# The Gendered Order of Caring

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## Introduction

One of the most frequently asked questions about women is, why is it that there are so few women who are leaders in the arts, in politics, in public and professional life? Why are there so few women who are film producers and sports stars? Why is it that in spite of Irish women's considerable educational achievements over the last 30 years that we still have so few women in leading positions in business, in the civil and public service, in the Dáil, in higher education and the universities? Why, given women's higher achievement than men in the Leaving Certificate, especially in languages and the arts, are so few of our highly promoted (note, we do not say 'leading') playwrights, authors and poets still men? Why is it that so many of our most senior medical professionals and scientists are men, although women and men have entered the profession in equal numbers for many years and women now comprise the majority of those entering the field?

There are multiple answers to those questions that cannot be addressed in a short chapter of this kind. There is an extensive research literature showing that women do not succeed in bureaucratic organisations for a host of reasons that are internal to the dynamics of organisations themselves, including indirect and direct discrimination, gender stereotyping of senior managerial positions, exclusion from key gendered social networking events and the gender segregation of occupational roles (see Witz, 1992, O'Connor, 1996, and Halford

and Leonard, 2001). There is also a gender order in society that pervades organisational culture and privileges male ways of working and organising that disadvantages women occupationally and socially in ways that are made invisible by being presented as both normal and inevitable (Bourdieu, 2001; Connell, 1987, 1995). Ideological institutions that define the feminine as an inferior category to the male also play a key role in legitimating women's subordinate position in society. As religion is a powerful institution of ideology (along with the media and education, see Althusser, 1971), and as the Catholic religion in particular has exercised considerable control over thinking about gender relations in Ireland, it has played a significant role legitimating women's subordinate position (Connolly, 2002).

While the ways in which gender relations operate in employment, in politics, in the cultural sphere, including education, are all vital for understanding women's subordinate position in the public spheres of life, none of these fully explain women's continued subordination. It is in the interface between the private and the public, between care[i] and love relations in the private domain of the household and family and the public world of politics, the economy and culture, that a major reason for women's subordinate status becomes clear. There are deep and profound gender inequalities in the doing of care and love work that work to the advantage of men, and there is a moral imperative on women to care that does not operate in the same way for men, which, when combined, eject women from the public spheres of life although they often see this as a 'choice' (Bubeck, 1995; Lynch, 2007; O'Brien, 2007).

**Love and Care Matter**

Caring, in its multiple manifestations, is a basic human capability serving a fundamental human need (Nussbaum1995a, 1995b; 2000). Being loved and cared is not only vital for survival in infancy, early childhood or at times of illness or vulnerability, but throughout human existence. Experiencing care, love and solidarity throughout the life course is also essential for human development and

flourishing (Kittay, 1999; Engster, 2005). Whether people subscribe to other-centred norms or not, their own existence is dependent on the successful enactment of such norms (Fineman, 2004; Sevenhuijsen, 1998). No human being, no matter how rich or powerful, can survive from birth without care and attention; many would die at different points in their lives, if seriously ill or in an accident, without care.

The reason love and care matter is because we are relational beings, emotional as well as intellectual, social as well as individual (Gilligan, 1995). All people have the capacity for intimacy, attachment and caring relationships. Bonds of friendship or kinship are frequently what bring meaning, warmth and joy to life. The inevitability of interdependency does not just apply in personal relationships, but also in work places, in public organisations, in voluntary groups or other social settings. While it is obvious that we cannot flourish personally without support, encouragement and affirmation, even in our paid-work lives we can only flourish fully if we work with others who are nurtured, fed and supported so they are willing and able to work. Love, care and solidarity labours produce outcomes and forms of *nurturing capital*[ii] available to us personally, socially and politically. The amount of nurturing capital available impacts on people's ability not only to relate to others at an intimate level, but also to flourish and contribute in other spheres of life. Being deprived of the capacity to develop supportive affective relations, or of the experience of engaging in them when one has the capacity, is therefore a serious human deprivation and injustice.

**Do Academics Care about Love and Care Work?**

Despite its centrality to human existence, there is great ambivalence about caring and loving in most societies (hooks, 2000). Mainstream sociological, economic and political thought has devoted little attention to the issues of care until very recently (Pettinger et al., 2006). In both liberal and radical egalitarian traditions, love and care have been treated as private matters, personal affairs, not subjects

of sufficient political importance to be mainstreamed in theory or empirical investigations (Baker, Lynch, Cantillon and Walsh., 2004). Sociological, economic, legal and political thought has focused on the public sphere, the outer spaces of life, indifferent to the fact that none of these can function without the care institutions of society (Fineman, 2004). Within classical economics in particular there has been a core assumption that the prototypical human being is a self-sufficient rational economic man (sic) (Folbre, 1994). There has been no serious account taken of the reality of dependency for all human beings, both in childhood and at times of illness and infirmity (Badgett and Folbre, 1999). Traditional scholarly interpretations of work have equated it with self preservation and self actualization through interaction with nature (Gúrtler, 2005; Pettinger et al., 2006). Mainstream scholarship has been blind to the importance of other-centred work arising from human interdependencies and dependencies as affective, relational beings. In particular it has ignored the centrality of caring for the preservation and self actualisation of the human species.

