

JUST CARE! RETHINKING THE UNEVEN GEOGRAPHIES OF CARE

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Summary: After COVID-19 was characterised as a pandemic in spring 2020, care and care work became very dominant topics in public discourse in Western Europe. Against this backdrop, the paper turns to the underlying social structures and conditions of caring relations and aims to go before and beyond the pandemic. The serious occasion of the COVID-19 pandemic and its unjust social effects will be taken as a starting point to engage with social theory to discuss pre-existing uneven ‘geographies of caring relations’ in capitalist societies, which pandemic-related measures are built on. For this, the paper draws on Joan TRONTO’s extended thoughts on critical feminist care ethics, emphasising her notion of caring-with as the possibility to trust in caring relations based on interdependencies and solidarity, and argues for explicitly linking caring relations to questions of social justice. This framework stresses the foundations of social injustice and shifts the perspective from individual caring subjects and places (‘who and where’) to unjust social structures (‘how’). Moreover, it challenges dominant biopolitics and care economies by way of an insourcing of caring relationships. By conceiving care as part of social theory and not only social analyses, care ethics provide a normative framework for geography and beyond to imagine and practise social change.

Zusammenfassung: Nachdem COVID-19 im Frühjahr 2020 als Pandemie eingestuft wurde, sind Sorge (care), Sorgearbeit und Sorgeverhältnisse als Teil des öffentlichen Diskurses präsent. Vor diesem Hintergrund wendet sich der Beitrag den zugrundeliegenden gesellschaftlichen Strukturen und Bedingungen von Sorge in Westeuropa zu und richtet den Blick auf die Zeit vor und nach der Pandemie. COVID-19 und seine ungerechten sozialen Auswirkungen dienen als ernstzunehmende und dringende Anlässe für eine grundlegende gesellschaftstheoretische Auseinandersetzung mit bestehenden ungleichen und ungerechten ‘Geographien der Sorge’ in kapitalistischen Gesellschaften, auf die pandemiebedingte Maßnahmen treffen. Dazu bezieht sich der Beitrag auf Joan TRONTOS erweiterte Überlegungen zur kritischen feministischen Sorgeethik, insbesondere auf ihr Konzept des *caring-with* (im Sinne einer Gesellschaft, die auf Sorgebeziehungen vertrauen kann, die auf Interdependenzen und Solidarität basieren) und argumentiert darüber hinaus für die Notwendigkeit, diese mit Fragen sozialer Gerechtigkeit zu verschränken. Dieser Ansatz verweist auf die strukturellen Mechanismen sozialer Ungerechtigkeit und lenkt den Fokus von individuellen sorgenden Subjekten und Orten (wer und wo) auf die zugrundeliegenden ungerechten sozialen Verhältnisse (wie). Darüber hinaus werden mit der Forderung nach *Insourcing* von Sorgebeziehungen vorherrschende Biopolitiken und Sorgeökonomien in Frage gestellt. Indem Sorge unter gesellschaftstheoretischen (und nicht lediglich sozialanalytischen) Aspekten begriffen wird, bietet die feministische Sorgeethik einen normativen Rahmen für die Geographie (und andere Disziplinen), um gesellschaftliche Transformationsprozesse hin zu einer gerechten und demokratischen sorgenden Gesellschaft anzustoßen.

Keywords: Care ethics, social justice, pandemic, biopolitics, capitalism, intersectional effects

1 Introduction

“The care crisis does not affect everyone in the same way, whether locally or globally. But societies that systematically erode their care infrastructures cannot thrive in the long term. The coronavirus crisis has been a painful lesson in this regard.”

