<table>
<thead>
<tr>
<th>Title</th>
<th>Inequalities of Love and Care and their Theoretical Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authors(s)</td>
<td>Baker, John; Lynch, Kathleen</td>
</tr>
<tr>
<td>Publication date</td>
<td>2012-08</td>
</tr>
<tr>
<td>Series</td>
<td>Social Justice Series; Vol. 12, No 1</td>
</tr>
<tr>
<td>Publisher</td>
<td>University College Dublin. School of Social Justice</td>
</tr>
<tr>
<td>Item record/more information</td>
<td><a href="http://hdl.handle.net/10197/3823">http://hdl.handle.net/10197/3823</a></td>
</tr>
</tbody>
</table>
In this paper we use the framework developed in *Equality: From Theory to Action* to review some recent empirical research into caring relationships. This research shows that even within the context of care, inequality is multidimensional. It reveals complex patterns of inequality of work, resources, love and care, power and respect and recognition, shaped by many social factors including gender, social class, family status and disability. We also argue that this research raises important issues for normative political theory. In some cases the implications seem fairly straightforward. In others, it highlights questions that egalitarian theorists need to address more thoroughly.

**Key words**
Equality, Inequality, Affective Equality, Equality of Condition, Love, Care, Social justice, Egalitarianism, Egalitarian Theory, Gender, Social Class, Family Status, Disability

---


---

**Abstract**

In this paper we use the framework developed in *Equality: From Theory to Action* to review some recent empirical research into caring relationships. This research shows that even within the context of care, inequality is multidimensional. It reveals complex patterns of inequality of work, resources, love and care, power and respect and recognition, shaped by many social factors including gender, social class, family status and disability. We also argue that this research raises important issues for normative political theory. In some cases the implications seem fairly straightforward. In others, it highlights questions that egalitarian theorists need to address more thoroughly.

**Key words**
Equality, Inequality, Affective Equality, Equality of Condition, Love, Care, Social justice, Egalitarianism, Egalitarian Theory, Gender, Social Class, Family Status, Disability
Introduction

The affective system can be defined as that domain of social relationships that is concerned with providing and sustaining relationships of love, care and solidarity. Like other social systems, it contains many types of inequality. And as in the case of other social systems, radical egalitarians – those who promote the ideal of equality of condition – should be aiming to eliminate these inequalities or at least to radically reduce them. In this paper, we summarise a set of studies that analyse inequalities within the affective system, and draw out the implications of these studies for normative egalitarian theory.\(^a\) We argue that the studies confirm the case for a multidimensional framework for normative and empirical analysis and that they throw light on a number of broader questions for political theorists.

Background

Equality Studies is an interdisciplinary field of studies that considers patterns of inequality and their causes, ideals of equality, the institutional and policy changes necessary for promoting equality, and political strategies available for achieving these changes. In *Equality: From Theory to Action* (Baker et. al. 2009; hereafter *Equality*), we develop a theoretical framework that is applied to a number of issues of equality and inequality. The central components of that framework are important for understanding inequality in the affective system.

The first component of that framework is what we call five dimensions of equality. These are (1) respect and recognition, (2) resources, (3) love, care and solidarity, (4) power, and (5) working and learning. We argue that these dimensions, though themselves complex, are sufficiently distinct to constitute different but

---

\(^a\) This paper is based on Lynch et. al. 2009, where the studies are set out in much more detail. We are grateful to all of the authors for their permission to make use of their work here. An earlier version of this paper was presented to a Priority in Practice conference in 2009.
related ways that people can stand in relations of equality or inequality. We note that although mainstream political theory has had a lot to say about respect and recognition, about the distribution of resources, about power relations and about some aspects of working and learning – largely under the heading of equal opportunity – the concerns with love, care and solidarity raised by feminist political philosophers have at best been treated as peripheral and have often been posed as issues about care versus justice rather than as attempts to incorporate issues of care within theories of justice. We emphasise that inequalities in all five dimensions are often structured around such major social divisions as class, gender, ethnicity, disability and sexual orientation.

The second component of the framework distinguishes between four contexts of equality. We call these the economic, political, cultural and affective systems. The distinction between the economic, political and cultural systems is in one form or another a long-standing one in sociological analysis. We maintain that the affective system is a fourth, equally important social system that has been the focus of a considerable body of feminist research but has not been mainstreamed in sociological analysis. We characterise it as the system concerned with providing and sustaining relationships of love, care and solidarity. There is therefore an important connection between love, care and solidarity as a dimension of equality and the affective system as a context of equality. But like other social systems, the affective system contains inequalities in all five of the dimensions highlighted.