*Role of Feminist Scholars in highlighting the importance of Care*

Despite the popular anti-feminist rhetoric in sections of the popular media, it has been feminist-inspired work that has played the key role in many care a public issue. Feminists have taken the issue of care out of the privatised world of the family to which it had been consigned by liberal and indeed most radical egalitarians (Benhabib 1992; Gilligan, 1982, 1995; Held 1995; Kittay, 1999). Feminist-inspired scholars have drawn attention to the salience of care and love as public goods, and have identified the importance of caring as a human capability meeting a basic human need (Nussbaum, 1995a, 1995b, 2000). They have also exposed the limitations of conceptualisations of citizenship devoid of a concept of care, and highlighted the importance of caring as work, work that needs to be rewarded and distributed equally between women and men in particular (Finch and Groves, 1983; Glucksmann, 1995; Hobson, 2000; Hochschild, 1989; O'Brien, 2005; Sevenhuijsen, 1998)

The complex way in which power relations and exploitation are embedded in all manner of care relations is the subject of a large body of feminist research (Ba, Bubeck, 1995; Fraser and Gordon, 1997; Folbre, 1994; Kittay, 1999; Nussbaum, 1995a, 1995b; 2000; Sevenhuijsen, 1998; Tronto, 2002). Feminist-inspired scholars have also contributed to understanding the potential for abuse of dependants in relations of care (Qureshi and Nicholas, 2001). Overall, what feminist scholars have managed to do is to shift intellectual thought from its sociological fixation with the Weberian and Marxist structuralist trilogy of social class, status and power as the primary sites for the generation of inequalities and exploitations. They have drawn attention to the way the affective domains of life are discrete spheres of social action, albeit deeply interwoven with the economic, political and cultural spheres.

**Care and Love in Ireland: the Data**

The Irish government collects data on unpaid caring within households both in the Census and in the Quarterly National Household survey (QNHS). Within the Census, care is defined as being given by " persons aged 15 years and over" who provide "regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability (including problems due to age)" (CSO, 2007: 63). The way care is defined in the Census excludes what constitutes a major category of care work, that of the ordinary, everyday care of children (unless the child has a recognised disability). Data on the care of children is compiled in the QNHS however and is also available through the European Community Household Panel (ECPH) survey. The focus in all three is on the hours of work involved in caring so we do not know the nature and scope of the caring involved. To date, just one pilot study has been undertaken indicating how time is actually divided between women and men in terms of specific care tasks within households (see McGinnity, Russell, Williams and Blackwell, 2005: Tables 2.2 and 2.3) . No national study has been undertaken of

the scope and nature of care and love work in private households in Ireland. Ireland has not been included therefore in European studies examine differences in time use (see EUROSTAT, 2003 data on 13 other EU countries) , including gender differences, as it has not invested in measuring this type of work on an ongoing basis.

**Gender Differences in Caring**

*Data Sources*

The picture of care work that is painted for us in Ireland varies with the sources of the data that are mapped on to our national canvas. One of the major sources of data, the National Census, is largely confined to measuring unpaid caring for adults (and children with disabilities). Consequently, focusing on data from the Census as a way of mapping caring gives a very incomplete picture of how much care for is undertaken in Ireland.

As can be seen from Table 1 below, according to the Census there are less than 150,000 people, 5% of the adult population, involved in unpaid care work (mostly with adults) of whom 61% are women and 39% are men.

**Table 1 Population Estimates of Unpaid Carers* (N=adults aged 15 and over)**

| YEAR | FEMALE | | | MALE | | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | No. | Female as % of all carers | Female Carers as % of All Females | No. | Male Carers as % of all carers | Male Carers as % of All Males | No. | Carers as % of Total Population |
| 2002 | 91,274 | 61.0 | 5.8 | 57,480 | 39.0 | 3.7 | 148,754 | 4.8 |

**Source**: Census (2002) Volume 10 Disability and Carers

*Unpaid care is defined as “regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability (including problems due to age)” (CSO, 2007: 63).

However, when we measure all types of caring activity, as has been done in the European Community Household Panel (ECPH) we see that there are 1 million peole who do caring who are not named as such in the census. Table 2 shows that 28% of the adult population have care responsibilities and of those involved in caring, 85% (973,220) are only caring for children, while a further 7% (all of whom are women) are caring for both children and adults with care needs. Only 8% of all carers are caring for adults only (Table 2).

