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Tracing State Accountability for COVID-19: Representing Care within Ireland's Response to the Pandemic

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COVID-19 triggers urgent questions about the social, political and ethical implications of care markets, practices and relations. This article presents analysis of the Houses of the Oireachtas Special Committee on Covid-19 Response exposing current discourses about care in Ireland. Utilising the Trace analysis method (Sevenhuijsen, 2004), grounded in feminist care ethics, reveals a state accountability exercise grappling with the failures of the care market and the inhumanity of congregated settings. Care discourses were constrained by a focus on the formal health system, normalisation of binary care giver and care receiver categorisations and a lack of recognition of gendered inequalities of care in homes and workplaces. Public discourse and feminist analysis revealed unreasonable labour conditions for women working in health and social care and a silencing of the voices of those with care needs. The article contributes to a reconceptualisation of care in post-pandemic futures and urges societal co-responsibility for 'universal care'.

Keywords: COVID-19, care, care ethics, Trace analysis, Ireland

Introduction

The COVID-19 pandemic has triggered urgent questions about inequities of care as they are experienced by diverse groups in society and the social, political and ethical implications of current care infrastructures (Fine and Tronto, 2020). A range of commentators have shown how COVID-19 has amplified the unmet care needs of those identified as 'at risk' or 'vulnerable', while also revealing complex hierarchies of care 'deservingness' in state responses to diverse groups of care receivers (Gary and Berlinger, 2020; Gulland, 2020; Flores Morales and Farago, 2021). Meanwhile, evidence of persistent gendered and racialised burdens of care within 'locked down' households and in health care settings has highlighted the on-going devaluing and inequitable distribution of unpaid and paid care work (Gulland, 2020; Boulton *et al.*, 2021; Mohammed *et al.*, 2021). States have been evaluated for failings of health and social care systems with authors suggesting that strained pandemic responses are grounded in the legacy of neoliberal political and economic regimes (Greer *et al.*, 2020; Altiparmakis *et al.*, 2021; Gordon-Bouvier, 2021).

Drawing on the feminist ethics of care-inspired Trace methodology (Sevenhuijsen, 2004), this article aims to analyse how, if at all, care was represented and understood within the Irish state's assessment of the response to the first wave of the COVID-19 pandemic. The feminist ethics of care has been reasserted as a crucial perspective to interrogate challenges and opportunities presented by the renewed visibility and valuation of care in the context of COVID-19 (Chatzidakis *et al.*, 2020a, 2020b; Fine and Tronto, 2020). Theoretical grounding of care ethics emerged from feminist perspectives on care in the intimate domain (Noddings, 1984) and the rejection of expectations that women should be responsible

for enacting care at the expense of their own needs in order to be valued as a mother, wife or daughter (Pettersen, 2012). Care ethics asserts care as a practice and a disposition (Tronto, 1993) and as a value 'worthy of the kind of theoretical elaboration justice has received' (Held, 2006: 38). Care ethicists have revealed the innate dependence and interdependence within care relations at personal, institutional and societal levels (Kittay, 1999) and questioned the legitimacy of care arrangements dependent on 'privileged irresponsibility' (Tronto, 1993, 2013) which enables some individuals to excuse themselves from basic caring and places burdens on others.

Care ethics has also been proposed as a powerful challenge to neoliberal political agendas which promote both an individualising imperative in which care responsibilities are dislocated from the state on to individuals, families and communities (Barnes, 2012; Liveng, 2015), and the marketisation of care infrastructures evidenced in a range of processes, including the growth in private sector, for-profit, provision of care services (Cullen and Murphy, 2020; Ward *et al.*, 2020; Lynch, 2021). This 'commodification of care' exposes the devaluation of care as labour, resulting in precarious and low paid work with notable gendered effects (Lanoix, 2013; Lynch, 2021).

