introduction

The COVID-19 pandemic has exposed entrenched care inequities, ailing care systems and a compelling need to elevate the political status of care (Chatzidakis et al, 2020a; 2020b; Daly, 2021; Lynch, 2022). During 2020–21, gender inequality was the subject of a government-established Citizens' Assembly (CA) in Ireland. The CA addressed a range of issues, including care and violence against women, and its final recommendations were widely praised. Ireland's Minister for Equality commended the CA's 'rich and nuanced portrait of the state of gender equality in Ireland' and 'high level of ambition for change' (Government of Ireland, 2021a), while an *Irish Times* (2021) editorial termed the CA's recommendations 'an exciting, progressive manifesto for change in a critical policy area'.

Recognising the significance of the CA's deliberations on future care policy and provision in Ireland, this article examines the representation of care that emerged at the CA, drawing on

insights from the feminist ethics of care (FEC). Care ethics challenges key precepts of contemporary care understandings, particularly that care is a private matter (Tronto, 1993; Held, 2006; 2007; Kittay, 2020), of concern only for a discrete group of 'dependants'. As a political theory that understands human interdependence and relationality as fundamental (Held, 2007; Kittay, 2020; Daly, 2021), the FEC demonstrates the value of care work in sustaining the public sphere (Lynch and Lyons, 2009; Lynch, 2022) and confronts entrenched inequalities, particularly of gender, race and dis/ability, in current care provision and systems (Tronto, 2013; Robinson, 2020; Lynch, 2022).

In this article, we draw on a discourse analysis of documents from the CA to explore how care itself was represented and understood at a key deliberative forum in Ireland. Our analytical framework seeks to integrate Carol Bacchi's (2009) notion of problematisation with an FEC lens to interrogate and potentially expand how societies represent and act on care. We believe that problematising care representations is necessary because a more effective challenge to the current neoliberal care limits requires 'new knowledges and understandings of how to care and how to think with care' (Lynch, 2022: 212). We identify three intersecting care outlooks in the FEC – care as value, care as relation and care as practice – which frame the lens used here to analyse the CA's representation of care. Care as value attends to the values displayed in undertaking, receiving and thinking about care (Held, 2006). The relationality of care recognises human interdependence within care relations, the fluidity of carer/ care receiver positions and connections between those relations 'closest in' to wider socio-political contexts (Barnes, 2012; Tronto, 2013). Approaching care as practice illustrates the labour involved in caring and the differences of care in intimate, institutional and commodified contexts. Exposing the work of care illuminates that carers, just like those they care for, have needs (Kittay, 2020) but that current uncaring systems, arising from gender, cultural, racial and colonial histories (Keller and Kittay, 2017), restrict the fulfilment that could be achieved in care work.

We begin the article by outlining the context for Ireland's deliberation of care and then turn to describe how discourse analysis of the CA was undertaken using a problematising methodology combined with an FEC perspective. Drawing on our analysis, we then move on to discuss how care was represented in two overarching ways at the CA – as a 'problem', first,

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of gender inequality and, second, of the market – and identify silences in the CA's representation of care. We conclude by examining how the CA's representation of care could have been challenged, or indeed extended, through a more overt application of the FEC.

The need to rethink care in Ireland

The need to expand care thinking is salient in Ireland, where a gender-conservative, low-tax welfare regime (Dukelow and Considine, 2017; Cullen, 2019; Cullen and Murphy, 2021) is manifest in care policy and practice. From the state's founding document, *Bunreacht na hÉireann* (Ireland's 1937 Constitution), care was codified via Article 41.2, colloquially known as the 'woman in the home' clause, as a private function of the patriarchal family – and of women specifically (Government of Ireland, 1937). Care services developed in a residual manner, reflecting care as a form of charity bestowed by the state, rather than citizen entitlement (Fischer, 2011; Van Aswegen et al, 2019). Caring expectations on women, as well as providing expectations on men, have remained remarkably fixed (Government of Ireland, 2021b). Ireland, following an 'unsupported breadwinner model' (Ciccia and Bleijenbergh, 2014: 70), has required increased labour participation by women without equivalent public childcare provision. Marketisation is an increasing feature across all care sectors as a result of recent austerity cuts, competitive tendering and a significant growth in large institutional investors entering Ireland's care 'market' (on home care, see Cullen, 2019). Low wages and job precarity for formal carers have limited the attractiveness of paid care work, provided by an increasingly migrant workforce (Cullen, 2019). Informal caring is supported via means-tested income supports, rather than the provision of universal care services (Hanly and Sheerin, 2017).