**Table 2: Number of Carers by Type of Care Activity (Base: adults aged 16+)**

| TYPE OF CARE ACTIVITY | FEMALE | MALE | TOTAL | TOTAL CARERS |
|---|---|---|---|---|
| | % | % | % | % |
| 1.Care of Children only | 34 (663,000) | 14 (290,220) | 24 | 85 |
| 2.Care of person(s) due to old age, disability or illness only | 3 (58,500) | 2 (41,460) | 2 | 8 |
| 3.Both Children and Other persons | 3 (58,500) | - | 2 | 7 |
| **4.No Care** | **60 (1,170,000)** | **84 (1, 741,320** | **72** | **NA** |
| TOTAL % UNWEIGHTED (N) | 100 (1,950,000) | 100 (2,073,000) | 100 (4,023,000) | 100 (1,147,000) |
| Chi-square | (p<.001) | | | |
| Source: European Community Household Panel (ECHP) survey – Ireland Wave, 2001 | | | | |

**The ECHP took ages 16+ for the cut off point while the 2002 Census took age 15+ as the cut off

From Table 2 it is clear that women are almost two and a half times as likely to be carers of children only than men: 34% of women were engaged in the care of children, only 14% of men were. As was found in the Census the ratio of women to men caring for adults or others with an illness or a disability is 60:40.

Overall therefore, we see that women do much more unpaid care work than men in Ireland. The disparity in unpaid caring stands at a ratio of 2.5:1: 40% of women aged 16+ years or older have some care responsibilities (mostly for children) compared with 16% of men (see Table 2 below). Women are especially more likely than men to have the primary responsibility for children, without pay. The pattern has not changed since the ECHP study was undertaken in 2001. In 2006, slightly less than 1% of all persons who identified themselves as principally working in the home were men; 99% of those doing family and other home-related work full-time were women (CSO, 2006:10). This pattern is not unique to Ireland as it is replicated in other countries throughout the world (Bettio, Simonazzi and Villa, 2006; Daly, 2001; Finch and Groves, 1983; Folbre, 1994; Ehrenreich and Hochschild, 2003; McKie, Bowlby and Gregory, 2001; Strazdins and Broom, 2004).

The difference in the data compiled on caring by the ECPH survey and the Census demonstrates how caring can become invisible by not being enumerated. Even though it is no doubt unintentional, the failure to collect data on hours spent on child care work in the Census, means that child care, which is **the** major form of care work in Irish society, is not counted in terms of work hours. Yet it is the form of care work that women of all social classes and ages are significantly more likely to undertake than men. There is a deeply patriarchal set of assumptions hiding women's unpaid work in the household in this way; it is a form of institutionalised sexism that needs to be addressed.

**Hours of Care Work**

Not only do women have more responsibility for care work than men, they also work far longer hours at caring. (Because the Census only measures care hours up to a maximum of 43+ hours[iii], it does not enable us to discriminate between those doing very long hours of caring with those with fewer hours and so we do

not analyse it in detail here) The ECHP does allow us to do such an analysis however.

From the ECHP data, it is clear that women are much more likely than men to be engaged in long hours (61+ hours per week) of caring. From Table 3 below, we can see that the modal (most typical) number of hours of care that women carers are involved in is 61+ hours per week: 40% of all women who are carers are involved in 61+ hours. In contrast, the typical number of care hours for male carers is 14-28 hours with 40% of men saying they spent that amount of time caring each week. When one counts those involved in more than 43 hours of care work per week, the ECHP data show that 58% of women carers are in this category compared with 12% of men. This means that women are almost five times as likely to work long care hours than men.

**Table 3 Gender Differences in Hours Spent in Unpaid Care work per week**

| **Unpaid Weekly Care hours** | **Women %** | **Men %** | **Total % share by women** |
|---|---|---|---|
| 1 – 14 | 10 | 28 | 15 |
| 14 – 28 | 12 | 40 | 19 |
| 29 – 42 | 20 | 20 | 20 |
| 43 – 60 | 18 | 6 | 15 |
| 61+ | 40 | 6 | 31 |
| Total<br>*Unweighted (N)* | 100<br>*(783)* | 100<br>*(320)* | 100<br>*(1103)* |
| Source:European Community Household Panel (ECHP) Survey, Ireland Wave, 2001 | | | |

The findings from the ECHP in relation to the distribution of care work between women and men has been confirmed in study of time use in Ireland in 2005. McGinty, Russell, Williams and Blackwell (2005: 11) found that “On weekdays women spend almost five times longer on caring activities than men”.

The area of care work in which there is least gender disparity is care involving older people, people who are ill or who are disabled. While women work longer hours in this type of care work than men, the gender differences are relatively minor compared with differences in child care, or in caring for children in combination with adults. Women are almost 1.5 times more likely than men to care for older people, those who are sick or those disabled for 61+ hours per week. However, women are almost eight times more likely than men to do 61+ unpaid child care hours and almost six times more likely to do 61+ hours of child care combined with other forms of care (Table A.1). While the major reason why women do longer care hours than men is because women are more likely to be full-time carers than men, this begs the question as to why it is women rather than men who leave the paid labour market to do care work especially given the educational profile of women: in 2004, Irish women comprised 56.8% of all third-level graduates (CSO, 2006: 39).

While one might expect a linear relationship to exist between hours of caring and employment hours, this is not the case: the majority, 56%, of the (relatively small number of) males who do 61+ care hours each week are working full-time as are 30% of the women who are doing 61+ hours per week. Overall, 42% of women who are carers are employed full-time as are 67% of men who are carers (Table A.2).