Analysis of how care has been represented and constructed in policy documents and political and public discourse during the pandemic can offer alternatives to the limits and deficiencies of care policy and practices, and foreground ways in which we might develop 'a politics that puts care front and centre' (Chatzidakis *et al.*, 2020a: 5). In order to explore current care discourses in Ireland, this article analyses one policy process, the Houses of the Oireachtas¹ Special Committee on Covid-19 Response. Our analysis explores what was understood to constitute care and spaces of care within the Committee's response; who was constructed as receiving and giving care and to what extent understandings of interdependence were visible; and how gendered analyses of care shaped the Committee's representation. Our analysis suggests that despite a small number of instances in which a more expansive notion of care as interrelatedness is acknowledged or where effects of 'market-mediated and commoditised care' (Chatzidakis *et al.*, 2020a: 10) are recognised, the Committee's discourse resorts to more narrow definitions of care. Moreover, its proposals to address care deficiencies remain firmly circumscribed within neoliberal, marketised systems of welfare and fail to take seriously the potential of care and care infrastructure as a public good. Following Cullen and Murphy (2020), we also identify little recognition of gendered burdens of care that intensified within the pandemic and utilise wider public critiques of the lack of gender sensitivity in Ireland's response to reveal silences in this regard. We suggest that a focus on 'universal care' (Chatzidakis *et al.*, 2020a) which implies that 'we are all jointly responsible for hands-on care work, as well as engaging with and caring about the flourishing of other people and the planet' (Chatzidakis *et al.*, 2020a: 96) may offer the potential to challenge these limited understandings of care and re-envision alternative care futures.

Interrogating the State response to COVID-19: the context of Ireland

Analysing the place of care within Ireland's response to the COVID-19 pandemic has to be situated within broader discussions about understandings of care and the development of care infrastructures within the State. Commentators have pointed to Ireland's 'pervasive undervaluing of care and poor care infrastructure' (Cullen and Murphy, 2020: 356) which can be attributed to both a conservative and gendered history in which care was constructed as a privatised activity of the patriarchal family, and the development of a residual, marketised welfare state in which initially charitable, non-profit institutions, and more recently, private sector entities, have become key care providers (Cullen, 2019; Flynn, 2022). Ireland has been described as a 'typical neoliberal state' based around low tax regimes, limited social expenditure and flexible labour markets (Mercille, 2018: 547). Successive centre-right, socially conservative governments have actively courted an agenda of care marketisation and have rejected calls for a publicly funded health and social care system (Mercille, 2018; see also Cullen and Murphy, 2020; Flynn, 2022) while

continuing to rely on unpaid women carers. This results in compounded gendered impacts: women are concentrated in low paid care work, fail to be adequately recompensed for informal care labour, and have limited access to the labour market through a lack of publicly funded child-care (Cullen and Murphy, 2020).

It is within this context that Ireland's experience of, and response to, the COVID-19 pandemic is situated. Ireland's encounter with COVID-19 began in early 2020 and in response, the government established a number of bodies to advise on the pandemic. The most influential of these was the National Public Health Emergency Team (NPHE) formed on 27 January 2020 to develop and implement strategies to contain the outbreak. On 12 March 2020, a day after the World Health Organisation characterised COVID-19 as a pandemic, the government first issued guidance that established the state's response during initial waves of the pandemic. Ireland has been classified as an early adopter, enacting the most stringent level of pandemic containment measures (Hale *et al.*, 2020, 2021). Inevitably, this led to public and political debate, including from feminist analysts who pointed to the disproportionate care burden which fell on women during initial lockdowns, the absence of women from senior leadership in public health decision-making, and the subsequent lack of awareness of the gendered effects of public health restrictions (Cullen and Murphy, 2020).

The Houses of the Oireachtas Special Committee on Covid-19 Response, on which our analysis is based, represents a specific process in which the Irish state sought to assess its response to the pandemic through the formation of a short-term parliamentary committee. Emerging from concerns about high rates of deaths in nursing homes and recognising a need for examination of the effects of stringent public health controls, the Committee was established on 6 May 2020 and was defined as 'the sole committee in the Houses of the Oireachtas at which the State's response [to COVID-19] could be held to account' (Houses of the Oireachtas, 2020: 8). Reflecting Ireland's consensus-style politics, the committee comprised nineteen parliamentarians, Teachta Dála (TDs), drawn from seven of the main political parties in the Oireachtas. Of these, eight were taken by members of the two traditionally dominant centre-right parties in Ireland who formed the coalition government of the time, with the remainder comprising a range of other parties, including the more left-leaning Labour and People Before Profit Party, and a number of independents.

The Committee's Terms of Reference identified the problem to be addressed as: 'examination of the State's response to Covid-19' and to 'consider and take evidence on the State's response to the Covid-19 pandemic' (Houses of the Oireachtas, 2020: 109). The Chair remarked that this was a 'broad mandate' (Houses of the Oireachtas, 2020: 8) and thus decisions were made about the problems that could feasibly be examined within five months: 'the priority focus of the Committee was of necessity on health-related matters, including the deaths in nursing homes, the adequacy of testing and contact tracing, the impact on health care workers and the impact on non-Covid health care provision' (Houses of the Oireachtas, 2020: 10). The Committee also considered problems related to the impact of the pandemic on society, sectors of the economy, and other basic services, such as education.