(DOWLING 2021: 191)

Not many people and organisations around the world had expected nor prepared for a virus to spread as fast as the COVID-19 virus. Although geographers are supposed to ‘know the world’, hardly anybody in the discipline had seen it coming and knew – neither professionally nor socially – how to deal with the severe lockdowns taking place in

Europe in 2020 and 2021. Yet, despite – or for some: because of – lockdown life for most of 2020 and well into 2021, geographers have been busy thinking about ‘coronavirus geographies’ professionally and socially. Thereby, an unsurprising list of underlying causes and effects was identified, mainly comprising buzzwords such as globalisation, individualisation and vulnerabilities (for an overview, see the special issues in *Dialogues in Human Geography* 2020 (ROSE-REDWOOD et al. 2020) and *Tijdschrift voor Economische en Sociale Geografie* 2020 (AALBERS et al. 2020)). Furthermore, scholarly debates also highlighted a special concern for basic needs and caring relations, including more-than-human ones (see, e.g. SPRINGER 2020).

Moreover, geographers have called attention to the uneven impacts of the pandemic as a global health crisis and the ways it is ‘managed’, stressing how existing inequalities place a particular burden on those who are already vulnerable (ROSE-REDWOOD et al. 2020, HO & MADDRELL 2021). This paper, however, does not aim for any kind of empirical analysis of the virus’s causes and effects. It neither presents any evidence-based evaluation of pandemic management, nor does it aim to assess whether lockdowns are ‘successful’ strategies or discuss alternative pandemic responses. Instead, we turn to the underlying unjust social structures and conditions of caring relations in Western capitalist societies and argue that a fundamental change of these conditions is needed to approach more just ways to deal with *social disaster*¹⁾ and crises such as the COVID-19 pandemic and beyond. Since the lockdowns have resulted in a reorganisation of everyday life, they particularly invite us to discuss these social processes and differences as well as the dominant spatial divisions related to them. Therefore, we agree with Victoria LAWSON (2007: 4) that our “[r]esearch agendas are often set by emotional responses to tragedy [...] Our research agendas are often set by our caring reactions to disaster and the challenges that disasters reveal.” Yet, we aim to go before and beyond the pandemic and the responses to it and focus on the fact that caring relations are always essential for survival but their necessity has become more obvious during the COVID-19 disaster.

During the pandemic lockdowns in Western Europe, the relevance of care work, which keeps a society going, became evident for everyone. The conditions and positions – how, where and by whom – of care work received crucial attention: as the availability of basic supplies for survival in supermarkets and as paid and unpaid care work, such as child and senior support services, healthcare, etc. – all of them resting on structural inequalities informed by, among others, gender, class and race. With the objective to take up one of the seven themes that SPARKE & ANGUELOV (2020: 503f) have identified as relevant in ‘coronavirus geographies’, we address the uneven geographies of care.

1) The term *social disasters* places “emphasis on those who suffer rather than on the threat” (REYES 2020: 263). Stressing the social dimensions (and not just the social effects) of disasters points to collective responsibility and the need for promoting long-term objectives towards social justice (instead of short-term risk management).

We thus use the serious occasion of the COVID-19 pandemic and its unjust social effects to engage with social theory to discuss ‘geographies of caring relations’. For this, we turn to Joan TRONTO’s extended thoughts on critical care ethics and a caring democracy respectively (TRONTO 1993, 2013, 2017) and discuss her work not only as a critique of neoliberal capitalism but also in the spirit of looking for alternatives based on social justice.

Against this backdrop, we refer to a co-authored article published in 1990 (FISHER & TRONTO 1990) in which TRONTO (see also 1993: 103, 2013: 19) defines care as follows: “On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex life-sustaining web.” This definition is well-established within human and, especially, feminist geography (see *Gender, Place and Culture* 2019 Vol. 26 (6) for a recent collection). Contrary to this heavily cited definition, TRONTO’s five principles or standards of care²⁾ are much less discussed, while they are as thought-provoking: They invite us to think about ‘coronavirus geographies’ in general and to rethink just geographies of care for post-pandemic times in particular.

TRONTO’s five principles of care comprise *caring-about* as the attention to and noticing of unmet needs, *caring-for* as the taking of responsibility for these needs, *care-giving* as the practice of doing care work and having the competence to do so, *care-receiving* as the responsiveness of the subject/object being cared for and, finally, *caring-with* as the possibility to rely on established caring relations based on interdependencies, trust and solidarity (TRONTO 1993: 103ff, 127ff, 2013: 35ff, 2017). Especially the latter points to a relational care ethics and to the fact that *all* people need care. However, differences in needs and vulnerabilities are produced by structural inequalities and must not result in individual responsibilities.