It is not just simply the fact of caring with all its management and related responsibilities that must be measured when assessing the relationship between care and paid work, but also the hours spent caring. Women undertake much more time at care work than men, even when they are employed.

**The Double Bind: Lack of Public Investment in Care Services and the Moral Imperative for Women to Care**

To have good public services, including caring services, a state must invest in them. However Ireland has one of the lowest rates of social expenditure within the EU. It ranks fourth from the bottom in terms of investment in social protection, education and health within the 27 member states, spending just 27.5% of Gross Domestic Product (GDP) on these services which is only 2-3% above Lithuania, Latvia and Estonia, three of Europe's poorest countries (Tables 4.1 and 4.2, Measuring Ireland's Progress, CSO, 2007). In contrast, Sweden spends almost 50% of GDP, Germany spends 45.6% and Austria spends 42.6% on social expenditures. Even Poland, at 33.6% and the Czech Republic at 31.7% have significantly higher investment in social expenditures than Ireland.

The lack of social investment in services generally is reflected in the care field. In an EU study of child care in 2004, *'Ireland and the UK obtain very low ranks in terms of childcare and maternity leave systems'* (EU, 2004:8). Ireland was ranked the worst of the original 15 member states in terms of public child care provision and Denmark was the best (EU, 2004). The lack of public child care support services has a direct bearing on women's employment rates. In 2004, 87.5% of women aged 20-44 who had no children were in employment; only 52.4% of women with children under 3 years of age were in employment. The reason at least one member of a household with children (and it tends to be a woman given the strong moral imperative on women to be primary carers, see O'Brien, 2007) is forced to leave employment is simple: child care is privatised and costly. Irish parents spend approximately 20% of their incomes on child care (and that is counting only those who can afford to engage in paid work!) (*Consumer Choice*, October, 2005). Those who are poorer cannot afford the prohibitive costs which were averaging €120 nationally per week early in 2005 with costs in Dublin averaging €145 but being much more in particular areas CSO, QNHS, 2005). by the National Children's Nurseries Association to be €172 per week for a baby under one year, although in Dublin the costs are much higher in many areas.

**Women's Attitudes to Caring**

Hakim's (2002) claim that the reason women are less engaged in the labour market than men is because of their personal preferences is strongly challenged by Irish data (as indeed it is internationally) (Jacobs and Gerson, 2004). From Table 4 below we can see that Irish women are not happy with their current position whereby are unable to achieve a desired balance between employment and care responsibilities: 40% of women who are carers stated that they felt that the care work they did prevented them from undertaking paid work on the terms they would like while only 8% of men felt this way.

**Table 4: Percentage of Carers Who Perceive that the Care Work they do prevents them from undertaking either the amount, or kind, of paid work they would otherwise do (Base: adults aged 16+ involved in care work)**

| CARE WORK LIMITS PAID WORK | FEMALE | MALE | TOTAL CARERS |
|---|---|---|---|
| | % | % | % |
| Yes | 40 | 8 | 31 |
| PRINCIPAL ECONOMIC STATUS: % reporting YES | | | |
| Full-time work | 25 | 77 | 29 |
| Part-time work | 1 | - | 1 |
| Unemployed | 2 | 5 | 2 |
| Education/Training | * | - | * |
| Home Duties | 70 | 9 | 66 |
| Retired | - | - | - |
| Other | 2 | 9 | 2 |
| TYPE OF CARE: % reporting yes | | | |
| Childcare only | 56 | 82 | 80 |
| Other care only | 35 | 7 | 9 |
| Both childcare and Other care | 9 | 11 | 11 |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| TOTAL %<br>UNWEIGHTED (N) | 100<br>(761) | 100<br>(305) | 100<br>(1,066) |
| Chi-square | (p<.001) | | |
| Source: Living in Ireland Survey (LIIS) 2001 | | | |

The women who expressed most dissatisfaction with their opportunities to do the amount and type of paid work they wanted to do were those who were working full-time at home who had third level education, and those who were working part-time with little formal education (i.e. those who had left mid-way through second-level education or before hand): 81% of those with third level education who were at home full-time were dissatisfied, as were 75% of those who were doing part-time work and had little formal education (Table A.5). Even women who were in full-time employment felt constrained by their care work in a way that men did not; 22% of women who worked full-time felt constrained by having to meet care and work demands; only 2% of men who worked full time had such concerns (ibid) (Table A.4)

The findings from the Living in Ireland Study are reinforced by findings from the International Social Survey Programme in 2002. Almost one third of women in Ireland felt that they 'did much more than their fair share' of housework while 62% felt they did more than their fair share of housework. Only 6% of Irish men felt they did more than their fair share (Hilliard, 2007:130).

**The Status of Carers as Workers**

Within the Irish Constitution, Article 41, care is defined in a deeply patriarchal code as a 'duty' for women in particular. The ideology of caring as a 'duty' of women has been strongly endorsed by all main religions, especially the Catholic Church, although it is an ideology which is not the prerogative of any one religion. The reluctance to recognise caring as a form of work arises from the widespread global allegiance to the traditional feminine (as opposed to feminist) ethic of care

which defines care as a moral obligation for women (in particular) governed by rules of selflessness and self-sacrifice (Gilligan, 1995).