Ireland's policy trajectory has explicit gender effects. While there is increasing policy discourse on men as carers (Hanlon, 2012; Cullen, 2019), national research (Russell et al, 2019) demonstrates that, on average, women spend double the time of men caring. In Ireland, as elsewhere, the COVID-19 outbreak exposed the profundity of care needs across society, as well as the limitations of austerity-scarred care services. Ireland's 'long history of leaving care work to women' (Dukelow and Considine, 2017: 328) was desperately apparent in the total lack of childcare, even for front-line health staff, during the first COVID-19

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lockdown (Hick and Murphy, 2021). During some of the longest lockdowns in the world (Cullen and Murphy, 2021), Ireland largely reverted to gender-blind policymaking. Male voices and sectors dominated political and media pandemic debate, while care and the concerns of the feminised front-line labour force in Ireland were given rhetorical praise in lieu of tangible support (Cullen and Murphy, 2021).

Ireland has increasingly used deliberative assemblies to reach policy consensus. In 2019, the government established a new CA of 100 citizens to make recommendations to 'advance gender equality'. On care specifically, the resolution tasked the CA to 'examine the social responsibility of care and women and men's co-responsibility for care, especially within the family', and 'recognise the importance of early years parental care and seek to facilitate greater work–life balance' (Seanad Éireann, 2019). The CA therefore provides an ideal discursive space through which to interrogate contemporary care understandings at a critical juncture in Ireland's policy development.

Methodology: combining problematisation with the feminist ethics of care

To problematise the CA's representation of care, we combined Carol Bacchi's (2009) *What's the Problem Represented to Be?* (WPR) discourse analysis with an FEC lens. Drawing on Foucauldian post-structural analysis, WPR examines problematisations as a way of establishing new modes of governance. Foucault (1977) referred to own his analysis of such concepts as madness and sexuality as 'thinking problematically'. He sought to examine how particular statements – such as those about care – become dominant. WPR rests on the premise that the ways in which issues are problematised is central to governing processes and therefore 'what we say we want to do about something indicates what we think needs to change and hence how we constitute the "problem"' (Bacchi, 2012: 4).

WPR takes a problem-questioning perspective through the holistic and flexible application of six questions:

1. What's the 'problem' … represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the 'problem'?

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3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5. What effects are produced by this representation of the problem?
6. How/where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced? (Bacchi, 2009: xii).

As designed by Bacchi (2009: 128), WPR is an adaptable methodology, 'with specific questions applied where the analysis occasions their use'. While applying all the WPR questions in our analysis, to draw out the CA's representation of care *and* to reimagine care through the FEC, we placed particular emphasis on three of the questions: 'What is the "problem" of care represented to be?'; 'What is left unproblematic?'; and 'How could it be questioned and replaced using the FEC?'.

To embed our theoretical perspective in the discourse analysis, we combined our WPR methodology with our FEC lens, which identified care as value, relation and practice. Examining care as value, we considered the CA's attention to the values displayed in caring and how the CA's recommendations would support a care-centred society. Approaching care as relational, we scrutinised how the CA attended to the interdependence and nested reciprocal relations and obligations surrounding care (Kittay, 2020). Recognising care as practice, we appraised how the CA dealt with the division of labour involved in caring and the differences in caring practices and conditions across sites of care. As such, our FEC lens kept us alert to the need to: release care from containment in the private sphere so as to be a political concern (Tronto, 1993; 2013); question the privilege of those who avoid care (Tronto, 1993; Lynch and Walsh, 2009); challenge the lack of justice in political and economic systems that denigrate care (Williams, 2018; Lynch, 2022); and develop space for an FEC representation of care, which we anticipate is, in Foucauldian terms, a subjugated knowledge (see Bacchi, 2009).

Initially, the authors became immersed in the vast volume of text and video material available across the CA's modules. Reviewing the modules, it was clear that the CA's delineated topics intersected. For example, the work and social protection module addressed gendered issues

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in low pay (of which care work emerged as an exemplar) and welfare entitlements, including the impact of care responsibilities on these. However, given that the focus of the current study was on how *care itself* was represented at the CA, a decision was made to focus analysis solely on the care module, which 'covered the treatment of care and caring in the economy and society, childcare, the experience of carers and those requiring care and Ireland's system of care for children, persons with disabilities and older people' (Citizens' Assembly, 2021: 112).