Human geography mainly addresses care in socio-spatial terms, i.e. ‘who and where’ (see, e.g. POWER & HALL 2018, MIDDLETON & SAMANANI 2021 for overviews). Long-established feminist critiques of the spatial division of labour and of gendered, classed and racialised dimensions of care work (both paid and unpaid), however, address these short-

2) TRONTO (1993, 2013) has described these principles originally as (not necessarily linear) ‘phases’ but also as elements or standards of care; we will use these terms interchangeably.

comings in the disciplinary understanding of care (ENGLAND 2010, ALLEN et al. 2020, BAURIEDL & STRÜVER 2020, STRAUSS 2020, SCHILLIGER et al. 2022). For us, rethinking the uneven geographies of care comprises a shift in perspective: Following LAWSON'S (2007) invocation, which was made more than a decade ago, we suggest to look beyond places and practices of care and stress the perspective on care ethics as social relations and caring interdependencies (see also GREEN & LAWSON 2011, RAGHURAM 2019, SCHWITER & STEINER 2020). For this, we turn to the underlying uneven social structures that are effects of and reinforce hierarchical social relations, thereby producing different needs and differences in vulnerabilities.

We thus engage critically with pandemic management and biopolitics (section 2) in order to look at their pre-existing social conditions in Western Europe: the uneven geographies of care in capitalist societies hit by austere neoliberalism (section 3). For this, we explicitly link caring relations to social justice as a way to approach just care (section 4) and conclude with a discussion of TRONTO'S care ethics, especially the principle of caring-with. Caring-with as a normative framework based on participatory justice allows us to imagine alternatives to unjust neoliberal (bio)politics and their respective, yet colliding, crises tendencies.

2 Pandemic biopolitics and differential vulnerabilities

“The global health crisis unleashed by the COVID-19 pandemic has been compounded by political, economic, and social crises that have exacerbated existing inequalities and disproportionately affected the most vulnerable segments of society.” (ROSE-REDWOOD et al. 2020: 97)

In Western Europe, stressing needs and vulnerabilities related to precarities and the giving and receiving of care became a fulminating phenomenon during the first pandemic lockdown in spring 2020. After the WHO characterised COVID-19 as a pandemic, care and care work became very dominant topics in public discourse. This included, next to unpaid care activities at home, public care work services done due to competencies and experiences as health, child and senior care workers, teachers, cleaners, delivery workers, etc. These workers actual relevance as key or essential workers became obvious (and widely debated) over night. In putting themselves at risk, new needs and vulnerabilities of care workers emerged

during the pandemic. The same was true for essential workers in supermarkets, who provided basic social and physical needs, but who were marginalised by gender, race, class and migration status above average (HÜRTGEN 2021). All these workers were confronted with the impossibility and *disability* of social distancing and the imperative to *care beyond self-care*. Yet, these workers have not been overexposed, under-protected and underpaid as a result of the pandemic but because of institutionalised structural inequalities and vulnerabilities (ALLEN et al. 2020). In the words of Panagiotis SOTIRIS, “[l]ockdowns did not prevent the tragedy of mass transmission and high mortality in nursing homes and care facilities. They did not answer the problem of hospitals themselves becoming hotspots of the pandemic, for lack of more-decentralised and community-oriented primary health structures. They could not stop the spread within households, especially large ones. Not all persons could ‘stay home’ since they had to continue working, thus continuing to be exposed to the virus, with many of these ‘essential workers’ having socially-determined underlying health conditions” (SOTIRIS 2020: 13). We therefore argue that many of the most precarious care givers did not receive enough attention, recognition and appropriate care beyond public claps and one-off bonuses. In caring for some during the pandemic, new needs and vulnerabilities have emerged or have finally become part of public discourse – but these needs were hardly voiced or considered in a serious manner. On the contrary, key care workers, who are already structurally marginalised and more vulnerable, have been extraordinarily exposed to the virus. This observation is by no means limited to the pandemic but is a general effect of hierarchical social structures. Moreover, and more important for our argument here, TRONTO includes care-receiving as the responsiveness of the person or object being cared for, including being responsive to the ways in which caring has *not* met needs: “Once care work is done, there will be a response from the person, thing, group, animal, plant, or environment that has been cared for. [...] Note that while the care receiver may be the one who responds, it need not be so. *Sometimes the care receiver cannot respond*” (TRONTO 2013: 22f, emphasis added, see also 147ff). Furthermore, “[n]eoliberalism is explicitly anti-care, since it views the giving and receiving of care a sign of failure, dependence or deviance” (ROBINSON 2013: 141). This pathologisation of dependency obscures the fact that care-giving and care-receiving are central to human well-being and that all humans always are, more or less, in interdependent caring relations.