The net effect of not recognising the work dimensions of caring is that it is not seen as producing anything of value although it does. Instead caring is seen as a low status activity, especially if engaged in fulltime. In most countries, people who are working full-time as carers at home (mostly women) are not defined as working and have no pay (Daly, 2001)[iv].

The lack of valued attached to care work at home in Ireland is shown by the rate of income granted to home carers by the State in the Carer's allowance and Carer's Benefit[v] and by the fact that family carers of children are not givenany allowance. While the rates and conditions for getting a Carer's allowance have improved in recent years, they are set at a level which give little financial comfort to carers. The Carer's Allowance is means tested and the maximum rate of the Allowance is €200 per week for someone caring for one person or €300 per week if caring for more than one person. To obtain the maximum allowance of €200 per week however, the carer can only have weekly means of €7.60 per week or less (information access from the Department of Social and Family Affairs Website 7/9/2007 (http://www.welfare.ie/publications/sw19). Those with weekly means of over €207.60 per week are not eligible for any allowance. A forthcoming study on carers of all types shows that there is strong dissatisfaction not only with the Carer's Allowance but also with the lack of financial support for child care (Lynch, Lyons, Baker et al., 2008).

The devaluing of care is also evident from the status attached to jobs in the care services sector. Personal service workers, especially carers are poorly paid and have low status. In the United States (in 2006) child care workers had a mean annual wage of $17, 120 which is lower than that of cleaners and janitors at $19,750 or those employed in food preparation and serving related work at $19, 690 http://www.bls.gov/oes/current/). In Ireland, as in many other countries, care

workers who are employed in the care sector have the same status as semi-skilled workers such as bar staff, goods porters and mail sorters, which is the second lowest occupational ranking. If care workers are employed in private households as domestic staff they are classified as unskilled workers and are at the bottom of the occupational ranking (Central Statistics Office, 2003).
Caring has been taken for granted and made invisible because it was seen as the duty of individual women not the responsibility of an entire household, family or society. It is only since women have begun to enter the paid labour market in larger numbers that the work of informal care has become visible, even though it remains largely unpaid.

**Implications for Women of Doing more Care Work than men**

Doing informal caring in the home has a direct negative impact on women financially especially in the absence of adequate public service supports for carers. In 2004, the average income for all women aged 15-84 was only two thirds of what it was for men: women earned an average of €19,512 per annum while men earned €29,691 (CSO, 2006: 16). Women's average income is much closer to that of men's, however, when they are younger and are likely to have no children or even just one child, than when they are older: women earn 82-83% of what men earn between the ages of 15 and 34; at age 35-44, they earn 63% of what men earn while at ages 55-64, they only earn a little more than half (53%) of what men earn. While there is no doubt that one major reason why women earn less than men is because they do not spend as much time in paid employment, such a response is merely a description of the problem rather than an explanation. It begs the question as to why it is women who do unpaid care work rather than men.

The lack of state investment in care support services means that women carry the cost. In 2006 Irish women had the highest risk of living in poverty (when social transfers were taken into account) of any of the 27 EU states: 23% of Irish

women are at risk of poverty compared with 12% in the Netherlands and 11% in Slovenia and 9% in the Czech Republic. (CSO, 2006: 19: Table 1.14). Irish women are also more likely to be holders of medical cards than men at all ages, but especially in their early 20s and 30s; this is further proof of their poverty especially in their child-rearing years (ibid: 45).

**Differences between Women**

As with any group, women are not singular in their identities. They vary by age, social class, cultural background, marital status, sexual orientation, beliefs etc. Some women do more care work than others, depending on their social class, citizenship status, age, marital and other statuses. However, in all social classes and groups, it is generally women who are responsible for managing and organizing caring even if they do not to all the day-to-day hands-on caring work (Bubeck, 1995).

There is a common tendency in policy and research to blame better off women for exploiting poorer and low income women who care for their children; such an allegation is both profoundly gendered and sociologically misleading. Caring is not simply a women's responsibility, so men in households that hire women to care on exploitative terms are as culpable of exploitation of carers as women. When child minders or carers of older people are exploited, the problem occurs because of weak labour laws (and lack of monitoring of the laws that do exist) that allow people to be employed in care situations, especially in domestic situations, without full regulation and proper wages. The problem is a policy one, not a personal one for individual women. There is, of course, an individual responsibility for employer's of carers to act ethically in their role as employers, but this is a separate issue (Tronto, 2002).

There is also a global market in caring labour; much of which is exploitative, but this is not especially a women's issue (Bettio and Platenga, 2004; Ehrenreich and

Hochschild, 2003). It is a problem of global justice whereby women are forced to migrate to care for other peoples' children (often at the the neglect of their own) due to poverty and unemployment in their own countries, problems that are often exacerbated by unequal terms of trade (Daly, 2001).