The Committee received over 275 submissions and held twenty-nine hearings attended by representatives to discuss submissions and be questioned by TDs. Reviews of submissions, transcripts and videos of hearings conducted for this analysis suggest that only few stakeholders, such as leaders of national representative organisations, were invited to hearings out of all those that lodged written submissions. For example, there were over thirty submissions concerned with people with disabilities but only three stakeholder groups were invited to a hearing. Other stakeholder groups, such as from the women's sector, were not invited to attend hearings. The Committee remarked that 'it did not prove feasible to meet many stakeholders that have been impacted by Covid-19' (Houses of the Oireachtas, 2020: 10).

The Committee's Final Report was issued in October 2020 and was debated in Dáil Éireann, the lower house of Parliament, on 19 November 2020. The Final Report is structured around a wide range of areas of concern, from impacts on healthcare related to COVID-19 and 'non-Covid-19

healthcare', through to education, restrictions on travel and re-opening the economy. The Committee issued eleven key recommendations and referred 120 matters to Sectoral Committees of the Houses of the Oireachtas for ongoing consideration and monitoring. We acknowledge therefore that the report reflects just one part of an on-going, and incomplete, political and policy process, in which government departments and other committees were to take up the Committee's recommendations.

Methodology

The research question for this analysis is: how is care represented in Ireland within the Houses of the Oireachtas Special Committee on Covid-19 Response? The data are analysed using the Trace method, an analytical approach developed by Sevenhuijsen (2004) for the purpose of utilising the perspective of the feminist ethics of care to analyse the discourses constructed within policy documents (see also Barnes, 2011; Bond-Taylor, 2017; Sihto, 2022). Trace is a compelling tool for evaluation of the State's response as it has the potential to identify findings which can 'further develop care into a political concept and to position care as a social and moral practice in notions of citizenship' (Sevenhuijsen, 2003: 1). Sevenhuijsen's approach seeks to uncover the normative paradigms and gender neutrality of care policy documents which lead to care being constructed and problematised in particular ways, but also asks us to reflect on alternative understandings that might be possible based on the 'counterfactual' of care ethics. The multi-step process to trace, evaluate, renew and compare how care is represented in selected texts is guided by posing 'a set of sensitizing questions' (Sevenhuijsen, 2004: 16). These include, amongst others, the context in which the text was produced; definitions of care utilised; reference to gendered dimensions of care; the perceived role of the state vis-à-vis care; and what 'leading values' are at work in the text, described by Sihto (2022: 197) as 'what is considered 'normal' or 'moral' behaviour in relation to care'.

Our Trace analysis began with the first author reading the Houses of the Oireachtas, Special Committee on Covid-19 Response, Final Report in full, to examine the context of the report's production (such as terms of reference of the group, membership, timing, purpose, audience and influence), before moving on to determine how the problem was framed, and assessing the leading values shaping the outlook in order to consider how these compared to care values.

It is important to note that the Special Committee report is not a policy document *solely* concerned with care, and thus as part of this initial phase of review, the first author sought to identify any instances where reference was made to care, whether in terms of services (healthcare or child-care, for example), specific individuals (carers or care recipients, for example) or indeed values. This led largely to text within key chapters on 'Congregated settings' and 'Non-Covid healthcare and capacity'. Having identified these initial inclusions from the Final Report, sections of text were re-read and discussed with the second author. From this point, the first author also investigated selected submissions and transcripts of hearings relevant to these key chapters, which were read as a way to deepen understanding of debates around care and interrogate how voices outside the Committee itself (from those representing non-governmental organisations, for example) had been incorporated into the Final Report.

Sevenhuijsen's (2004: 27) Trace approach also refers to recognising 'silent suppositions' in the text, asking us to consider what is not said about care and to reflect on how feminist care ethics might lead to alternative, renewed, understandings. As part of this, she advocates utilising 'alternative social knowledge' from public discourse to illuminate specific silences. Thus, in the context of the absence of gendered analysis within the Committee's work, we drew on a number of other sources, including webinars convened during the period that the Committee was operating, and subsequent op-eds, articles and reports, to provide feminist perspectives on the gendered impacts of COVID-19. Documents included in data analysed are listed in Table 1.

