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School of Applied Social Studies,
University College Cork,
Ireland

‘Can’t Care/Won’t Care’? An Investigation into the Feminisation of Care

Lisa Culloty, BSocSc

Abstract

There is significant representation of females in the informal care sector. This research considers the association between care and gender in Ireland, offering an insight into the complex networks of care relationships that support the informal care sector. Through qualitative analysis of primary and secondary sources, it argues that care systems encourage continuity of informal care with little recognition of women’s predominant role. The changing role of women in society and their increased labour force participation rate causes a divergence from traditional assumptions about women’s caring role. This shifting attitude reduces the number of carers available. A growing older population and a decreasing availability of younger carers could lead to a potential crisis in the informal sector. The research finds a consensus amongst participants that the state assumes that carers will continue to care, therefore the state does not develop supports for carers, and rather it reduces them. This research finds that both male and female interviewees emphasised that men were capable of caring although some made reference to women’s ‘inherent’ nurturing capabilities. It also suggests that men as carers should be acknowledged and valued alongside a goal of increasing their participation in the caring field.

Key words: Patriarchy; gender; informal care; subsidiarity; duty of care.

Introduction

‘In the broader vision of care as an activity’, Sevenhuijsen (1998:84) observes, ‘care is primarily seen as an ability and willingness to “see” and “hear” needs and to take responsibility for these needs being met’. This research investigates the role of caring in women’s lives and questions what has caused us as a society to presume women are ‘natural’ carers? Care, as a norm, is assumed to be the female’s role, and is something that is socially constructed as an obligation and an activity that should occur in the private sphere. In considering these positions, the historical development of care within Irish society is examined with a focus on how notions of care became associated with women. The role of the state and the Catholic Church is crucial; as Cousins (2005) notes, gender segregation was reinforced by a Catholic and conservative Irish state. This research also investigates Irish policy in relation to women and care, the development of legislation for carers, and how this has impacted or changed women’s role as carers.

Understanding the Feminisation of Care: The Key Concepts

To understand the idea of the feminisation of care it is necessary to investigate three interconnected concepts, namely, (1) caring as a concept, (2) the mixed economy of welfare and (3) the patriarchal family, which, collectively, continue to have an impact on women’s historical and contemporary position in Irish society.

Caring as a concept

Caring as a concept is broad and difficult to define. Care is something everybody needs at some point in their lives; as Holland (2010:72) states ‘care is not restricted to marginalised groups in society and that all of us are involved in care relationships’. Care occurs in a variety of social contexts. Sevenhuijsen (1998: vi) believed ‘care is important to everyone [and] most of us agree that adequate provision of care is a valuable social good’. Parton (2003:10) argues that ‘care work is usually devalued as a social activity [...] through its assumed connection with privacy, emotion and the needy’. Within this study it is evident that the issues of (1) devaluation of caring work and (2) the ‘private’ unseen nature of care are major issues. Two interlinked concepts of social constructivism and an ‘ethic of care’ are important in our understanding of care. Gilligan (1982) argues that the ethic of care was rooted in female morality. Social constructivism asserts the idea that if something occurs in a society enough it

becomes the norm and social conditioning in society creates an association between care and women. Clement (1996:43) argues social construction of identity is linked to the ethic of care 'when social construction of the self is interpreted to mean that one has an overriding obligation to preserve one's relationship, it undermines the carer's autonomy.' Social constructivism refers to societal norms and processes by which people define themselves. Therefore, a critical stance on conventional 'truth' must be taken (Parton, 2003).