The discussion in Equality leaves plenty of scope for further thinking about the dimension of love, care and solidarity and for further empirical research into how inequality operates within the affective system. At the core of this paper are the results of recent research into this area. One major empirical study, led by Kathleen Lynch and Maureen Lyons, consisted in a study of love and care in twenty-one
households, involving thirty ‘Care Conversations’ with carers and care recipients, together with two focus groups with teenagers. The households were chosen for their diversity, and included ten involving the care of children and eleven involving the care of adults with high care needs. Three complementary studies, by Maeve O’Brien, Niall Hanlon and Maggie Feeley, were concerned, respectively, with mothers’ emotional work in education, men’s perceptions of masculinity and caring, and the relationship between care and literacy learning among people who had spent their childhoods in institutional care. All of this work focused on what may be called primary care relationships, namely relations of love and care for intimate others, and therefore looked in detail at the ‘love labour’ involved in such relationships. This paper summarises some of the results of these studies using the five-dimensional framework and analyses their implications for egalitarian political theory.

Inequalities in primary care relationships

Inequalities in the work of love and caring

The most salient inequality brought out by these studies was the gendered division of labour and the consequent inequality between women and men in the dimension of working and learning. It is well-established internationally that women do most paid care work as well as most unpaid care and love work (Bittman 2004; Lynch and Lyons 2008). The studies discussed here confirm those of other feminist scholars, namely that women are the default providers of unpaid family-based love and care unless there is no suitable woman available (Gerstel and Gallagher 2001; Noonan et al. 2007). Even where couples actively attempted to parent on an equal basis, the persistence of the gendered attitudes of others (including family, friends and

\[ b \] For the distinction between primary, secondary and tertiary care, see Lynch et. al. 2009, ch. 2.
childminders) made it virtually impossible to put this into practice (Lynch et al. 2009, ch. 5). Because primary care work is indispensable, and because women are not only socialised to do it, believing it to be in their nature, but morally sanctioned for failing to provide it (O’Brien 2007, 2009), the affective system plays a major role in generating gender inequality in society more generally. This finding supports the hypothesis in *Equality* that the affective system needs to be problematised if equality of condition is to be achieved, especially between women and men.

To understand why women are the default providers of love and care in society, one must also understand men, and especially men’s relationship to care giving. Both the Care Conversations study and Hanlon’s (2009) research show that care giving is culturally encoded as feminine and therefore an activity that most men actively avoid (cf. Russell 2007; Simpson 2004). None of the heterosexual men who were fathers and living with partners saw themselves (or were seen by their partners) as the primary carers of their children. The men who were primary carers of parents had only taken on this responsibility because of their marital and family status (all were single sons living with a parent) and their specific economic circumstances: two were small farmers who had inherited their farms and were thereby able to combine care with some paid work, while the third held another legitimating public status (disability arising from previous employment). While Hanlon (2009) found that some understandings of care giving are accepted as masculine activities (notably by construing breadwinning as a type of caring), this conception of caring only reinforced hegemonic conceptions of masculinity, as it was premised on the assumption that women (and children) are dependent on men. The irony of men’s avoidance of primary care is that they are less likely to have opportunities to engage in the more emotionally involved aspects and forms of caring relationships. So
although they are advantaged in status, power and income by defining themselves as breadwinning carers, they may end up receiving less care than women.

Although the studies confirm the gendered order of caring, they also provide some resources for resistance to that order. On the one hand, although both women and men sometimes subscribed to the naturalness of gender roles, there was also a dissatisfaction and resistance on the part of women to their unequal care work burden (Lynch et. al. 2009, ch. 5): the gendered order was not accepted without question. On the other hand, there was evidence of a genuine commitment among some men to take caring seriously (ibid. chs 5 and 9). Men whose circumstances had placed them in caring positions exhibited a capacity to care and an orientation towards care that was similar to that of women in their sense of emotional attachment and moral obligation (ibid. chs 3, 5, 6), and they experienced the same obstacles of lack of recognition, lack of material support and lack of time (ibid. chs 4 and 7). The studies therefore support the claim that the gendered order of care is not inevitable.