Table 1 Documents utilised in Trace analysis

Document	Author
Special Committee on Covid-19 Response, Final Report	Houses of the Oireachtas
Hearing - Congregated Settings 26 May 2020	Houses of the Oireachtas
Hearing - Disability Sector 17 July 2020	Houses of the Oireachtas
Dáil Debate on submission of the Report of the Special Committee on Covid-19 response - 19 November 2020	Houses of the Oireachtas
Submission (undated)	Care Alliance Ireland
Submission - 26 May 2020	Irish Refugee Council
Submission - 4 June 2020	Irish Human Rights and Equality Commission
Submissions - 29 June, 1 July 2020	Disability Federation of Ireland
Submission - 30 June 2020	Inclusion Ireland
Webinar: The Feminist Agenda and COVID-19 20 May 2020	National Women's Council Ireland
Webinar: Setting the Feminist Agenda for the Economy 28 May 2020	National Women's Council Ireland
Op ed - 3 February 2021	COVID Women's Voices

Findings: tracing the Oireachtas Special Committee on Covid-19 Response

In the next sections, we identify the core findings that emerge from our Trace analysis. It is evident that the Final Report embodies certain normalised assumptions about care as an activity, particularly in terms of where care takes place and who gives and receives care. Absent however is any articulation of what Sihto (2022: 196) refers to as care as an 'ethical orientation' or (political) value. In common with much political discourse during the pandemic in Ireland and beyond (see, for example, Flynn, 2022), the Final Report's foreword invokes a spirit of collective endeavour, solidarity and public responsibility, highlighting the 'individual and collective caution and sacrifice' (Houses of the Oireachtas, 2020: 7) made by members of the public; it also makes reference to the significance of wider societal relations and responsibilities, stating that 'We need to protect ourselves, protect our family, friends and neighbours, especially the many who are particularly vulnerable to this virus, and we need to protect our society and democracy' (Houses of the Oireachtas, 2020: 9). However, these calls for collective responsibility and protection also sit alongside divisions and absences in terms of care discourses, which we go on to explore in the next three sections. These are: a circumscribed understanding of care which is limited to health care and specific congregated settings; a reinforcement of categories of care receivers and givers, which draw on sometimes problematic understandings of 'vulnerability'; and a de-gendered understanding of the impacts of the pandemic on care responses.

Circumscribing care in the neoliberal state

While expansive definitions of 'universal care' (Chatzidakis *et al.*, 2020a) lead us to think about care practices, relations and values in a broad sense, our analysis suggests that the Committee's identification of care, and care discourse, was circumscribed and only partially elaborated. Care was predominantly discussed in relation to the formal healthcare system and spaces of care such as congregated settings (hospitals, nursing homes, and international protection accommodation for asylum seekers known as Direct Provision). The report briefly references the impact of societal

lockdown on maintenance of home care supports delivered by the Health Service Executive (HSE) (Ireland's national health service body). However, there was only minimal recognition of informal care that was taking place in the more private domain of the household, and this recognition was partial; for example, mention was made of older people and people with disabilities receiving informal care in the home, but there was little recognition of childcare taking place in these spaces.

Preoccupation with the need to safeguard the capacity of Ireland's health system and services, along with a focus on congregated sites of care, reflects the broader context in which Ireland's welfare infrastructures have emerged. The legacy of institutionalisation as it pertains to so many groups in Irish society (Dukelow and Considine, 2017) from older people to people with disabilities, and most recently asylum seekers housed in Direct Provision centres, is unspoken in the Report's discourse. However, congregated settings, framed both as spaces where those receiving care reside but also as spaces for care work, were acknowledged by the Commission as being less resilient to coping with the spread of SARS-CoV-2. Particular attention was given to nursing homes as a site of care failures; care in nursing homes was assessed as suffering due to 'systemic issues that led to poor outcomes for residents' (Houses of the Oireachtas, 2020: 14). The Committee acknowledged, however, that at that time it was unable to establish why deaths in nursing homes represented '56 per cent of all deaths in the State from Covid-19 . . . totally disproportionate for a group comprising of 0.65 per cent of the population' (Houses of the Oireachtas, 2020: 12); it subsequently called for the establishment of a public inquiry on nursing home deaths.