Contributions to the care module consisted of experts (three academics and inputs from a research institute), five advocates from non-governmental organisations (NGOs) and three individuals who might be described as 'experts of experience', as well as material related to care from almost 250 public submissions summarised by one of the experts. The final sample was the publicly available material on the CA's website (Citizens' Assembly, no date) from the care module (main meeting, 16 January 2021; care ballot development, 13 March 2021; care ballot vote, 17 April), comprising 31 documents (including contributors' presentations and papers, session transcripts, draft ballot papers and the care-related sections of the CA's final outputs, members' open letter to parliament, and the CA's final report and press release) and 14 videos (of the module's sessions and an externally produced International Labour Organization [ILO] video). Excerpts from the sample are quoted in italics in the following text and are denoted as provided by Citizens (CA members), Chair, Experts, Advocates and Individuals, or as excerpts from submissions, the final report or accompanying citizens' open letter.

The first author read and watched all the documents and videos a number of times to become immersed in the module material. Following this, text directly related to the problematisation of care was extracted from across the sample and organised by the relevant WPR question. An analysis guide was developed outlining the WPR questions and the elements of the FEC lens that might emerge or, alternatively, be absent in relation to each. Following the authors' joint refinement of the analysis guide, the first author undertook open coding and documented emerging themes as she moved between the data, the WPR methodology and the FEC lens. Both authors individually reviewed this analysis before coming together to discuss interpretations and agree key themes (outlined in the following).

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Findings: the CA's representation of care

In this section, we present the findings from our analysis. The first section focuses on the way in which care was problematised, that is, as an issue, first, of gender inequality and, second, of the market. We then go on to consider what was unsaid in the module and who and what were silenced. The third part of our analysis considers what reimagining the CA with an FEC lens might look like.

The CA's problematisation of care

Care as a 'problem' of gender inequality

Our analysis suggests that a key way in which care was understood was as a 'problem' of gender inequality. Opening the CA's care discussion, the Chair outlined the conundrum to be considered:

> *why is it that so much of the caring in our society is done by women inside and outside the home? Is it really acceptable that we put a low economic value on the contribution of those who work in the care sector? Is it acceptable that unpaid care receives very limited support? Why do paid carers earn so little while they do these demanding and responsible jobs? And why do so few men go into these areas of work?*

In the analysis of care submissions made to the CA, the gender inequality at the centre of care was parsed as: '*Women over-represented in care: reinforces gender stereotypes; women excluded* [from] *public life & leadership; poverty & disadvantage for women*'; and '*Men disincentivised to provide care: men miss rewards of care; few male role models; limited paternity leave*' (Expert 3). State, census and economic statistics were relied upon, showing that women make up 98 per cent of full-time carers, 95 per cent of adult dependants in the social protection system (Expert 1) and 98 per cent of childcare workers (Advocate 5). The advocate representing a women's NGO focused on the impact of care inequalities on women, calling out the '*Longstanding, societal and cultural expectations and deeply engrained*

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patriarchal norms [that] *continue to tell us that care is "women's work"*' (Advocate 2). Yet, despite women's documented responsibility for the majority of paid and unpaid care, the '*issue of men's welfare and experiences of inequality*' (final report) became significant in the representation of the 'problem' of gender inequality discussed at the care module. (The impact of women's disproportionate caring activity on gendered labour market participation, pay and social protection entitlements was discussed during the work and social protection module.)

Caring was identified at the care meetings as central to women's dependency, as the '*burden of caring often falls on the shoulders of women*' and '*they* [women] *should not be punished for that by being economically dependent on others*' (Individual 1). Women were depicted as '*disproportionately pushed out of the workforce by caring responsibilities*' (Advocate 4). Such attention to the individual economic costs of caring both overshadowed the potential fulfilment of caring and avoided discussion of the democratic costs women incur, whereby their caring activity reduces their opportunity to politically advocate for care-centred societies (see Cantillon and Lynch, 2017; Lynch et al, 2021). Care was presented at the meetings as a pathway to get women into employment, both by creating '*care jobs*' and by providing care services that '*smooth the way for many more women to join the workforce in all fields*' (ILO video). Solutions were suggested '*to support women to access the labour market and participate on the same basis as men*' (Advocate 3). Equality in the workplace, rather than women's overall social participation or children's education, was identified as the key driver of Ireland's laggard attempts at childcare provision (Expert 2). One significant attempt to address structural inequity during the care meetings was made by Expert 1, who argued: '*the care economy is central to every discussion on gender equality in Ireland and that in order to discuss the gender equality aspect of care we need to think about how care could be made more visible and tackle the disadvantage that is associated with taking on care responsibilities*'.