## Conclusion: The Care-Full Model of the Citizen Vs The Rational Economic Actor Model

The gender disparity in the care world could not be more startling; yet it is not the subject of a major national debate, nor is there any serious debate about challenging the gender imbalance in the doing of care work. Paternity leave is unpaid: parental leave is also unpaid and optional for both men and women. Ireland sits at the bottom of the child care league table in Western Europe.

While there is a strong public tendency to construct care work as simply a women's issue, this is a practice that needs to change if women are to have substantive as opposed to formal equality with men. Because all equality issues are relational issues, one can only address the care equality problem by addressing it relationally, that is in terms of female-male relations. As long as the moral imperative to care is confined to women (men are generally only expected to care when there is no woman available to do the caring (Gerstel and Gallagher, 2001) it will be impossible to have gender equality in society.

The problem is that patriarchal practices of caring do not have to be re-configured in every individual case or in every household; they are already encoded in the norms of femininity, masculinity and domesticity. For middle class women in particular, there is strong command to be 'Moral Mothers', to care competently and professionally (Hays, 1996; O'Brien, 2007; Williams, 2001). The morally encoded mother of all classes is not the subject of reports or analysis, her domesticity persists as *'embodied history, internalized as second nature, and*

*so forgotten as history'* (Williams, 2001: 38). Equally for men, hegemonic masculinity (that is the view that to be male is to be in a dominant position) is assessed in terms of male pay cheques and power (Connell, 1995). Being a primary carer means living a life of economic vulnerability; this type of vulnerability is not part of the male trajectory.

What needs to be challenged initially is the way masculinity is constructed as a care-less identity not only in Ireland but internationally (see Hanlon, 2008). Men are neither reared nor educated to define themselves as carers. In fact, quite the opposite is true, they are generally reared to be *care commanders*, people who are free riders on women's care labour. So there is a need to educate young men, both informally in families and formally in education, to accept an equal role with women in caring. And there is also a need to educate women to accept that men can care as well as women (Lynch, Lyons and Cantillon, 2007).

The challenge to the construction of men as care's assistants[vi], raises deeper questions about how citizenship itself is constructed in Western society. At present the ideal citizen in most European countries is defined as a paid worker, someone who is contributing to the economy directly through some form of employment (Sevenhuijssen, 1998; Lewis, 2003). A rational economic actor (REA) model of the citizen prevails that fails to recognise the profound importance of caring for not only individual well being but for the functioning of the economy, polity and cultural sphere. The idealised citizen in Western democracies is not a caring one; the public citizen is assumed to be primarily a rational economic actor who consumes and makes choice in a market-led economy (Duncan and Edwards, 1997; Lister, 2001; Sevenhuijsen, 2000; Tronto, 2001). The allegiance to the REA model of the citizen is not entirely new; it is deeply rooted in Western political thought (Fraser, 1997; Held, 1995; Lynch, Lyons and Cantillon, 2007). At the individual level, the purpose of education, for example, is defined in terms of personalised human capital acquisition, making oneself skilled for the economy *'the individual is expected to develop a*

*productive and entrepreneurial relationship towards oneself'* (Masschelein and Simons, 2002: 594). No serious account is taken of the reality of dependency for all human beings, both in childhood and at times of illness and infirmity (Badgett and Folbre, 1999).

Despite the moral opprobrium accorded increasingly to the employee REA citizen as one who is not only autonomous and rational but also market-oriented, consuming, and calculatingly self-interested, the fact remains that a large part of humanity at any given time are not self-financing consumers, notably children, people who are very frail, unpaid carers, people with work-constraining disabilities and people who are ill. Many people are in no position to make active consumer choices due to the poverty of their resources, time and/or capacities. Moreover, while people are undoubtedly rational economic actors and consumers, neither their rationality nor their economic and consumer choices can be presumed to be devoid of relationality (Gilligan, 1982; 1995). For most of humanity, much of life is lived in a state of profound and deep interdependency, and for some prolonged dependency (Kittay, 1999). The Rational Economic Actor model of the citizen need to be complemented by a Care-Full model, of the citizen one that recognises the centrality of care and love relations to the mental health and well being of all members of society (for a further discussion of these issues see Lynch, 2007; Lynch, Lyons, Baker et al., 2008).

*Love Labour the what is not Commodifiable in Care terms*

Although it is not possible to elaborate on the subject in this short paper, it is important in policy terms to recognise that not all care labour can be commodified. Certain forms of caring, namely love labour cannot be provided on a hire and fire basis. (Love labouring is affectively-driven and involves at different times and to different degrees, emotional work, mental work, cognitive skills and physical work. It is the nurturing work we do which is other-centred in the sense of building relationships with others and nurturing their sense of well being, see Lynch 2007

for further discussion), There is a mutuality at the heart of intimacy which does not enable us to offload that aspect of the relationship to others without destroying it. As yet there is little understanding of this in the public arena (Lewis and Giullari, 2005).