Mixed Economy of Welfare

The mixed economy of welfare involves four key sectors whose respective roles have developed over a period of time and the relations and associations between the sectors have changed. O'Riain and O'Connell (2000: 32) characterise 'the evolution of the Irish state as one of delayed and interrupted development'. The implications of this individualistic approach to welfare resulted in 'dependant roles being ascribed to women in society [such that] the family was and continued to be the primary source of welfare for individuals' (Considine and Dukelow, 2009:86). After independence Ireland's welfare state expanded with developments such as the National Health Insurance Act 1929. Evidence of a gendered economy is clear in the Irish Constitution 1937 which ascribed a specific domestic, caring role for women and this is very clear in Article 41.2.1. in which it states that '...in particular the state recognises that by her life within the home women give to the state a support without which the common good cannot be achieved'. The mixed economy of welfare has implications for this study in relation to understanding the positioning of women previously in Irish economy and how this evolved.

Catholic Church

Many commentators such as Powell (1992), Fanning (2004 and 2006) and Considine and Dukelow (2009) highlight the strong influence of the Catholic Church in the provision of social services in Ireland. Subsidiarity was a key concept associated with Catholic teaching and it essentially meant the 'devolution of responsibility for welfare to the family' (Fanning, 2006:14). The implications of subsidiarity were significant on the family as this was seen as the primary source of welfare and the state was to assume a very residual role (Powell, 1992). The Church sought to create a tight hold over the family unit and much of its focus on authority and morality were worked

through attempts to control the family and women (Considine and Dukelow, 2009). As a result of this women's duties were limited to child-rearing and household duties in the private sphere.

Male Breadwinner Model

The pre-dominance of a male-breadwinner model was a feature of the Irish welfare state and was maintained through a system of patriarchy. Cook and McCashin (1997) found that the Irish welfare state was greatly influenced by the Beveridge Report and its male breadwinner model. Williams (1989) believed that the Beveridge model allowed for institutional inequalities in the treatment of women. According to Fanning (2006:15) 'The National Insurance Act 1911 established a social insurance system to insure that the male breadwinner could provide for the family'. The Minister for Industry and Commerce, Sean Lemass, exposed the male dominance in Irish society by stating 'we should regard the father as the head of the family and responsibility for the proper utilisation of income' (Considine and Dukelow, 2009:39). It was encouraged for women to adapt themselves to this bread-winner model through legislation with the marriage bar in place until 1973 resulting in women in civil servant positions had to give their job up once married. At the time in Ireland 'the dominant concepts of work tend to make women's contributions to both household and public production invisible'(Lynn and Todoroff 1995:24) . The Marriage Bar 1933, Juries Act 1927 and Conditions of Employment Act 1936 all discriminated against women with no supports for carers. Fanning (2006:15) supports this argument by stating 'Unpaid care work, mostly by women constitutes a significant element of the welfare state.' The fact the majority of work by women was invisible welfare this may of created perhaps an association between women and invisible care. That unpaid care work was the social norm thus issues of recognition, support and gender bias were not addressed.

The question now arises as to the situation in 21st century Ireland with regard to the patriarchal system and carer's role in society. Powell (1992:26) asserted that Ireland engaged in a process of modernisation in the 1960s and 1970s which 'was to turn the nation's attention to more secular concerns'. Women's participation in the workforce has increased; according to the CSO (1997) in 1971 married women accounted for 14% of the labour force and this figure increased to 41.1% in 1996. Kiely's (1995)

study found that 30.7% of women agreed housework should be shared equally though in reality few husbands shared the burden. While there has been an increase in women's participation in work the state had put little infrastructure in place to enable women to go work. Kennedy (2004:81) states 'childcare facilities are underdeveloped and there is no tax relief on childcare.' However progress has developed in this area with the Free Pre-School year. Women are still predominantly associated with care. Taylor-Gooby's (1991) observation that in Ireland the issue of care work and the unequal status of providers of care is still very prevalent retains relevance. The mixed economy of welfare implies interdependence between the sectors in the delivery of welfare services but questions arise about a number of issues of care such as the assumed role of the women as providers of care and lack of a rights-base for carers.

Irish Policy Development in relation to Women and Care

In Ireland legislation relating to women and carers was based on a male breadwinner model which made assumptions about care. Successive pieces of legislation have reinforced this patriarchal system and this is why women are still assumed to be carers and little value is placed on caring. The data used in this research is drawn from both statutory and non- statutory sources.