Men's needs were consistently made visible in the CA's representation of gender inequality, as in the citizens' open letter: '*While there are still many inequalities in women's lives that need to be eliminated, we also recognise that gender inequalities are intensified by discrimination on other grounds. Men also suffer from inequality, lack of opportunity and*

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discrimination' (Citizens). In her reflections in the final report, the Chair noted that addressing gender equality will benefit men through such mechanisms as better parental leave and more balanced representation of women in public life, resulting in '*more balanced and inclusive policy and decision making*'. Deftly silenced was the privilege and position that men in market-focused Ireland would cede for this equal future.

The CA's discussions recognised the need to expand caring identities to men and those outside the gender binary: '*caring is often seen in Ireland as a very gendered issue, most care is provided by women and so women are over affected by problems around caring in Ireland, although obviously men and people not in the gender binary also do have issues around caring that should be addressed*' (Advocate 4). Such recognition of broader care relations is to be welcomed; nevertheless, there is also a danger that this may render invisible women's current care burden. Further, such progressive attempts to acknowledge the full spectrum of caring identities coexisted with some harking back to past configurations of care: '*When did we change from kind of being brought up by our aunt or our grandparents, or minded I should say, not brought up*' (Citizen).

Instead of addressing the systemic basis of gendered care inequalities, including the constitutional codifying of a Catholic-infused, patriarchal and minimalist state (Hughes and O'Sullivan, 2017), attention within the care module quickly attached to the possibility for salaries, facilities and career ladders to encourage care gender parity. Among the individualised solutions the citizens debated were: '*showing role models of both genders in various jobs with the focus on care type jobs*'; a school programme '*focusing specifically on normalizing the provision of care*'; and '*gender quotas to enable shared care*' in teaching, nursing and childcare (Citizens). Notably, quotas are generally suggested where there are power barriers, rather than in sectors (such as care) in which gender segregation reflects the societal devaluing of 'feminine' activity.

The goal of shared caring – '*women and men being co-responsible for care*' (Individual 3) – was strongly endorsed. Men were to be 'encouraged' to take up the family leave and employment rights once imagined as the panacea to women's full labour participation. While there was some, relatively muted, discussion of the '*responsibilities of men with regard to*

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care' (Advocate 2), much more was made of the need to support men into care. Men were also held to be experiencing stigma when '*deviating from that traditional breadwinner role*' (Advocate 1). That it is predominantly a woman's lot to provide so much care in a world that undervalues caring was left opaque, albeit that, at one point, Expert 1 advanced: '*men in general may benefit from the unequal division of labour but rigid gender roles result in men's separation or disengagement from care and caring*'. Evidence shows that while there have been some generational shifts in men's engagement in caring (Hanlon, 2012), men's involvement is still often regarded as 'helping out' (Hoang and Yeoh, 2011). Men's non-specified desire to care stood unsubstantiated in the meetings against the stark gendered care statistics; neither was there recognition that some men, despite future supports, may not engage in care. A jaundiced view of men's interest in care was funnelled through a labour-market calculus because '*men are attracted to things that have higher salaries or higher rates of pay*' (Citizens) and failed to contend with the need for men to take on *unpaid* care.

The care market 'problem'

The second overarching way in which care was represented at the care module was as a market 'problem'. Care was broadly constructed as *services* within a care market. This representation reflected both the make-up of current provision – '*our care model is almost exclusively a private sector one. Of course, the state has policies on care but it generally leaves the delivery of the care services to the market*' (Chair) – and the way in which care thinking in Ireland, and consequently at the CA, appeared to revolve around the market. At the CA, the need for care to pay was in evidence, and even public services must '*compete positively with the private*' (Citizens). Market thinking reached apotheosis in the input of Advocate 5, representing childcare providers, warning that '*Even with the current level of state subsidies, providers face low and unpredictable profit margins*' (Advocate 5). Not-for-profit charitable disability providers were also constructed as having to maintain their market position: '*the main pressure is to remain competitive as an employer of staff*' (Advocate 4). Here, pay was an outcome of market competition, rather than a reflection of the value of care activity.