**Inequalities in receiving care**

The Care Conversations study showed that within families, love is an assumed food on the table of emotional life. The young teenagers who participated in focus groups took the care and attention of their parents as a given (ibid. ch. 6). It was something that was assumed and was not the subject of discussion or debate; it was deemed to be natural and inevitable. By contrast, Feeley’s (2009) interviews with adults who had been confined in industrial schools, and who had been neglected or abused in care, showed that neither love, care nor solidarity can be taken for granted. Her research with survivors of institutional abuse showed how they had experienced inequalities not just of primary care, but also care at other levels, due to neglect by
guardians, teachers and the state. The state had defined them in their childhood as only needing the most basic forms of protection (and had even failed in that); they inherited the morally suspect identities attributed to their parents and with them a profound lack of love, care and solidarity. Their neglect in love and care terms had had a huge impact; most had left institutional care with a profound sense of emotional neglect, a neglect which seriously impeded their literacy learning. As those consigned to industrial schools were predominantly of working class origin, the severe inequality of love and care between these children and their counterparts in families was strongly related to social class.

Although care is often viewed as an asymmetrical relationship between a care giver and a care recipient, it is almost always also a relationship of interdependency, mutuality and trust (Hansen 2004; Strazdins and Broom 2004). For this reason, we cannot draw a neat dichotomy between care givers and care recipients. No matter how limited the reciprocity may be, care relations run both ways, even if this consists in giving or withholding a nod or a hand to show appreciation on the part of a vulnerable care recipient. Where care is given within families or defined communities, care relations persist over protracted periods of time, and a generalized reciprocity may occur inter-generationally rather than between particular pairs of care givers and recipients. In the Care Conversations, a widow spoke affectionately about the value of the company of her intellectually disabled son, for whom she was the primary carer, while another mother spoke about how she enjoyed the company of the thirteen year old son for whom she was the sole carer. An autistic daughter spoke about her love for her mother, who reciprocated, talking about how much she enjoyed her daughter, even though she also found caring for her very demanding. A son conversed at length about the fun he had at times with his infirm father and the satisfaction he got from caring for him so well (ibid. ch. 6). All
of these examples show that even in families with high levels of dependency there may be less inequality in the receipt of love and care than is sometimes assumed.

**Inequalities of resources**

A third dimension of inequality in the affective system is that of resources. Within this social system economic resources play an important role, but other types of resource, including social, cultural and emotional capital and free time, are also significant. From the Care Conversations it was evident that those who were well-educated and had relatively high and secure incomes had choices about how they organised their care world (cf. Folbre 2006). They could not only pay for supplementary care for their children, but also had the resources to call on supportive family care as needed. Low income carers and lone carers, be they caring for children or adult dependants, were heavily burdened in care terms, especially in the absence of affordable and accessible care-support services. While couple households could and did share care responsibilities, if often unequally, no such option existed for sole carers. Sole carers of children with few economic resources had little independence; they experienced social isolation, stress, lack of leisure and general exhaustion. Unpaid family carers of adults were especially burdened by caring if they had low incomes and little support (Lynch et. al. 2009, chs 5 and 7). The demands of caring were exacerbated by a lack of hope of an independent future, and the challenge of living within an uncertain time frame.

O’Brien’s (2009) study showed how a lack of resources, including economic, cultural and social capital, all impacted negatively on the ability of mothers to care for their children in the way that they would choose to do. For example, lack of economic capital precluded one mother from making any choices about the schools her four children attended, while in another’s case it led to constant anxieties about
unforeseen costs for schooling. In the Care Conversations (ibid. ch. 5), a son found the hidden costs of caring for his father very burdensome, while a mother was physically and mentally exhausted from undertaking her multiple care responsibilities on a very limited budget. The lack of economic capital also had indirect costs in terms of the emotional resources required to do love labouring. O’Brien found that mothers’ emotional capital – their emotional skills, energy and resources – was depleted through having to manage a deficit of economic capital. In this context, even those with cultural capital were unable to activate this capital in the interests of their children, because they lacked social or economic capital.