The 1970's were viewed as the high point in the expansion of welfare states (Cousins, 2003). Payments such as Deserted Wives Allowance 1970 and Prisoner's Wives Allowance 1974 were made available to women however it can be argued that they only reinforced the dependency role assigned to women by the Constitution. Lewis (1997:170) believes that '...historically women achieved welfare entitlements on the basis of their own dependency status...' Despite the welfare developments there was little or no recognition of the informal sector which arguably delivered far more care than the formal sector. By 1990 Irish legislation had been modernised due to E.U policies in Ireland on equality and this had indirect consequences in terms of rights for carers. Currently in Ireland there is no strategy completely directed at supporting and addressing carers needs alone. Attempts were made at delivering a National Carers Strategy under the National Partnership Agreement Towards 2016. According to Social Justice Ireland (2006) the Agreement was intended to deliver a national strategy on caring and carers which focused on an infrastructure for carers needs. The decision was made by Fianna Fail not to proceed with the strategy as a

result of a lack of resources and funding. Commentators such as The Citizens Information Board (2002) argue that the Carers Allowance is mainly aimed at carers on low incomes who live with individuals who require full time care. A carers benefit was introduced in 2000 and was aimed at supporting employees who have paid adequate social insurance but who have left their employment to care for an individual (Carers Association, 2009). According to National Economic and Social Council (2005) carers allowance beneficiaries were 38,931 and their share of total assistance was 5.0. In comparison to disability allowance whose total share came to 10.8 and the old age pension came to a share of 13.9.

The Equality Authority 2005, The National Action Plan for Social Inclusion 2007-2016, The National Development Plan 2007-2013 and the Nursing Home Support Scheme (2008) are all policy documents that make reference to carers. However there is no comprehensive evaluation of other issues posed to carers such as the presumption of carers as females or men's non-traditional role as carers. Non-statutory organisations such as The Citizens Information Board (2002), Care Alliance Ireland (2010) and The National Women's Council of Ireland (2002) found issues in caring including lack of recognition and rights base for carers. In relation to women in caring the lifelong impact of caring was investigated in terms of state entitlements. Caring has a substantial impact on women's entitlements as 80% of men are entitled to a state pension compared to 60% of women as people excluded from the labour market due to caring are also excluded from the social insurance system. In 2000 there were 16,500 people receiving carers allowance with 80% of them women (Department of Social, Community and Family Affairs, 2001).

Methodology

In completing primary research, qualitative semi-structured interviews were used as the primary data collection method. Thirteen questions were undertaken in total, which aimed to investigate the interviewees' opinions and experiences on the issue of the feminisation of care. This approach was adopted to attempt to obtain a primary understanding of the realities of caring for both women and men. A dictaphone was used to record the interviews for accuracy of data collection and transcription of data. The process of contacting and arranging the interviews was completed in a space of a

month with the aid of a key contact that the researcher knew as a carer. The aim was to obtain an interview from four data subjects, two female carers and two male carers.

Consent and Confidentiality

Any caring role requires a close connection between the carer themselves and the person they care for. Therefore asking questions about a person's caring experience can sometimes be quite personal for that individual and disclosing information to a relative stranger can seem quite daunting. With this in mind any questions used were quite general and not specific to that one interviewee. None of the questions were extremely personal or related to the individual being cared for. It was up to each interviewee how much information they wanted to disclose. Some disclosures made during the interview could be quite personal and intimate and thus to insure anonymity there was no usage of identifying features in any transcripts, notes and recordings.

Limitations to data set and resulting analysis

The sample of carers was taken from the southern region of Ireland alone. For a more varied and comprehensive results interviews from different parts of the country would have been taken. While this researcher aims to be as objective as possible due to the fact the researcher is female this could impact on research as it is a feminist analysis. The researcher's assumptions about men and women are influenced by her own familial, social and cultural upbringing and these prejudices are deeply engrained and thus not so easily identified.