The interweaving of the family and care provision was consistently examined at the care meetings through the lens of remunerated and unremunerated work. Family (or

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uncommodified) care, that is, '*Caring for children inside and outside the home … by a parent, grandparent or neighbour; Eldercare provided by family or community-based services drawing on volunteers*', was redrawn as '*unpaid work*' (Expert 1, underline emphasis added). Care work was characterised as '*unpaid or low paid*', carrying '*little recognition or value*' and '*mostly carried out by women*' (Expert 1). The CA's solutions to the challenges carers face, including '*little recognition, support, or allowances*', were summarised in the call to '*recognise care as vital social employment and pay carers for the value of the work done on behalf of the state*' (submission excerpts), thereby drawing care into the market to be monetarily (and socially) valued. While improving supports for carers is essential, the CA's focus on paid care work and on monetarily valuing unpaid care work often made care into a remuneration problem to be solved. The undervaluing of paid care was taken up by the Citizens, who '*feel as though carers in Ireland are undervalued. We feel there needs to be a higher pay recognition*' (Citizens). However, value, it seemed, could only be expressed in terms of recognition in the market: the '*State needs to put a cost on caring and support it appropriately*' (submission excerpt), and '*we need to make caring more attractive as a career and this would involve paying people in the sector more*' (Citizens), in order to '*place the job in higher regard*' (Citizens). This ledger-book approach to value suggests that good care will be provided by those buffered by qualifications and status, placing carers as a group apart.

The familialisation and commodification of care within neoliberalism has led care ethicists to 'focus not only on what care workers do, but also on the circumstances in which they do it' (Barnes, 2012: 62), including the social and economic forces impacting care arrangements. The care meetings grappled with the functioning of a care system dominated by private providers and state subsidies. A defective care market was described, in which public services have '*little or no accountability about how State resources are spent*' (Citizens), while private childcare providers '*know that they have parents cornered*' and '*are making huge profits on staff being paid the minimum wage!*' (Citizens). Dysfunctions have led to '*increasingly prohibitive*' costs and attendant '*new structural inequalities*' (Expert 1).

At the care meetings, the pandemic was seen to have exposed the '*fragile nature*' (Expert 2) of care in Ireland. Further, COVID-19 was presented as changing the status of care within the CA itself:

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> *The outbreak of Covid-19 … shone a strong spotlight on care, its importance in our society and the gendered nature of its provision. The topic of care therefore permeated all the work of the Assembly and was seen as relevant to all the other items set out in the resolution.* (Final report)

Citizens outlined their view '*that there is a crisis in care and that COVID has highlighted that we really need to seize the moment now and to encourage a shift in attitudes around cultures around care and how we value care as a society*' (Citizens). Emergency measures requiring the '*curtailment of care and educational services, sudden withdrawal of full spectrum of care supports, increase in unpaid work in the home*' were represented as providing the possibility for '*rethinking and revaluing care??*' (Expert 1). The double question marks are noteworthy here for the way in which they appear to reflect ongoing uncertainty about the future position of care. This caution was compounded by acknowledgement that despite high levels of government emergency funding for childcare providers, in some cases, parents' fees were increased during lockdowns (Expert 1), pointing to the continued individualised responsibility for care.

As discussions progressed, resistance to myopic market provision appeared to develop. Citizens outlined preferences for '*more public investment but also more public intervention in the management of care and the state should have the ultimate responsibility around caring*'; '*it really should be about quality of care rather than profits*' (Citizens). There were also some attempts to challenge market thinking, through a focus on benefits for workers (rather than care receivers): '*Value for money does not mean the cheapest solution. For example, while public nursing homes "cost more" than private ones, they offer better pay and conditions to workers*' (Advocate 2). Making a case for care that is good, Expert 1 suggested a system of care supports that could achieve the '*dignity and autonomy of care recipients, recognition of the needs of carers and their families, independent adaptive and supportive housing and the continued important role in the community, voluntary and NGO sector and the importance also of one-to-one assistance services and long-term needs*'.