Despite the rather narrow understanding of care articulated by the Committee through its focus on the performance of formal health and social care systems, the acceptance of care failures and pressures initiated a re-evaluation of the marketised infrastructures shaping Ireland's health system. Ireland operates a strained two-tiered public/private health system which does not ensure broad equity of access (Dukelow and Considine, 2017; Edwards and Fernández, 2017). Around half of the population subscribes to private health insurance, with private provision often also taking place in public hospitals. As mentioned earlier, the private sector is dominant in the provision of nursing home care in Ireland (Mercille, 2018; see also Cullen, 2019) and the pandemic brought the problems with this market into sharp relief, leading to the state reckoning with its limits. The Committee critiqued the privatised model of care provision which has resulted in 'eighty per cent of residential care being in the private sector' (Houses of the Oireachtas, 2020: 13) and lamented changes in oversight from 'a State-controlled one to a slightly distanced one' (Houses of the Oireachtas, 2020: 34). It was suggested that the fragmented care market had contributed to poor communication between hospitals, and private sector nursing home providers, leading in some cases to the inappropriate and 'large scale discharge of patients from acute hospitals to nursing homes' (Houses of the Oireachtas, 2020: 12).

The Committee asserted that a new 'model of care' for older people was needed (Houses of the Oireachtas, 2020: 14) and issued policy recommendations which could encourage new models of provision, including supporting older people at home through a 'publicly funded and publicly provided model of care underpinned by community intervention teams from the HSE' (Houses of the Oireachtas, 2020: 14), and creating 'person-centred integrated systems of care which support people to stay in their own homes and receive care in the community where possible' (Houses of the Oireachtas, 2020: 63). Whilst such proposals may appear progressive and reflect the existing trajectory of policy in this area to a certain extent, they remain ill-defined. The principles of person-centred care, for example, were left unarticulated. Moreover, it is notable that little mention was made in the report of *Sláintecare*, an initiative proposed as far back as 2011 (Burke *et al.*, 2016) to introduce a new universal single-tier health and social care system in Ireland. For example, among the hearing transcripts analysed, no state interlocutors mentioned *Sláintecare* in their interventions. Meanwhile, the Committee's solutions to address care failures fall back on neoliberal modes of governing (Edwards and Fernández, 2017); these include greater surveillance of nursing homes by the quasi-governmental health regulator HIQA (Health

Information and Quality Authority), and the recommendation of a ‘proper framework relating to the number and skills capacity of health care workers in nursing homes’ (Houses of the Oireachtas, 2020: 14). These do not suggest radical care solutions, but rather increased governance and regulation of health and social care ‘at a distance’ (Edwards and Fernández, 2017).

Constructing care givers and receivers: discourses of vulnerability

Feminist care ethicists have drawn attention to the complex interrelations and interdependencies of care that exist between individuals and suggest we eschew binary descriptions of care givers and receivers. Care ethicists have highlighted that an individual can be both a caregiver and care-receiver, that both experience dependency, and have asserted that carers must be able to attend to their own needs in order to provide good care (Gilligan, 1982; Kittay, 1999; Barnes, 2005; Pettersen, 2012). Such a perspective recognises the universal human condition as one shaped by complex social relationships of interdependence rather than autonomous selfhood, and the ‘corporal vulnerability’ of human subjects (Gordon-Bouvier, 2021: 213). However, the Committee’s report reflects a continued delimiting of binary categorisations of care receivers and care givers and we suggest they assert problematic discourses of vulnerability which place boundaries around understandings of need. This has the potential to stigmatise groups deemed to be ‘exceptional’ in terms of their vulnerability, rather than seeing vulnerability as an ‘inherent and inevitable aspect of the human condition’ (Gordon-Bouvier, 2021: 215).

It is notable that in terms of *who* is referred to as requiring care, older people, people with disabilities and those living in congregated settings garnered particular focus. The Committee was particularly concerned with older residents of nursing homes, who were framed in the report as ‘the population who were unique in terms of frailty and vulnerability’ (Houses of the Oireachtas, 2020: 12). Such portrayals speak to notions of welfare deservingness and the need to protect particular groups from risk; it sets older people apart as ‘other’ in the context of neo-liberal ideals of autonomous selfhood and has the potential to reinforce paternalistic notions of dependency, whilst also hiding from view other groups with support needs. Indeed, as Brown (2012: 42) notes, while policy uses of vulnerability are often presented as a ‘well meaning’ way of identifying groups deemed worthy of support, the term can have ‘less benevolent effects related to bureaucratic condescension, selective systems of welfare, paternalism and social control’.