Primary Data

In analysing the interview process undertaken a number of themes were used to identify similarities, differences and patterns. The four themes include motivation, personal/emotional impact of caring, economic impact, gender issue and social value accorded to care.

Biographies of Carers:

- *Interview 1* (9/01/2012): Sandra (pseudonym) is in her late fifties and was a full time carer in her own home for a period of ten years caring for her own mother who had suffered a stroke. Her caring role for her mother ended four

years ago and she then took on a caring position with the Irish Wheelchair Association and is currently still occupying this position.

- *Interview 2* (21/01/2012): Alan (pseudonym) is in his late sixties and has been a full time carer for sixteen years beginning in 1996. His caring role has revolved around caring for his wife Evelyn who suffered a stroke that severely impacted on her mobility and ability to function as an independent person. Ted has been Evelyn's sole carer since she became ill and cares for her in their family home.
- *Interview 3* (21/02/2012): Stephen (pseudonym) is in his late fifties and is a full time carer for his wife Aileen since they were married thirteen years ago. Aileen suffers from diabetes before they were married and contracted MS nine years ago. The caring work undertaken by Stephen became more intense when Aileen was diagnosed with MS. Two years ago Aileen fell and broke her hip resulting in her ability to care for herself being restricted again. Living in the house also is Aileen's uncle who is ninety and only recently he has become sick and Stephen has taken on a caring role for him also although to a lesser degree.
- *Interview 4*(26/01/2012): Andrea (pseudonym) is in her early fifties and is a full time carer for her own mother, who is eighty five and a first cousin, a male who is seventy six. Her mother requires assistance in completing everyday tasks due to her old age and Andrea has cared for her for five years. Her first cousin has senile dementia and she has also cared for him for five years.

The interviews were very informative as they went beyond the theoretical and showed the everyday realities of caring. There was definitely a reoccurrence of some of the issues in care as identified by the researcher in the literature and policy review in the interview process.

Duty and Gender

In the literature review it was clear social institutions, such as the church, assigned roles to women as nurturers and housewives. Stephen, Andrea and Sandra all mention the assumption of women as carers and even though their view is that women

do not have a duty to care they reflect the social ethos of their upbringing. Both Stephen and Alan felt it was the norm for women to care but today their view has changed. This could be due in part to a changing Irish society or their caring role has impacted their view. Stephen mentions societal expectations and caring when stating 'It seemed to be the norm that women do the caring.' However he does go on to assert that 'I know some men who are amazing you know if not better than some women, it's down to the individual itself too'. However Stephen made the interesting observation that he knew people who were diagnosed with MS and it was mainly husbands than wives who then left them, 'It's a choice but I know people who were diagnosed with MS and the husband went off, he could not cope with it and wives too but it was mainly the men that left rather than the women but there was the odd woman who could not hack it either'. Alan did not believe it was female responsibility to care and that the situation is important as he became a carer because he had to, similar to other women. While Sandra makes reference to the strong female participation in caring she emphasises that caring should not be based on gender but it is based on the individual as she states 'I think it is like any other job or profession like a teacher you have to be a certain type of person'.

All interviewees made reference to the maternal instincts of females in relation to caring. Sandra believes that women may be in some ways better carers due to their maternal instincts, 'Yes I suppose women are maternal really, I suppose biologically and in the case of children with disabilities a mother will have a motherly instinct to look after and nurture the child'. Andrea strongly asserted the point that women in some ways are more suitable for caring, especially evident when she stated that 'Now men can do a certain amount, they'll do basic things and there is other things that need to be seen to that are not done'. She was of the opinion men did not realise the smaller things like cleaning, washing and intimate jobs such as sponging and moisturising a person.

All interviewees felt they had a duty of care to the persons they cared for as if they were not in position to care who would? Alan strongly asserted that the state is now in such a bad economic situation and will target cuts at carers as 'They know that people caring are not going to suddenly say "I'm not going to do it anymore"'.