An absence of care was identified in the government's nursing home '*unfair deal*' (Individual 2) (a wordplay on the government's Fair Deal scheme available to support some of the costs of nursing-home care), which precludes state support for home-care services. Moreover,

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good care could not but be absent in the current average 42 minutes of personal assistance, which does not reflect '*disability is a 24-hour affair*' (Individual 3). In its final accounting, the CA recommended that public services and social protection '*should be funded firstly through greater efficiency and accountability for public funding and reprioritisation between current spending and revenue raising. If necessary, we are also prepared to support and pay higher taxes based on the principle of ability to pay*' (final report). Yet, despite astute recognition of market and model failures in current provision, the care module broadly sought new managerial solutions, to be achieved via increased state investment and regulation in tandem with private providers.

Care silences at the CA

The CA echoed with key silences, made apparent through our application of our FEC lens. There was a lack of engagement with the: values that underpin caring; the relationality and interdependence that make all people recipients and givers of care; and the care networks necessary to sustain paid and unpaid care work. The CA's relatively fixed understanding of care receivers limited their attention to other groups requiring care, including the care needs of migrants, who were considered only for their potential as care workers. Such silences were exacerbated by a limited conception of intersectionality that made racial inequities opaque. Further, the CA's emphasis on the position and career trajectory of care workers limited the discursive space, preventing an examination of the more fundamental changes required at political and societal levels to create a care-centred society.

The overwhelming focus at the care meetings was on care as generic *care services*, without regard for individual care needs or the interrelationality of care relations. At the most basic level, the concept of 'care' under deliberation was ill-defined, with different contributors speaking to discrete care activities and individual sectors. The CA's representation of care at the care module was constructed around particular groups of care receivers/givers and specific sites of care (family care, paid care work and care systems, particularly childcare). Three groups of care recipients – children, older people and people with disabilities – were central to the representation, and there was little engagement with care as a universal need of all citizens, highlighting an invisibility of care needs unless they fit within certain groups

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valorised as *deserving* of care. Universal care needs, beyond deserving individuals, were identified at the CA primarily in relation to the pandemic, which briefly positioned care workers as 'heroes' (Mohammed et al, 2021). There was no attention to the necessity of care for the planet (Chatzidakis et al, 2020a; Lynch, 2022).

There was little discussion at the CA of how citizenship's long-standing definition in terms of a white, male worker continues to shroud care needs within welfare states (see Lewis, 2000) or of the racialised nature of caring. Perhaps as a result, there was only superficial attention to the compounded nature of care inequalities, with scant attention paid to how marketisation continues or increases gendered, racial and other inequalities in care (Cox, 2013). The potential for intersectional analysis – a political perspective intended to directly challenge oppressions (Hill Collins, 2017) – was blunted in the Chair's framing of intersectionality within the final report as discrete provisions (living wage, employment rights and so on) for specific marginalised women to ameliorate the '*multiple obstacles faced by these women, in addition to the issues facing the general female population*'.

As a political project seeking to reframe society around caring, care ethics 'presumes that we are equal as democratic citizens in being *care receivers*' (Tronto, 2013: 29). Yet, through the CA's emphasis on caregivers' position, pay and recognition, the CA overshadowed the significance of care receivers. Children and older people's care experiences were refracted through experts and advocates, with the perspective of disabled people in receipt of care given voice only through Individual 3 (a disabled woman), who recounted: '*Although I see myself as independent, the reality is that I am dependent on my mother, father and sisters and on the informal support that I receive from friends and colleagues.*' Groups requiring care outside the CA triad (children and older and disabled persons) were absent from the care meetings.

Nor was there attention to the relational nature of caring, where all are interdependent and in need of care networks (Gulland, 2020; Kittay, 2020). Care at the CA was a practice consistently associated with employment (in care jobs or freeing those caring to enter the labour market), rather than of value in its own right. Care was identified as a series of tasks, which could be taught, even to parents: '*we realised that you're trained to be a nurse, you're*

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trained to be a doctor, you're trained to be a teacher, parents don't get training as carers even though they do provide the majority of the care and the majority of care is provided at home' (Citizens). As illuminated by the FEC, interdependence dates to birth, when a child relies on others completely, and then continues throughout each person's life (Held, 2007). The interweaving of our dependence and caregiving through our 'extended and thinner caring relations … make[s] a group a society' (Held, 2006: 136).