The effect of paternalism was particularly evident in the context of people with disabilities, who were described in the report as having been significantly affected by the suspension of home care and other services, with some choosing to limit personal assistance services coming into their homes in a bid to prevent infection. Yet disabled people’s narratives were presented in the report through the voices of care givers, with a significant emphasis on the challenges faced by family carers. For example, the Final Report states ‘the pandemic has led to greater pressure and anxiety on carers and families of individuals with a disability . . . families have had to cope with the effects of disruption to treatment and therapies and are dealing with challenging behaviours as a result’ (Houses of the Oireachtas, 2020: 68).

Suspension of care supports was framed as ‘creating full dependence on family members for those who are most vulnerable, resulting in significant impacts to health, well-being and mental health for some . . . as family members experience burn out’ (Houses of the Oireachtas, 2020: 68). While we do not wish to diminish these experiences, there is a danger that such narratives reinforce care giver and receiver binaries, emphasising burdens on family carers and stigmatising people with disabilities. Such conceptualisations demonstrate little movement towards a more considered view of caring relations offered by care ethics such as ‘nested dependencies’ (Kittay, 1999); nor do they represent the argumentation of disability rights advocates against being constructed as passive and dependent (Morris, 1995). Extending the Committee’s concerns about the fragility and unsustainability of family care, including linkages with formal care systems, more

broadly could result in thinking about new ways to support all those engaged in care giving and care receiving and disrupt care giver/receiver positionalities.

Understandings of vulnerability in the Committee's report were intertwined with institutionalised care contexts, with the Committee identifying that the State is 'over reliant on institutional care for our vulnerable population' (Houses of the Oireachtas, 2020: 14). These sites of care are also where we see discourses of vulnerability emerge in relation to care workers. The Committee sought to explore 'the impact on health care workers' (Houses of the Oireachtas, 2020: 10) as a 'priority focus', and the Report drew attention to the challenges faced by 'low paid vulnerable workers' which the Committee suggested fuelled COVID-19 transmission in institutionalised settings. Drawing attention to the precarious nature of care work, the Committee found 'workers felt compelled to attend for duty even though they were potential carriers of the virus due to the absence of income support if they reported sick'; thus, they were deemed to have 'posed a high risk of unwittingly transmitting the disease to residents' (Houses of the Oireachtas, 2020: 15). This marks a rather different understanding of vulnerability, connected less with discourses of protection and deservingness of care, and more with ideas of care workers as 'risky bodies' (Bennett, 2021) which needed to be managed insofar as they could become transmitters of disease.

Given the dominance of neoliberal discourses which shape care policy and practices in Ireland, it would have been easy for the Committee to revert to discourses of individualism and individual responsibility in the context of care workers. However, a number of TDs, mainly those from left-leaning political parties, drew attention to the need for further state intervention to support low paid workers. In a hearing, one TD from the People Before Profit party noted how the precarity of care workers' conditions undermined public health guidance as it was revealed that 'eighty per cent of workers in nursing homes . . . have absolutely no access to sick care provision or sick care leave. We had people forcing themselves to go into work' (Smith, 2020). Similarly, another Committee member asserted 'there is a deep flaw at the heart of our long-term care and it is how we treat the people who work there' (O'Dowd, 2020). We also see glimmers of an awareness which recognises the intersecting and overlapping identities of care giver and care receiver, with the Committee acknowledging that low paid nursing home and care workers included 'residents of direct provision centres and . . . migrant workers who, because of the low pay in the (nursing home) industry, were forced to cohabitate with fellow workers in over-crowded living conditions and thus also could not self-isolate' (Houses of the Oireachtas, 2020: 15). On the basis of these findings, the Committee issued the recommendation to 'make provision for statutory sick pay scheme to cater for low paid workers such as those in nursing homes' (Houses of the Oireachtas, 2020: 16). This recommendation, which resulted in the establishment of the *Sick Leave Act* (Government of Ireland, 2022), indicates the beginnings of a greater recognition of a renewed role for the state in intervening to create a 'caring infrastructure' (Chatzidakis *et al.*, 2020a: 65).

De-gendering care in the State response

Trace analysis helps identify that the Committee had a significant blind spot around the gendered impacts of the COVID-19 pandemic, and there was little recognition in the Committee's work of the gendered burden of care experienced amongst both unpaid care workers and those working in healthcare. This is perhaps not surprising given the persistence of gender inequality in Ireland with structural barriers including the continued reliance on a 'modified male breadwinner model', and a context in which supports for caring remain limited (Russell *et al.*, 2019: ix; see also Cullen and Murphy, 2017). Indicative of this was the total lack of provision of childcare in Ireland for working parents, even among health workers, during the pandemic (Hick and Murphy, 2020).