As an object of public intervention, care forms part of biopolitics. However, care is a central yet unacknowledged element here. While GREEN & LAWSON (2011) made this point with reference to welfare, we transfer it to lockdown life and pandemic biopolitics. On 11 March 2020, the WHO made the assessment that the spread of COVID-19 could be characterised as a pandemic and that all countries needed to take urgent and aggressive action: “We cannot say this loudly enough, or clearly enough, or often enough: all countries can still change the course of this pandemic. If countries detect, test, treat, isolate, trace, and mobilize their people in the response, those with a handful of cases can prevent those cases becoming clusters, and those clusters becoming community transmission” (WHO 2020). Thus, the WHO recognised the urgent need to initiate measures to prevent the local and global spread of the virus. In their reaction, the organisation strongly encouraged governments to implement national regulations in order to prevent critical numbers of people needing hospitalisation or even intensive care. In many parts of the world, this resulted in lockdown life, closed borders, digital tracking and tracing, i.e. governmental regulations that can be summarised as pandemic biopolitics closely tied to management and control.

FOUCAULT’S concepts of biopolitics and governmentality seemingly offer key contexts for this kind of neoliberal population management (see, e.g. KITCHIN 2020) that aims at self-care and thus individual responsibility. In FOUCAULT’S (2010) framework, biopolitics is power exercised on everyone and in every aspect of people’s life. Governmentality – as the conduct of self-conduct – is therefore less concerned with discipline than with the control of bodies, minds and practices. Yet, biopolitics are also politics of *differential* precarity, *differential* vulnerability and *differential* exposure. With reference to LOUISE WAITE’S (2009) discussions of a critical geography of precarity, we employ a relational understanding of precarity as social relation and, thus, refer to structural mechanisms of vulnerability. While all people are vulnerable, not all people are in precarious relations, which make some people more vulnerable than others: In this regard, pandemic biopolitics “is a politics that structurally relies on the establishment of hierarchies in the value of lives [...] [In the context of COVID-19, the] virus does not put us on a basis of equality. On the contrary, it blatantly reveals that *our society structurally relies on the incessant production of differential vulnerability and social inequalities*” (LORENZINI 2021: 43f, emphasis added).

While the pandemic and the dominant political response to it expose differences in vulnerabilities, politics failed to acknowledge their structural causes. Vulnerabilities are neither naturally given (due to sex/gender, race, class or any other social category) nor distributed by chance. They are results of capitalism as an institutionalised social order based on socio-economic, gendered and racialised differences as structural inequalities. Uneven – and more importantly: *unjust* – social structures influence people’s social *and* biological vulnerability (see DZUDZEK & STRÜVER 2020, FÜLLER & DZUDZEK 2020).

In most European countries, dealing with the virus was built on uneven notions of care, i.e. relying on and reinforcing the hierarchical social structures of neoliberal capitalism. In light of this, we do not elaborate in more detail on governmental pandemic interventions and the discussion on the uneven effects of COVID-19 management (see EAVES & AL-HINDI 2020, REYES 2020, SPARKE & ANGELOUV 2020, ROSE-REDWOOD et al. 2020, VAN UDEN & VAN HOUTUM 2020, HO & MADDRELL 2021, SCHWITER & STEINER 2021). Instead, we shift the emphasis to how care and care work are framed and done and how caring resources are distributed. We argue that it is not the pandemic or specific measurements that create vulnerabilities and inequalities but the social relations and hierarchical differentiations – the structural conditions – it encounters. Accordingly, we stress that there is a more fundamental need to rethink the uneven geographies of care beyond the pandemic and to challenge the mechanisms of differentiation and not their effects: the gendered, racialised and classed division of labour in capitalist societies.