While certain care tasks are commodifiable, and there is a case for substantially improving the conditions of its commodification to preclude exploitation (Meagher, 2002), the nurturing, other-centred labour involved in primary care relations cannot be commodified in the same way. The emotional work involved in loving another person is not readily transferred to a paid other by arrangement; neither can it be exchanged. To attempt to pay someone to do a love labour task (sharing a meal with a partner, visiting a friend in hospital, reading a story to a child or making a sick parent's favourite meal) is to undermine the premise of care and mutuality that is at the heart of intimacy and friendship (Strazdins and Broom, 2004).

This is not to suggest that paid care is neither desirable nor necessary. Public care supplements love labour rather than substitutes for it (Waerness, 1990:122-3). Where intimate care is poor or even abusive, paid care is necessary and often preferable at the very least to supplement weak forms of care; however, it is fundamentally different.

Recognising that not all care can be commodified presents a profound challenge to the way we organize our society. All people need care, and they need time to do care, especially intimate love labouring. That is to say, people need time apart

from paid employment and from individualised leisure to do loving of others. It is not possible to produce fast-care like fast food in standardised packages. If we go the McWorld route in caring what we will get is not care but 'pre-packaged units of supervision', feeding and attending without intimacy, and a lack of focus on the welfare of others (Badgett and Folbre, 1999: 318).

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Appendix

**Table A.1 Distribution of Unpaid Hours of Care work by Gender (N = Adults aged 15 and over)**

| UNPAID WEEKLY CARE WORK HOURS | FEMALE | MALE | TOTAL (% SHARE BY FEMALE) |
|---|---|---|---|
| | % | % | % |
| | **A. CHILDCARE ONLY (Mean weekly hours=48)** | | |
| 1-14 | 7 | 26 | 12 (41% female) |
| 15 – 28 | 12 | 40 | 20 (44% female) |
| 29 – 42 | 22 | 23 | 22 (71% female) |
| 43 –60 | 20 | 6 | 16 (89% female) |
| 61+ | 39 | 5 | 30(95% female) |
| Total<br>*Unweighted (N)* | 100<br>*(661)* | 100<br>*(274)* | 100 (72% female)<br>*(935)* |
| | **A. CARE DUE TO OLD AGE, DISABILITY OR ILLNESS ONLY ( Mean Weekly hours=27)** | | |
| 1 – 14 | 53 | 43 | 49 (64% female) |
| 15 – 28 | 13 | 40 | 24 (32% female) |
| 29 – 42 | 13 | 3 | 9 (88% female) |
| 43 – 60 | 4 | 3 | 3 (67% female) |
| 61+ | 17 | 11 | 15 (69% female) |
| Total<br>*Unweighted (N)* | 100<br>*(57)* | 100<br>*(33)* | 100 (59% female)<br>*(90)* |
| | **C. BOTH CHILD CARE AND OTHER CARE (Mean Weekly hours=75)** | | |
| 1 – 14 | 6 | 33 | 9 (% female) |
| 14 – 28 | 4 | 33 | 7 (% female) |
| 29 – 42 | 9 | 11 | 9 (% female) |
| 43 – 60 | 15 | 11 | 15 (% female) |
| 61+ | 66 | 12 | 60 (% female) |
| Total<br>*Unweighted (N)* | 100<br>*(65)* | 100<br>*(13)* | 100 (% female)<br>*(78)* |
| **TOTAL UNWEIGHTED N** | **783** | **320** | **1103** |
| **Source:** ECHP – Ireland Wave, 2001 | | | |

**AppendixA.2 Table Principal Economic Status By Gender of Carer** (N = Adults aged 15 and over)

| PRINCIPAL ECONOMIC STATUS | FEMALE CARERS (FEMALE POP.) | MALE CARERS (MALE POP.) | TOTAL CARERS (TOTAL POP.) |
|---|---|---|---|
| | **%** | | |
| Full-time work | 42 | 67 | 54 |
| Part-time work | 1 | * | 1 |
| Unemployed | 3 | 7 | 5 |
| Education/Training | 7 | 6 | 7 |
| Homemaking | 39 | 1 | 20 |
| Retired | 5 | 14 | 9 |
| Other | 3 | 5 | 4 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| **Source**: Living in Ireland Survey (LIIS) 2001 | | | |

Appendix **Table A.3 Principal Economic Status By Gender of Carer and Weekly Hours of Unpaid Care Work** (N = Adults aged 15 and over)