Both the Care Conversations and O’Brien’s study show that the experience of one parent carers is especially challenging (cf. Oliker 2000). Not only was the cost of child care premised on the assumption that it is funded from a double-income household budget, but lone parents also had to manage the emotional and social isolation that was part of being a lone parent family and is an important aspect of emotional capital. Emotional energy was also expended in managing the stigma that was often part of the single parent experience. Being poor and a lone parent confounded one’s difficulties, as a lack of economic resources meant one was tied to caring mentally and emotionally, if not physically, all of the time. The one parent families with young children had not availed of paid child care as they could not afford it.

While lone parents with young children struggled to manage care and paid work, or care and welfare, or paid work, care and education, they saw this as a clearly defined phase of life no matter how arduous. Carers of dependent adults did not hold this view. They could see no definite end to their caring lives, lives that were often seriously constrained by lack of supports and services for those on low income. Caring for adult dependants, without adequate respite and care-support services, was
seen as arduous and stressful. Carers outlined the constraints it imposed on them in terms of their health, income, sleep, leisure and quality of life generally, findings which concur with those of similar studies (Bittman 2004).

Another resource inequality that the Care Conversations brought out very clearly was inequality of time (Lynch et. al. 2009, ch. 7). Time stress was an issue that affected all carers. They were pressed for time, always rushing, running and chasing time. This severely limited the time they had for themselves and in several cases compromised their health and emotional well-being. However, the gender, class and family status differences that structure inequalities of care work, and the levels of economic resources and emotional capital available, also structure inequalities of time. Women were likely to be time-poor, whether they were engaged in full-time care or combining paid work with caring. This contrasted with evidence, in both two-parent households and wider family networks, that men had more free time. In families that were better off financially, time was more easily managed, by buying in domestic services. For obvious reasons, time pressure was also worse for lone carers than for households with two carers.

**Inequalities of power**

Because men are culturally defined as care commanders and women as care’s footsoldiers, men exercise a silent power over women in relation to the day-to-day work involved in primary caring (ibid. ch. 7). In the Care Conversations, primary caring was defined by most men and women as essentially women’s work, and only a small number contested this binary code (ibid. ch. 5). As a result, men exercised an implicit power over women’s caring and loving capabilities and over the time they devoted to loving and caring – not through personal command, but through the power of the moral imperative on women to be primary carers, and the
complementary masculine imperative that men only do primary caring when women are not available.

Within caring relationships, relations of power are more complex. While the carer does exercise power over the care recipient, an issue emphasised by disability researchers, it is a power that is tempered by cultural mores and conventions and by the survival needs of dependants. Care is not always given on the carer’s terms, not least because of the power of the care recipient to refuse certain forms of care and because of the cultural norms that operate in relation to care. People who are very vulnerable due to illness or infirmity can show appreciation for care or fail to show it; they can call on culturally available moral imperatives to enforce their care expectations, especially in relation to women (Bubeck 1995; O’Brien 2007). This was very evident in cases where aging mothers made it clear to their daughters that they did not want to go into a nursing home. Another mother, who was in her 70s and needed some care support, also spoke about how she pressed her daughter into caring for her when she was ill. Although she felt guilty about it, she could not help making demands at the time as her fear of leaving her own home and entering nursing home care was so great.

The imperative to care is not just culturally defined, it also arises from the deep dependency that characterises relationships between the carer and the very vulnerable; the command to care arises from having to provide for basic needs. The profoundness of the vulnerability of an intimate other calls forth a level of attention that may not be desired by the carer. Moreover, the failure to meet the survival and elementary care needs of vulnerable dependants is highly visible and this visibility exposes carers to wider social sanctions. So while vulnerability can and does allow for
the carer to exercise power over the care recipient, it also enables care recipients to
exercise some unspoken power over their carers.

**Inequalities of respect and recognition**

The studies found two very different evaluations of caring, one in the public sphere
and the other in the personal domain. In policy-making, employment and formal
politics, carers and care recipients are not highly valued except at a rhetorical level.
Most of those who engaged in Care Conversations spoke about how politicians and
employers did not respect their care responsibilities (ibid. ch. 4). They felt that their
caring lives were secondary in the eyes of the state and of most employers. They
believed that the paid work world is *care-less*, in the sense that it does not have to
accommodate caring unless legally required to do so. All types of carers felt publicly
invisible and undervalued in their various forms of care work; they felt that care
came last in the public order of priorities. Those who had been denied not only love,
but also the secondary forms of care that were supposed to be provided for them by
educators and by the state, were also aware of the low value placed on their care
needs by most other adults (Feeley 2009). They felt robbed of part of their life and
incapacitated by their love and care losses.