3 Uneven geographies of care

“A lot has been written about care this last year. As multiple crises unfold and we work out how to reorganise our lives, both online and off, to meet our needs, the ways in which we connect to and care for each other have shifted into new territory.” (RUTHERFORD 2021)

In Western capitalist societies, care work is widely considered apolitical, as private social activities that are nevertheless increasingly commodified. Care work has been related to domesticity in the 19th century, to professionalisation and institutionalisation in the 20th century and to marketisation in the 21st century. This includes a shift from dyadic to structural domination in paid care work (FLANAGAN 2019) but also on the societal level (FRASER 2016).

Despite this trajectory on a transnational scale, care is still attached to the private sphere, both materially and symbolically (ENGLAND 2010, TRONTO 2013). During the phase of state-managed capitalism in the second half of the 20th century, the idea(s) of a family wage and public welfare were dominant. Neoliberal capitalism then forced women into paid work and privatised caring institutions such as child- and healthcare. As part of neoliberal restructuring, care-giving and care-receiving became privatised once more. “The result, amid rising inequality, is a dualized organisation of social reproduction, commodified for those who can pay for it, privatized for those who cannot” (FRASER 2016: 104, see also TRONTO 2017). The commodification of care in the 21st century is tied to the return of care work to private homes. The accompanying individualisation plays a substantial role in ensuring neoliberal capitalist societies. From its beginning, capitalism rested on unequal gender relations and underlying stereotypes. In its neoliberal extreme, it is still based on gendered, classed, racialised and spatial divisions of labour. The pre-COVID-19 reshaping of care work can be characterised by the (re-)relegation of care work to the private sphere (its privatisation and individualisation) in the course of the dismantling of the welfare state. At the same time, care work continues to be approached as a service and a transnational commodity (FRASER 2016, FEDERICI 2019, SCHWITER & STEINER 2020). Next to the marginalisation of care workers, the commodification of care has resulted in its scarcity and the global financial crisis since 2007/08 has given full expression to what is now described as a *care crisis*: lower wages, flexible part-time employment and diminishing job security have been coupled with a ‘second shift’, i.e. a much higher share of unpaid care work at home due to cuts to welfare programmes, public childcare and health services (HOCHSCHILD 2012, DOWLING 2021, SCHLITZ et al. 2022). A care crisis thus refers to societies in which the demand for paid and unpaid care work is regionally or nationally higher than the available amount of supply. While it does not refer to deficits in individual households, the different experiences in different households do matter (ENGLAND 2010, TRONTO 2013, FRASER 2016).

The commodification of care does not only obscure, it first and foremost obstructs an approach to care that recognises all humans as vulnerable and in need of care. Moreover, “[n]otions of care have been resituated and dislocated within transformed social imaginaries in which the social is replaced by

the market as the instrument of interventions while the family is increasingly [and again] framed as the naturalized location of care” (GREEN & LAWSON 2011: 650). Instead, the social is taken over by the profitability of efficient markets – even though care-work is hardly profitable and its marketisation will not make it more efficient (LAWSON 2007, TRONTO 2013, 2017).³⁾ The marketisation of care renders it even more impossible to distribute care evenly and neglects that not all people have the same chance to recognise and voice their needs.

Summarising this short discussion of the inequalities of care, we highlight the contradictions of care in capitalist societies and problematise the neoliberal idea that ‘the market’ – and marketisation – will make care more efficient. As market thinking obscures and relies on unequal social structures, the most precarious people are less cared for. This is true in general but especially so in pandemic times, when people who are more exposed to the virus are blamed for being harmed and their incapacities to take care of themselves. Against this background, we take up FRASER’s (2016) and TRONTO’s (2013: 68ff) plea to place care in interdependence with socio-economic and cultural inequalities – as (1) care and caring relations are always marked by gender, race and class and (2) recognising their intersectionality is the only way to approach social reality.