Carers Allowance/Recognition/Health Impact

All the carers interviewed were in the 55-64 age category and all were full time carers. This supports the finding in the policy review that the highest number of hours are provided by the 55-64 age category (Census, 2006). Sandra felt that legislation developed for carers was not adequate for their needs as found in the policy review that a lack of policy directly created for carers does not exist. The Equality Authority (2005) believed issues of recognition and financial supports are prominent for carers. Every interviewee mentioned a feeling of not been recognised by society and the state. Also while they acknowledge that the carers allowance is valuable support it is insufficient and does not adequately reflect the value of care work. Interviewees also stressed the emotional and physical impact of caring and this has been proven in other research. Edwards (2008:1) stated that 'Caring for a person with a disability can have a considerable psychological and physical impact'. The Carers Association (2009) estimate in Cork city alone 114,745 hours of care work are provided each week and valued at €13 per hour this amounts to over €77.5 million per annum. Andrea and Alan make reference to this point that their work saves the government money.

What do the findings tell us?

The findings from this research show an in-depth picture of caring and its issues. Women still occupy a huge role in the caring spectrum and while it is acknowledged to a certain degree at a policy level there is no more discussion of the issue. Instead problems such as recognition, poor financial and physical/emotional support for carers are continually being mentioned by organisations such as the Carers Association as policy issues to be tackled. It appears until these immediate problems are addressed as well as the demographic issue where the need for carers will exceed the carers available that the wider issue of a gender bias in caring will then be seen as a policy priority too.

These findings have a number of implications for policy. There needs to be comprehensive legislation developed for carers and their needs. This legislation can provide a rights base for carers and make the issues they suffer from daily known to the whole country. There should be targets set to address these issues and a more extensive recognition of care and its association with females. Support for carers needs such as counselling and support groups to share insight and expertise is

required. There needs to be an acknowledgment of carers and their huge contribution to society by the state and the wider population. Also individual caring experiences need to be understood in a wider context as well. A greater awareness of entitlements and need to address isolation should become targets to be addressed. The demographic problem of an increasing aging population and decreasing carer's population will mean in the future that care will have to become a policy priority due to the huge amount of people with no carer to meet their needs. A strategy should be developed now by the state to make steps towards preventing this demographic problem from occurring rather than allowing it to reach crisis point. This strategy could include methods to encourage male participation in caring so as to widen the carer's base available.

Ireland's caring model is very precarious and this is not adequate for carers or people being cared for. There should be a package of care provided by the carer, the HSE/private company and community organisation. The current care model of care in the home or an institution is not working and creates an aging caring population caring for the elderly too which is not appropriate. There are assumptions by the state about caring and an exploitation of the loyalty of carers as Ted (interviewee) stated that they know carers suddenly won't stop caring. There needs to be more of an emphasis by the state on subsidiary and citizenship due to the deteriorated economic situation where carers will require financial/personal support from both the state and their community. Therefore more people unable to afford residential care for their loved ones will have to begin care in the home and face the same issues as the interviewees have.

Social values have changed where women have increased participation in labour and decreasing the number of children they are having. Sociological changes in social values have occurred as society has become more secular and Durkheim's (1986) traditional society based on duty, obligation and organic solidarity fades away. There is formal division between generations now which did not exist in the past as caring is occurring in a more fragmented world. This has an implication for caring as its primary source of carers, women, are no longer prepared to become carers due to the changing nature of society and women's role in it. Therefore there needs to be a challenge of the assumption that all males are unable to care and that it is exclusively

a female role. Even though there is a feminisation of care men are carers too as seen in the interviews. Perception of care as female orientated is socially constructed and the fact people are not used to seeing carers as male is due in part to socially constructed roles. There is a socialisation of what we should think the gender of a role should be. Having male carers will help create an association that care is not exclusively a female role and assumptions may be challenged.

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