Indeed, the only mention of disproportionate gender burdens in the Final Report is drawn from a submission from the Irish Federation of University Teachers which outlined that in addition to 'maintaining caring responsibilities' at home, women working in higher education also provided

pastoral care for students and colleagues. These women workers asserted that this ‘aspect of gendered impacts is a reality which must be acknowledged and factored into the assessments of this crisis’ (Houses of the Oireachtas, 2020: 53). Remarkably, this is the only acknowledgement in the report of gendered imbalances of care within the pandemic and reflects an absence of gender-based analysis throughout the Committee’s work.

Trace involves drawing on ‘alternative social knowledge’ to inform how care could be represented in public and political discourse (Sevenhuijsen, 2004) in order to present policy alternatives to privatisation and gendered imbalances in care provision. Such evidence is essential to illustrate how the pandemic intensified gendered care burdens. This perspective was missing in the Committee’s work as it did not explicitly seek input from organisations representing women. The National Women’s Council of Ireland (NWC), whose request for invitation to a hearing had been refused, hosted a series of public webinars in order to explore the disproportionate impacts of COVID-19 on women (NWC, 2020). Utilising a care ethics perspective, a panellist on one of the webinars reflected on how the pandemic highlights our interdependence stating, ‘we do now recognize that those who take care of us, who give us care, who keep our lives going, that these people so often, so typically are in low paid, low status and very often precarious jobs . . . we have to put care, the recognition of the importance of care, whether that’s childcare, elder care, health care, social care . . . right at the centre of our social policy and our thinking . . . as we come out slowly and painfully from this pandemic’ (Smyth, 2020).

Gendered reflections on the experiences of health and social care workers were also conspicuously absent from the Final Report, despite women representing eighty per cent of healthcare workers in Ireland (Central Statistics Office, 2020). The COVID Women’s Voices campaign group described what women in health and social care in Ireland experienced since the emergence of the pandemic. They stressed that: women hold most of the care roles for older people and people with disabilities; underscored that women’s paid care work is precarious and has low monetary and social value; and argued that while women’s unpaid care work is undervalued the cost to individual carers is high. The campaign was acutely concerned with the State’s failure to provide childcare for the predominantly female health workforce who were ‘facing dual challenges in the workplace and at home, can only absorb so much of the societal and economic shocks of Covid-19 . . . can no longer take the strain of carrying the burden of providing essential medical services, in the absence of childcare, whilst supervising homeschooling and caring for vulnerable family members at home’ (COVID Women’s Voices, 2021).

Some feminists did try to utilise the COVID-19 crisis to press for the provision of publicly provided childcare. Cullen and Murphy (2020: 357) note, for example, how ‘nurses testified to using annual leave for childcare and or being separated from children for long periods to fulfil their work commitments safely’. Surprisingly, this testimony was not included in the Final Report, and it could have been a salient point within the Committee’s admission that a planned scheme to provide childcare in the homes of healthcare workers was not implemented. The Committee did not explore impacts of the lack of childcare on healthcare workers nor what this failure meant for the healthcare system. These are some of the compromised realities obscured by the media rhetoric about ‘heroic’ health care workers (Boulton *et al.*, 2021). If the Committee had foregrounded the voices of women health and care workers and sought the participation of the women’s sector, gendered burdens of care may have been uncovered and informed future care policy-making.

Applying Trace’s utilisation of alternative social knowledge provides insights into other gendered limitations of Ireland’s response to the pandemic. In addition to Cullen and Murphy’s (2020: 355) aforementioned critique which asserts that the Irish state enacted a ‘gender blind policy response’, analysis undertaken by the Sex, Gender and COVID-19 Project identified that Ireland had only a single policy that could be assessed as ‘gender sensitive’: the COVID-19 Vaccination Strategy and Implementation Plan (Global Health 5050, 2022). Policy areas where Ireland was considered ‘gender blind’ or to have no ‘gender responsive’ features include clinical guidelines, essential health services, protection of healthcare workers, public health messaging and

surveillance (Global Health 5050, 2022). The consequences of the Irish state remaining blind to gendered disparities could thwart its aspirations to reform health and social care.