Intersectional analyses are indeed essential to grasp the complexity of social relations and the resulting uneven geographies of care. However, the analysis must not end with the ascertainment of intersectional inequalities, nor with the identification and attribution of discriminatory social categories as basis for identity politics. Besides the analysis necessarily remaining incomplete, the focus on social and analytical categorisations and its intersections tends to obscure the *mechanisms* of hierarchisation as organising principles of capitalist societies while emphasising their *effects*. Thereby, categories are often perceived as the cause of power relations and, in consequence, it remains hidden that capitalism produces and relies on uneven social categorisations and relations (SOILAND 2020). This concealment results in an individualisation of structural inequalities and perfectly matches neoliberal self-responsibilisation. Furthermore, “[i]dentity politics,

³⁾ The recent platformisation of care work – as digitally mediated intensification of its marketisation – is about to change this. As this is not for the benefit of care givers and receivers, we will not elaborate on this here (but see BAURIEDL & STRÜVER 2020, SCHWITER & STEINER 2020).

intended as a call for an inclusivity that recognizes the ways in which oppressions are marked by intersectionalities and as a site for organizing against neoliberalism, have been taken up within neoliberal logics to paradoxically both flatten ingroup differences [...] and further cleave marginalized populations” (LOPEZ 2019: 833, see also FRASER 2019).

As a result, individual people are made responsible for giving and receiving care, which is marketed as the freedom of choice. However, these choices are neither free nor do they rely on equality or justice. When dealing with justice related to democracy, TRONTO (2013) refers to FRASER’S (2009, 2013) distinction between – and combination of – redistribution, recognition and presentation, which allows for an inclusive democracy beyond formal identity politics and ‘add-on’ intersectional analyses. This distinction also acknowledges *addressing the differences in needs* as important for justice and democracy.

Thus, there is a need to care beyond acute disasters and look beyond the ‘who and where’ of geography’s approach to care. As such, we make a plea to care about structural inequalities such as racism, classism, sexism and geopolitical discrimination – a plea to care about injustice. Therefore, we turn to social justice in combination with feminist care ethics.

4 Just care!

“Profit over people is the true pandemic.”

(SPRINGER 2020: 114)

In rethinking the uneven geographies of care, we rely on Nancy FRASER’S *Scales of Justice* (2009) and the difficulties of participatory justice, especially in times of neoliberal capitalism. Participatory justice in FRASER’S sense refers to social arrangements that allow all members of a society to relate to each other as equals. Although the structures of economic and cultural inequality are formally independent of each other in capitalist societies, they, in fact, operate in conjunction with each other. Economically disadvantaged social groups also lack cultural recognition – and vice versa. However, neither type of injustice is an indirect effect of the other, as both types share the same origin. Because of this, FRASER (2009, 2013) stresses three dimensions of justice, namely distribution, recognition and political representation, which are connected by the overarching principle of justice: parity of participation. “First, the distribution of material resources must be such as to ensure participants’ independence and ‘voice’

[...] Precluded, therefore, are social arrangements that institutionalize deprivation, exploitation, and gross disparities in wealth, income, and leisure time, thereby denying some people the means and opportunities to interact with others as peers. [The second condition] precludes institutionalized value patterns that systematically depreciate some categories of people and the qualities associated with them. Precluded, therefore, are institutionalized value patterns that deny some people the status of full partners in interaction – whether by burdening them with excessive ascribed ‘difference’ or by failing to acknowledge their distinctiveness” (FRASER 2013: 164).

FRASER’S thoughts on participatory justice not only disclose the contradictions of care and capitalism, they also address the necessity to rethink care beyond market values (FRASER 2016). Further, her argument “provides a basis for alternative ideas and policies surrounding work and care at multiple scales, from the household to the global. Contrary to widespread assumptions, solutions do exist” (ROBINSON 2013: 133). TRONTO’S (2013) principle of caring-with envisages an alternative and more just societal context for care: It starts with accepting that *all* people are vulnerable and in need of care and live in interdependent caring relations. Such a relational understanding of care breaks neoliberal accounts of individualisation as well as the “destructive linking of dependency with pathology” (THE CARE COLLECTIVE 2020: 30) and individual vulnerability turned into self-responsibility.