Within the interpersonal world, however, love, care and solidarity work was
highly valued and protected, often at a high personal cost to the carer. The life world
of caring is a space where carers and care recipients verbalise the value of love and
care for themselves. Perhaps for this reason, carers are not passive recipients of
negative labelling. They articulate a strong resistance to the low public evaluation of
caring; they contest the values of the public spheres that assume the presence of love
and care work while ignoring its existence and importance (ibid. ch. 4). People are
willing and able to contest economic rationalities and to articulate the primacy of nurturing rationalities.

**Implications for normative egalitarian theory**

*Equality* distinguishes between basic equality, liberal egalitarianism and equality of condition, each of which is defined in terms of the five dimensions already discussed (Baker et al. 2009, ch. 2). More specifically, basic equality is defined as concerned with basic protections against inhuman and degrading treatment, including the most blatant forms of violence. Liberal egalitarianism is construed as concerned with the fair regulation of inequality by means of two pervasive ideas. First, there are stronger standards for the protection of the worst off, and, secondly, a commitment to some form of equal opportunity to succeed. Equality of condition is set out as a radically egalitarian objective that aims at overall equality in the conditions of people’s lives. In contrast to liberal egalitarianism, it could be thought of as a commitment to ‘equality of outcome’, but it is perhaps more accurate to call it the principle that, overall, people should be roughly equally enabled and empowered to live their lives.

The studies outlined above help to clarify and expand the understanding of these conceptions of equality in a number of significant ways. First of all, they support the idea of a multidimensional understanding of equality, because they show that inequality in the affective realm is itself multidimensional. If, therefore, we want to promote equality in the affective sphere we need to attend to all five of its dimensions.

Secondly, they demonstrate some of the interrelations between equality in one dimension and equality in others. For example, a very strong theme in the Care Conversations was that the lack of material support for carers was seen by them as expressing a lack of recognition for care giving (Lynch et. al. 2009, ch. 4). This is clearly one way in which we cannot expect to promote equality of recognition without
simultaneously promoting equality of resources. Similarly, it is clear from all the studies that a shift in the gendered division of care labour, which belongs to the dimension of working and learning, is intimately connected with shifts in inequalities of recognition and resources. Greater equality of recognition and resources for carers would be, in the first instance, more beneficial to women than to men precisely because of the gendered division of care work, but this equality could itself have the effect of making care work more attractive to men. Conversely, one might reasonably hope that encouraging men to take on their fair share of care work would help to bring about greater equality of recognition and resources for carers.

Thirdly, the studies in general, and particularly Feeley’s (2009) discussion of the survivors of institutional abuse, invite a reconceptualisation of the dimension of love, care and solidarity. In *Equality*, this dimension was largely construed as concerned with providing and supporting positive relations of love, care and solidarity, and inequality was construed in terms of the differences between those who had access to these positive relations and those who did not. Little explicit attention was given to what may be called the negative counterparts of these relations – relations of hatred, abuse and social antagonism. Yet if there is an inequality of care between those who receive it and those who do not, there is clearly an even greater inequality in the same dimension between those who are cared for and those who are abused. We should therefore think of the range of the dimension of love, care and solidarity as extending in two directions and not just in one.

Fourthly, the studies raise some serious questions for liberal egalitarianism. A general feature of liberal egalitarianism is a commitment to some form of equal opportunity. One aspect of this position is the idea that social justice should be concerned with providing people with an opportunity to gain valued goods rather than with the goods themselves, because individuals should be free to accept or
refuse the benefits they have access to. In the case of care, this distinction seems in many cases to lack any point. Children, the ill and the infirm need care itself; in these cases, the idea of equal opportunity is a redundant concept. The carers featured throughout this book were not concerned with providing care recipients with an opportunity for getting love and care but with giving love and care themselves.