Reimagining the CA's representation of care with an FEC lens

FEC perspectives, placing care at the centre of life and politics, were largely absent from the CA's representation of care. Support for a wholescale societal revaluing of care remained largely at the rhetorical level: '*As a society we need to care more about care*' (Individual 3). This embryonic FEC representation at the meetings could have been deepened by applying the full import of an FEC lens: centring the universality of care and of human interdependence; discerning good care models and care networks; and striving for a more caring political process centred on the needs and knowledge of care receivers and caregivers. While care is 'central to capitalism's survival materially' (Lynch, 2022: 37), in its unpaid forms, it is perceived to have no exchange value. Attempts were made at the care meetings to learn from the more socially directed approaches to care of other cultures. However, by continuing to approach care as services, rather than as the foundation of all social and political relations, the CA's attention to Nordic countries remained wedded to labour market agendas. As a result, the cross-country comparisons did not problematise the gendered power relations in care that persist even in the Nordic states with more gender-equal labour market participation (Lewis, 2000; Rothstein 2012). Tronto's (2017: 30) FEC analysis shows that care within neoliberalism is a 'closed circuit of ideas', thought of only in three ways: as personal responsibility, as family responsibility and as a problem for the market. To disrupt the private market mindset, the care meetings could have examined ways to move care away from reliance on private providers and back into the public system (Chatzidakis et al, 2020a). Instead, largely trapped in path dependency, the meetings became entangled in how – or if – care services in Ireland could be publicly funded/provided: '*the system would simply not be capable of shifting from the system we have now to one … where it was provided fully by the public sector*' (Expert 4). In the longer term, however, Expert 1 did posit broader solutions

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of '*state responsibility and the public provision of quality, universal basic care services and that will lead to decreased reliance on the market*'. At times, individuals and experts also drew on personal experiences and data to suggest that good care is often not achievable through the market.

Identifying and providing 'good care', or noticing its absence, is central to FEC analysis (Barnes, 2012). As recognised by Lynch and Walsh (2009: 38), 'the primacy of love, care and solidarity is often most visible in their absence'. FEC shows that confronting the troubling side of care is necessary to properly challenge gendered notions of selfless empathic carers and ableist stereotypes of passive care receivers. Yet, at a CA tasked to address gender inequality, the gendered spectre of care abuses in Ireland was muted, except in an aside where Expert 1 sought to mark the publication of report of the Commission of Investigation into Mother and Baby Homes (Government of Ireland, 2021c) into abuse perpetrated against unmarried women and children in Irish institutions. This, she pointed out, is a '*disgraceful history but it's the antithesis, or the very opposite to the concept of putting care at the centre of our economy*'.

However, there was some evidence of more expansive conceptions of care at the CA. Before the care meetings turned towards care services, the care module opened with a video referencing the '*universal bond*' (ILO video) of care needs, as '*in our lives each of us will need care and most of us will be giving care to others*' (Chair). A '*broad sentiment*' was also identified across submissions that '*care is fundamental to all human activity but responsibility for it is unevenly distributed across society*' (Expert 3). Those inputting into the care meetings from advocacy and personal perspectives sought to widen the representation of care through rights-based approaches. Centring the standards of the UN Convention on the Rights of Persons with Disabilities (CRPD), Individual 3, for example, identified the '*need to talk about rights, not charity*', and that the '*26 important rights*' outlined in the CRPD '*should inform the development of all policies, services and supports relating to care*'. There was also recognition of the connection between care and politics at the meetings (linking with Tronto's [2013: x] contention that 'what it means to be a citizen in a democracy is to care for citizens and to care for democracy itself '). One submission venerated the CA's '*potential to change the political and public conversation on care. It can make clear that care*

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is not a private matter to be left to mostly women behind the closed door of the home, but a public matter, whose rectification will benefit us all' (submission excerpt), while the citizens suggested that '*the voices of child care workers, carers and those who receive care are included in all policy decisions*' (Citizens). Ultimately, though, this political perspective on care was often overwhelmed by the particularities of carers' remuneration and advancement.