Discussion and conclusions

The ‘avalanche’ of care needs exposed by the pandemic provides a vital context in which to re-evaluate and rethink concepts of care and inform research agendas (Daly, 2021). The feminist ethics of care-inspired Trace method has enabled us to explore the normative assumptions, limits and silences of the ways in which care was constructed within political and public debate emerging from the Special Committee on Covid-19 Response. Our analysis shows that the Committee justified their focus on the State’s response to health-related matters, to formal care services and settings, and to particular groups of care givers and receivers. There were few insights into care values within the evaluation of how health and social care systems performed in the face of an extraordinary public health crisis, and an underdeveloped understanding of how formal care networks intersect with informal ones. Lacking recognition of the interdependencies and complexities of care relations, inequitable care burdens enacted in privatised and gendered spaces of the home garnered little attention.

We suggest that feminist ethics of care perspectives can enable us to reassert care as a value that can be widely embraced, and which moves beyond understandings solely confined to clinical or other formal settings of care practices. The notion of ‘universal care’ encourages us to centre care in how we think about, and organise, our societies (Chatzidakis *et al.*, 2020a). It recognises the interdependencies and relationalities which shape how we live, and the multiple ways in which we all give and receive care, from our closest personal relationships to wider communities and networks. Crucially, care ethics also has a wider political imperative and raises questions about current neoliberal norms which emphasise individual and family responsibility for care. This emphasis ‘hides the fact that not everyone has societal sources to draw on’ (Sihto, 2022: 203), and stymies collective responses to care in a context of increased marketisation of welfare infrastructures (Chatzidakis *et al.*, 2020a).

It is clear that the Committee was in some way cognisant of these critiques, as they issued their own scathing assessment of the impacts of Ireland’s privatised, fragmented, nursing home sector, the inappropriateness of institutionalised care settings, and the consequences of low paid work. We therefore see glimpses of a recognition of the complex interconnectedness of human relations and policy issues foregrounded by feminist care ethicists. However, the Committee’s recommendations to address the problems within the care sector are far from radical, and only tinker with reforms by suggesting further governmental oversight and regulation (via HIQA inspections, for example) and the need for professional training and regulation of healthcare staff.

Our analysis therefore raises questions about how far the COVID-19 pandemic as a moment of crisis has disrupted or challenged neoliberal care trajectories (Cullen and Murphy, 2020). We do see some evidence of a ‘breaking’ from existing trajectories: by introducing short term welfare innovations such as the COVID-19 Pandemic Unemployment Payment (Hick and Murphy, 2020); the passage of the *Sick Leave Act* (Government of Ireland, 2022); and the government’s decision at the height of the pandemic in 2020 to temporarily take over nineteen private hospitals to provide health care to the public (Flynn, 2022; Mercille *et al.*, 2022). Yet whilst the latter development showed what might be possible in terms of a publicly funded, national health system, commentators have suggested that ‘the experiment is best interpreted as a lost opportunity to integrate and simplify Ireland’s hospital system’ (Mercille *et al.*, 2022: 232). It remains unclear how many of the Final Report’s recommendations which were destined to be addressed by other committees have been actioned. There is a danger, therefore, that the State persists within path dependency, particularly given continued economic uncertainty wrought by both COVID-19 and other emerging crises.

As an alternative, care ethics suggests avenues through which different models of collective societal responsibility for care might be developed. In practical terms, raising compensation of public and private sector care work and providing financial support for care provided in the home are ways in which ‘joint responsibility for hands on care work’ (Chatzidakis *et al.*, 2020a: 26) could be embraced. In the interests of developing what Tronto (2013) terms a ‘caring democracy’, bringing care to the centre of public and political debate is a key goal. We suggest that subsequent evaluations of the State’s response to COVID-19 or to persistent care crises must draw on perspectives from a broader group of those involved in caring relations. This includes enabling those who receive care to express what they need in their care experiences, but also amplifying the voices of diverse groups of women engaged in formal and informal care work. Cullen and Murphy (2020: 360) draw attention to the innovative ways in which feminist activists and alliances in Ireland were able to powerfully articulate and reframe key issues during the pandemic, including attempts to ‘frame care outside of market rationales’. We suggest that through activist reframing, deliberating with care (Barnes, 2008), and disrupting gendered norms of *who* cares, we may re-imagine a society that embraces joint responsibility for care within post-pandemic futures.

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Note

1 The Houses of the Oireachtas refer to the Irish Parliament.

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