Another aspect of the liberal-egalitarian emphasis on equal opportunity is the idea of personal responsibility: that people should be held responsible for the choices they freely make. The affective sphere raises serious issues for this stance. Does the ‘choice’ to provide care count as a free choice for which carers should be held responsible? This choice occurs within the context of a social system that, as we have seen, places family members, and particularly women, under a moral imperative to provide care. That they thereby feel ‘responsible’ for others is not just a play on words but shows that the concept of responsibility itself is more complicated than liberal egalitarianism tends to portray it. Moreover, the moral imperative to care and therefore our responsibility for the care of others is partly constituted by people’s need for care. Is a socially mediated response to a need a free choice for which the responder should bear the costs? These are rhetorical questions because it seems clear enough that these needs must be met by someone if societies are to function at all and therefore are the responsibility of society as a whole and not simply of family members. But acknowledging this social responsibility makes the distinction liberal egalitarians emphasise between personal choice and brute luck extremely problematic (cf. Anderson 1999).

A fifth problem that the studies pose for normative egalitarian theory is the issue of how to develop social norms and institutions in ways that are actually capable of satisfying the needs for love and care that the studies so amply document. Egalitarian theorists have paid some degree of attention to how we might design
egalitarian economies, political systems, schools and even families, but these exercises have almost always been concerned with the other dimensions of equality. The key questions have concerned how these social institutions affect the distribution of income, wealth and cultural capital, how they generate or mitigate inequalities of opportunity, how well they can accommodate cultural and other group differences and the degree to which they can reduce inequalities of power. If love, care and solidarity matter then all of these institutional questions have to be revisited with a view towards assessing how well different institutions promote equality in this key dimension.

A central point of the studies is that certain kinds of care, falling within what they call love labour, are inalienable and uncommodifiable. It may not always be possible to provide the love people need, but that does not make it any less of a loss. So in developing norms and institutions to deal with the issues of love, care and solidarity, it is going down an entirely wrong path to assume that all of this work can be allocated to public services or commodified for the sake of market-based providers. We are not denying that people contracted to care for others can also establish long-term loving relationships, but one cannot commit oneself by contract to love someone, much less to do so on a life-long basis. In thinking about social norms and institutions, then, egalitarians must take seriously the objective of freeing both women and men from a level of commitment to paid work that is incompatible with meeting the love and care needs of intimate others. This objective has wide-ranging implications for the economic system.

These points are related to a sixth question for egalitarian theorists, the question of rectification. As Gheaus (2009) has argued, failures of love and care are all too frequent in contemporary societies, and even the best institutional designs are imperfect. These failures do not just harm people emotionally, but as Feeley’s (2009)
study in particular documents, have huge effects on other aspects of their lives. Should we aim to compensate those whose needs for love and care have been frustrated? How? Egalitarian theory has paid some attention to compensation for lack of material resources, lack of opportunities and physical impairments, but apart from Gheaus’s work, little attention has been paid to compensation for lack of love and care.

Finally, the studies help us to understand how equality of condition should be defined in the affective sphere. In the dimension of respect and recognition, perhaps its most important lesson is that recognition can be very tightly connected with other dimensions of equality. What came up time and again in the conversations with carers was the view that the true measure of the lack of regard others had for their role was the lack of material support they were given, irrespective of public expressions by politicians of what a fine job they were doing (ibid. ch. 4). Perhaps a further investigation would reveal other, more symbolic forms of expressing recognition for care but its material expression was central to the perspective of carers. This does not at all show that the dimension of respect and recognition is indistinguishable from that of resources, because it was clear from the Conversations that carers felt deeply about the lack of public recognition for their work and not just about its under-resourcing.

In the dimension of resources itself, the studies deepen our understanding of the range of resources we need to take account of in promoting equality of condition in the affective sphere. They provide plenty of evidence that inequality of material resources has a very strong impact on people’s ability to provide care, but they reveal other resources, including time, that are also crucial. O’Brien’s (2009) study in particular showed that mothers’ capacities to provide the care their children needed during the transition to secondary school were strongly influenced by their social
capital, their cultural capital and their emotional capital, each of which influenced the others.

In relation to the dimension of love, care and solidarity, the studies contain a number of important insights. First of all, they confirm that this is a very important dimension of equality for many people. In particular, it is clear from the Care Conversations that many people prioritise relations of love and care over other dimensions of equality, and that they are therefore willing to incur low social esteem, poverty, time stress, powerlessness and lack of career prospects for the sake of maintaining their caring relationships. As mentioned above, the studies also show that in many cases it seems pointless to characterise equality in this dimension in terms of the opportunity for, access to, or capability for relations of love and care because what people in those cases need is love and care themselves, not just access to them.