Discussion and conclusions

An early and sustaining concern of feminism has been the level of unpaid care provided by women. Building on this, the FEC attends to *both* the paid and unpaid labour involved in caring because 'care of dependents is *work*' (Kittay, 2020: 35). Particular policy areas contain within them constructions of gender (Bacchi, 2017; Hearn and McKie, 2018), even if attempts are made – as at the CA – to address care from a gender-neutral or degendered perspective. As we have demonstrated in this article, the CA's care meetings largely followed contemporary care policy intentions to move 'unproductive' women into paid work (Williams, 2018) and failed to address the interdependence, specificity and time that characterise real-world caring. There was also a missed opportunity to confront men's 'relatively care-free' life in Ireland (Hanlon, 2012: 63). Tronto (1993; 2013) developed the concept of 'privileged irresponsibility' to describe how certain individuals (often men) excuse themselves by using 'passes', such as the production pass of breadwinners, to exempt themselves from caring activities. Attention to affective relations using the FEC uncovers how 'male control of state institutions impact on women as primary carers, both institutionally and ideologically' (Lynch, 2022: 47), including through the lack of public debate about and investment in care infrastructure flowing from a general masculine inattention to caring concerns as a result of 'their own relatively, and sometimes entirely, care-free experiences' (Lynch, 2022: 48).

As an outcome of the care module, the CA made wide-ranging recommendations. These included: better pay and conditions for paid carers; improvements to welfare payments and pensions for unpaid carers; augmented respite provision; movement towards a publicly funded childcare model; additional paid leave for parents; improvements in person-centred

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supports and resources for older and disabled people to live independently and to participate in their care decisions; a statutory right and enhanced access to home care; and an ending of the division of disability services for those aged under and over 18 years. Within the context of preceding Irish social policy, these recommendations can be understood as progressive, particularly in valuing the care needs of particular groups, seeking to address the conditions of care workers and, significantly, challenging the state's retreat from caring. Our FEC-led problematising finds that the recommendations were limited to particular types of solutions (predominantly at the level of improvements in care services and employment fixes) by the way in which care was represented during the module. As such, while beginning to question 'care as usual', the care module veered away from possible radical care fixes, continuing to '*work from where we're at*' (Expert 2) through improvements to existing care services/supports and the extension of neoliberal governing (see Lynch and Walsh, 2009; Tronto, 2017; Lynch, 2022) via further professionalisation of the care sector and supports for private providers.

The huge political, institutional and economic import of seeing care as *the* centre of our lives (Tronto, 1993; 2013; Lynch et al, 2009) may bring not only enormous discomfort, but also the potential for transformation, to the systems and societies that rely on care for their very survival and operation. As the FEC illustrates, to be fair and fulfilling, our care relations demand 'a response from public services to enable social justice' (Barnes, 2012: 59). The emergent discernment of collective vulnerabilities through the pandemic years may halt the state's retreat from care provision and provide the basis for a politics 'that recognises this interdependence and puts care front and centre of life' (Chatzidakis et al, 2020b: 892). However, such a shift is far from certain, and based on this analysis of a mid-pandemic deliberation of care, we argue that it will require an expanded understanding of care needs and a societal commitment to end care inequalities. The difficulties entangling affective relations in capitalist societies (clearly visible in the CA's tussle with the care market) make care relations 'a site where conflicts are examined, where alternative narratives can be created, and where political platforms for moving towards a more human, non-exploitative way of organizing the world are established' (Lynch, 2022: 203). Critical approaches to discourse, as undertaken in this article, not only describe the world as it is, but also open up how the world *ought* to be (Fairclough and Fairclough, 2012). The silences and constraints

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we identify in the CA's representation of care provide a gap in which to think differently about the 'problem' of care and to envision a care-centred society in which all take responsibility for care arrangements (Tronto, 2013). In her own theorising of care, Virginia Held (2006: 77) invited FEC proponents to engage in 'an exercise of the imagination' about the best form of caring relations. The CA's representation of care, with market thinking, edgings of misogynistic lament (the aunts no longer available to 'bring up' children) and the othering of migrants, demonstrates the ambivalence and tension that care conversations can expose. At the same time, through efforts to centre individuals' experiences of care, the CA's care module sought to identify good care values and practices. On the basis of this analysis of the CA's representation of care, we argue that FEC-led representations, which seek practical improvements in the experience of hands-on care and that advance care as politics, can assist us to think beyond existing care limits. We suggest that the caring counterfactual provided by the FEC and the collective pandemic experience provide us with a method and a moment to define a care-filled future.

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Conflict of interest

The authors declare that there is no conflict of interest.

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