By acknowledging that “most needs for care exceed the capacity of individuals” (TRONTO 2013: xiv), feminist care ethics move away from accounts that centre on the individual and shift towards caring relations and caring as practices. Care, then, must be considered a common societal concern – and an equally shared responsibility. As such, feminist care ethics counter neoliberalism as ideology, economy and societal structure. Going beyond the reproduction of the system, its precarities and underlying inequalities, this approach highlights the need for a caring democracy where the provision of basic needs for all beings, human and non-human, is pivotal: A caring democracy places care centre stage as an essential organising principle of societies. In TRONTO’S words, “[a] world organised around care would be organised very differently. [...] We need now to stop being dazzled by neoliberal forms of resilience and, instead, have the courage ourselves to return to a forestalled alternative future, one in which care truly matters” (TRONTO 2017: 39).

TRONTO's plea and radical relational care ethics are the precondition to address uneven geographies of care beyond the 'who and where'. They allow us to focus on the underlying social structures, inequalities and injustices on the one hand, and on public institutions, such as the state, the family and the market, on the other. Moreover, care ethics invites us to tie justice and care together seriously and to respect care as a public and democratic concern in order to imagine socially just geographies of care – and caring societies. The reorganisation and democratisation of care towards a caring democracy is pivotal and indeed imaginable and includes both sufficient time and material resources to do care (TRONTO 2013, THE CARE COLLECTIVE 2020, DOWLING 2021). Consequently, there is a need for publicly funded social infrastructures with well-paid care workers and radical reforms that allow *all* individuals to engage in caring-for themselves and caring-with others. These social infrastructures ensure public healthcare; sufficient financial and professional support of family caregivers; free comprehensive childcare provision as well as working hours adjusted to parental needs; high quality education for all; labour law protection for domestic care workers; residual rights and access to housing and labour markets for illegalised and/or asylum seeking people; and material and mental support in individual emergencies – in short: meeting basic needs for all people (WINKER 2015, NEUMANN & WINKER 2020, THE CARE COLLECTIVE 2020). Only when these existential human needs are met can people engage in caring activities and democratic processes.

Furthermore, scholars and activists alike have stressed the necessity to fundamentally reorganise structural labour relations in order to establish more just caring arrangements that no longer built on discriminating social divisions of labour. They have argued for a notion of work that comprises socially necessary activities beyond wage work and for overcoming capitalism's separation of productive work (as wage work) and reproductive domestic work (DOWLING 2021, FEDERICI 2021). Moreover, shorter standard working hours (with full pay) in paid work allow all people to have both time and resources to care (WINKER 2015, NEUMANN & WINKER 2020).

Alongside these concrete demands for immediate reforms to improve the conditions for a just everyday life, it is essential to pursue extensive and long-term transformation processes towards an alternative just caring society. This includes the democratisation of care infrastructures, as well as the de-commodification of care, i.e. to withdraw care infrastructures

from the logic of profit maximisation (WINKER 2015, FRASER 2016, DOWLING 2021). As such, a caring democracy in TRONTO's sense is inseparable from solidarity and a solidarity-based economy that foregrounds human (and more-than-human) needs and approaches responsibility collectively. Accordingly, the distribution of resources is a collective, inclusive and democratic process of caring-with that rests on care value rather than exchange value (WINKER 2015, THE CARE COLLECTIVE 2020). This implies a resocialisation and *insourcing* of care infrastructures (e.g. through cooperatives or public-common partnerships) (THE CARE COLLECTIVE 2020). In this regard, "developing collective forms of care and reproduction means challenging and transforming existing social and cultural divisions and hierarchies [...] – and the relationships of power and inequalities that shape them" (DOWLING 2021: 203).