Taken as a whole, the studies help us to see more clearly what’s involved in meeting people’s need for love and care. They emphasise the importance of love and not just of physical provision. Some of the men interviewed by Hanlon (2009) maintained that the ‘masculine’ mode of caring for others does not consist in the emotionally intense, temporally prolonged and highly attentive activities involved in love labour, but in being the household breadwinner. The problem with the breadwinner view of care, however, is that it cannot substitute for the kinds of primary care that people need; it entails either that breadwinners will themselves have a ‘second shift’ as primary carers, or that they will rely on and perpetuate a division of labour within the household that defines the care giver as a dependant and has played a central role in sustaining gender inequality. It is of course to be welcomed that people in paid work should apply some of their earnings to the care of their dependants, but that is not an adequate response to the need for care.
The studies also suggest that, just as egalitarians expect people to treat each other with respect, they should also expect people to treat each other with love, care and solidarity, as appropriate to the context and their relationships. In the Care Conversations, carers repeatedly spoke positively about the value of the reciprocal nature of their relationships with those for whom they cared, whether these were young children or other family members, and even in situations where the care recipient was highly incapacitated. Although they were not framed within the idea of equality, these remarks suggest that a truly equal society involves not just mutual respect but mutual care.

The studies also illuminate the idea of equality of condition in the dimension of power. In large-scale contexts, radical equality of power is most straightforwardly conceptualised in terms of democratic political structures. In the affective contexts focused on by most of the studies, namely families and other households, power relations are more subtle. In some cases, carers clearly had significant power over care recipients and many of those were situations – such as the care of young children or of incapacitated adults – where this aspect of the power relationship was inevitably unequal. Even in cases where equal power is possible in principle, which in the case of children could be at quite a young age, there may be obvious good reasons for unequal power. What is less obvious is the case for the power that care recipients exercise over primary carers, sustained by high levels of dependency, by the moral obligations primary carers feel, and by broader social norms about the gendered division of labour. Here again it was not always clear that equal power was a feasible alternative: if, for example, the care recipients were not really capable of abating their demands. But in such cases it is easier to see unequal power as an unavoidable wrong rather than a justified inequality. The social and moral norms governing caring are also a good example of the way impersonal, decentred power operates in
the affective sphere. In this respect, the egalitarian ideal of equal power requires a deconstruction of those norms and their replacement by norms that are as far as possible equally empowering. This is not to say that no one should feel a moral obligation to care for others – quite the contrary. But it is to say that those obligations would not be oppressive in a society where caring was taken seriously and the burdens and benefits of caring were equally shared.

Finally, the material in the studies helps us to clarify the idea of equality in the dimension of working and learning. They provide ample evidence that love and care do involve work. Although some carers resisted that label, they did not deny that love and care were burdensome or that how love and care were arranged had an important effect on the extent to which their caring activities were satisfying and fulfilling or stressful and tedious. The studies also show the persistence of the gendered division of love and care labour, which most of the women were justifiably unhappy with. So the general idea that equality of condition requires access to satisfying and fulfilling work, whether it is paid or unpaid, together with a reasonably strong form of occupational equal opportunity, inconsistent with the gendered division of labour, is supported by the studies. What is more problematic is the sense so often expressed by carers not just that they had no choice but to care, but also that they had a moral obligation to do so. Should we say that true equality in the dimension of working and learning rules out any sense of obligation as an infringement on freedom of occupational choice, and that everyone should be free to undertake love and care work or not, as they feel inclined? That would be unreasonable, given that such work is a crucial and unavoidable condition for human survival, and therefore that we have a collective obligation to ensure that it is accomplished. At the very least, then, everyone has an obligation to contribute to supporting love and care work. The stronger claim that everyone has at least a prima
facie obligation to engage in such work is certainly suggested by the contribution such a universal obligation would make to eroding the gendered division of care labour, but the case for that claim needs to be further developed.

**Conclusion**

In this paper we have used the framework developed in *Equality: From Theory to Action* (Baker et. al. 2009) to review some recent empirical research into caring relationships. What this research shows is that even within the context of care, inequality is multidimensional. It reveals complex patterns of inequality of work, resources, love and care, power and respect and recognition, shaped by many social factors including gender, social class, family status and disability. We have also argued that this research raises important issues for normative political theory. In some cases the implications seem fairly straightforward. In others, it highlights questions that egalitarian theorists need to address more thoroughly.

**References**