| MARITAL STATUS | FEMALE CARERS (FEMALE POP.) | MALE CARERS (MALE POP.) | TOTAL CARERS (TOTAL POP.) |
|---|---|---|---|
| | **1-14 hrs** | | |
| Full-time work | 30 | 93 | 63 |
| Part-time work | - | 2 | - |
| Unemployed | 2 | - | 3 |
| Education/Training | 5 | - | 2 |
| Homemaking | 55 | - | 26 |
| Retired | 4 | 4 | 4 |
| Other | 4 | 1 | 2 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| | **15-28 hrs** | | |
| Full-time work | 53 | 80 | 68 |
| Part-time work | 2 | - | 1 |
| Unemployed | - | 9 | 5 |
| Education/Training | 2 | 1 | 2 |
| Homemaking | 38 | 1 | 17 |
| Retired | 1 | 3 | 2 |
| Other | 4 | 6 | 5 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| | **29-42 hrs** | | |
| Full-time work | 70 | 98 | 78 |
| Part-time work | - | - | - |
| Unemployed | 3 | 2 | 2 |
| Education/Training | 1 | - | - |
| Homemaking | 26 | - | 19 |
| Retired | - | - | 1 |
| Other | - | - | - |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| | **43-60** | | |
| Full-time work | 49 | 85 | 54 |
| Part-time work | 2 | - | 2 |
| Unemployed | - | 5 | - |
| Education/Training | - | - | - |
| Homemaking | 46 | 5 | 4 |
| Retired | 1 | 5 | 1 |
| Other | 2 | - | 2 |
| *TOTAL* | *100* | *100* | *100* |
| | **61+ hrs** | | |
| Full-time work | 30 | 56 | 31 |
| Part-time work | 1 | - | 1 |
| Unemployed | 2 | 17 | 3 |
| Education/Training | - | 5 | - |
| Homemaking | 65 | 5 | 62 |
| Retired | - | 11 | 1 |
| Other | 2 | 6 | 2 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |

**Source**: Living in Ireland Survey (LIIS) 2001

**Table A4 Percentage of Carers Who Perceive that the Care Work they do prevents them from undertaking either the amount or kind of paid work they would otherwise do by Principal Economic Status and Highest Level of Education completed** (Base: adults aged 16+ involved in care work who have completed formal education)

| | FEMALE CARERS (FEMALE POP.) | MALE CARERS (MALE POP.) | TOTAL CARERS (TOTAL POP.) |
|---|---|---|---|
| | **Less than 2nd Stage 2nd Level** | | |
| Full-time work | 22 | 2 | 13 |
| Part-time work | 75 | - | 75 |
| Unemployed | 25 | 6 | 5 |
| Education/Training | - | - | - |
| Homemaking | 49 | - | 49 |
| Retired | - | - | - |
| Other | 30 | 40 | 29 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| | **2nd Stage 2nd Level** | | |
| Full-time work | 22 | 10 | 17 |
| Part-time work | 33 | - | 33 |
| Unemployed | 67 | - | 50 |
| Education/Training | - | - | - |
| Homemaking | 63 | 100 | 63 |
| Retired | - | - | 25 |
| Other | 20 | - | 20 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| | **Recognised 3rd Level** | | |
| Full-time work | 33 | 8 | 20 |
| Part-time work | - | - | - |
| Unemployed | - | - | - |
| Education/Training | 33 | - | 33 |
| Homemaking | 81 | 100 | 83 |
| Retired | - | - | - |
| Other | 100 | - | 100 |
| *TOTAL* | *100 (100)* | *100 (100)* | *100 (100)* |
| | **All who have Completed Formal Education** | | |
| Full-time work | 23 | 7 | 16 |
| Part-time work | 50 | - | 50 |
| Unemployed | 42 | 5 | 17 |
| Education/Training | 17 | - | 11 |
| Homemaking | 55 | 100 | 56 |
| Retired | - | - | 7 |
| Other | 29 | 40 | 33 |
| *TOTAL* | *100* | *100* | *100* |
| | | | |

**Source**: LIIS, 2001

[i] It is evident that love and care are not synonymous with each other and indeed each of these can in turn be distinguished from solidarity. For a discussion on the differences between these three concepts, see Lynch, 2007

[ii] It is important to distinguish between emotional capital, and the related but separate phenomena of *nurturing capital.* While emotional capital (and the associated emotional work involved in love labouring and caring that produces it) is integral to nurturing capital, not all nurturing involves emotional work (and neither does all emotional work involve nurturing as Hochschild showed in her work, *The Managed Heart)*. Nurturing can involve the enactment of practical tasks with limited emotional engagement at a given moment. The doing of nurturing tasks is generally motivated by feelings of concern for others, however, the undertaking of the task itself may well be routinized at a given time and require low emotional engagement.

[iii] The classification of hours of caring in the Census is as follows: 1-14 hours a week; 15-28 hours a week; 29-42 hours a week; 43 or more hours a week (CSO, 2007: 63)

[iv] The failure to recognise the value of care as work is a serious economic and political issue in its own right and cannot be addressed in this short paper.

[v] There are two types of allowances for carers in Ireland, the Carer's Allowance and the Carer's Benefit. The Carer's Allowance is a payment made to people who are full-time carers of persons in need of constant care and attention; it is generally paid to a person who lives with the dependent person but it can also be paid to someone living nearby who is accessible 24/7 to the care recipient. The Carer's benefit is a payment made to insured persons who leave the workforce to care for a person(s) in need of full-time care.

[vi] ,In our Care Conversations study, women spoke to us about the 'How can I help you? mentality This was the questions men asked them in relation to child care and related work. The question itself assumes that the person who asks the question is doing the person who is being asked some kind of favour, that care is the primary responsibility of the woman and men are there to help if asked or if they offer (Lynch, Lyons, Baker et al., 2008)