5 Geographies of caring relations

"A truly equal society gives people equal chances to be well cared for, and to engage in caring relationships."
(TRONTO 2013: 170)

During the first COVID-19-related lockdown in Europe in spring 2020, solidarity among people and with key workers became a visible and audible public concern. However, solidarity was not only impeded by social and physical distancing but also by previous neoliberal austerity politics, including the weakened health system, the precarisation of work and the commodification, and yet individualisation, of care. Despite the disruptive effects of lockdown life, the pandemic has not made it tangible that *all* people are vulnerable and living in interdependent relationships. Rather, the responses to the pandemic and the biopolitical management further enforced the individualisation of caring responsibilities and being blamed for being harmed. "A picture emerges of a pandemic that is linked to the structural aspects of capitalist social relations of production and reproduction, to neoliberalism as a regime of accumulation that increased inequality and attacked public health systems, and contemporary forms of imperialism. Capitalism indeed kills us, but in many complex ways" (SOTIRIS 2020: 10, see also SPRINGER 2020). Consequently, quarantines and lockdowns were implemented to minimise the risks of exposure for some people while maximising it for many others. Such politics depend on some people being continuously exposed, on the *imp*arity of participa-

tion as socially structured patterns of injustice. Thus, COVID-19 has not only been particularly harmful to people being more vulnerable anyway, but it has disclosed and applied the ongoing neoliberal austerity logic of destructing care capacities in its broadest sense. Yet, FRASER (2022) points to the ‘perfect storm of capitalist irrationality and injustice’ during the pandemic, because it helps to envision resistance to capitalism as an institutionalised social order.

Resistance will be born out of the realisation that all people are care givers *and* care receivers. In order to strive for participatory justice, however, challenging unjust social relations remains pivotal. Otherwise, only the paternalistic care discourse built on charity rather than solidarity is reproduced. Consequently, there is an urgent need to rethink neoliberal capitalism and care during and after the pandemic, to place people over profit and to admit the failure of capitalism to value caring relations and care work. The reorganisation of care towards a caring society is then no longer built on economic inequalities and cultural injustices – and their conjunction. It challenges the structural patterns of socio-economic and cultural differentiation and hierarchisation that capitalism continues to rely on. Thus, there is an urgent need for systematic reforms and, ultimately, system change rather than short-term lessons learned from pandemic management.

TRONTO’S (2013) fifth perspective, caring-with, is not about individual needs nor individual responsibilities but conceptualises care as a necessarily social and thus public concern. Moreover, by taking care as the organising principle of a society, it imagines a social order that no longer (re)produces utopias of economic growth and, therefore, categorisations of people and places that are hierarchical and thus unjust. Moreover, this feminist call for caring-with is close to anarchist thoughts on mutual aid and “caring geographies of togetherness” (SPRINGER 2020: 114) as well as to democratic biopolitics as collective care. Whereas disciplinary measures such as lockdowns represent neoliberal biopolitics as it disrespects the socially structured nature of health and vulnerabilities and failed to care for the precarious, democratic biopolitics, Panagiotis SOTIRIS (2020: 25) argues, “is a way to rethink questions of health and care, as part of a broader attempt to radically transform social relations and experiment with new forms of social organisation?”. These notions also involve participatory justice, inclusive discussion, collective responsibility and solidarity. However, while SOTIRIS (2020) imagines democratic biopolitics as part of a socialist governmentality, we follow a feminist care

ethics and take it a step further: Rather than considering care in the sense of caring-with, which includes democratic accounts of biopolitics as one of many elements, we consider it as the starting point, as the organising principle of society.

By conceiving care as part of social theory and not only social analyses, feminist care ethics provide a normative framework for geography and beyond to imagine and practise social change. Thus, taking a relational, democratic account of care seriously does not uphold the existing societal configurations, nor does it aspire to return to ‘normality’. It strives for a radical transformation and democratisation of care, responsibility and the social relationships that constitute our societies more broadly – a point that Doreen MASSEY (2000) has made a long time ago. Accordingly, just care built on participatory justice is less about the even distribution of care, nor is it solely about recognition: It is genuinely about the imperative to *just care!* and to accept and enjoy people’s interdependencies.

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