Constructions of older people and their care during the coronavirus pandemic in Ireland:

A Grounded Theory analysis of official discourses

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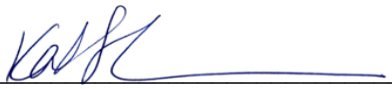
Signed: 

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30 April 2023

Summary

Beginning in March 2020, the Irish government implemented among Europe's most stringent and sustained lockdown measures to mitigate the spread of the novel coronavirus. Identified early on as a group at particularly high risk, older persons living in the community were instructed to self-isolate at home and older people living in nursing homes were locked down and locked in for extended periods of time. Despite the strict isolation measures, at the one-year mark, 63 percent of fatalities linked to outbreaks in Ireland had occurred among nursing home residents, raising critical questions about the government's response.

This qualitative study set out to analyse social constructions of older people and their care in the official discourses emerging around the government's pandemic response. The rationale being that a discursive analysis of such social constructions might tell us something original and insightful about the structures and processes through which power is exercised in such crisis situations, the power relations involved in decision-making related to older persons and their care, the actors driving the discourses, and crucially, the actors whose voices are not heard.

Working within a Critical Realist ontological framework, the study applies a novel blend of Grounded Theory (GT) methodology. It draws on Clarke's (2005) Situational Analysis variant of GT to come to grips with the discursive situation under study, and on Charmaz' Social Constructionist GT (Charmaz, 2006) to identify the structures and processes at work in the construction of older persons in the discourses. Official government texts, collected from the websites of multiple agencies and branches of government, as well as select texts from non-governmental, civil society organisations and private/voluntary associations comprise the discursive data analysed. The data collection period spans January 2020 to March 2021, from first mention of the coronavirus in official Irish documents, to the point at which the rollout of the vaccine among older age groups was documented and discussed.

Two main conceptual categories emerged over the course of the data analysis. The first speaks to *silences and absences* in the discourses, to the near total marginalisation of older persons' voices by dominant medical professionals-as-experts, appointed by and reporting to the state's executive branch. This marginalisation is effected through the prominent construction of older people's vulnerability and dependence, and their constructed lack of autonomy and agency. The second conceptual category, *continuities and discontinuities*, sees the virus emerge from the discourses as a powerful disruptor and catalyst for innovation, providing the government with the opportunity and momentum to reform the country's beleaguered health and social care systems once and for all. Yet ultimately, the analysis suggests that the virus-pandemic underscores a regression, a reversion to type, if not a continuity, in the state's attitudes towards and treatment of older members of the population. In fact, the construction of older persons as a vulnerable group obscures the very real

institutional vulnerability of Ireland's health and social care infrastructure, a vulnerability born of several decades of under-investment and under-development by the public sector. Several factors have influenced this trajectory, not least entrenched social and political norms that define care for older adults as the responsibility of family members and the local community in the first order, attesting to the indelible imprint of Catholic social teaching, notably the principle of subsidiarity, on Ireland's social welfare system.

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Dedication

This work is dedicated to the memory of my grandparents, Katalin Fejes (née Zsigmond), Zoltán Fejes, Grete Schulmann (née Reiter), and Fritz Schulmann. I thought of them often while writing this and wonder what they would have made of it. They continue to be powerful figures in my own internal discourses.

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List of Abbreviations

CDC	Centers for Disease Control and Prevention (United States)
CMO	Chief Medical Officer
CR	Critical Realism
CSO	Central Statistical Office
DCYA	Department of Children and Youth Affairs
DOH	Department of Health
EAG	Expert Advisory Group [of NPHET]
EC	European Commission
ECDC	European Centers for Disease Control
EEA	European Economic Area
EU	European Union
GP	General Practitioner
GT	Grounded Theory
HIQA	Health Information and Quality Authority
HPRA	Health Products Regulatory Authority
HPSC	Health Protection Surveillance Centre
HSE	Health Service Executive
ICCL	Irish Council for Civil Liberties
ICGP	Irish College of General Practitioners
IEMAG	Irish Epidemiological Modelling Group
IHREC	Irish Human Rights and Equality Commission
LGMA	Local Government Management Agency
LTRCF	Long-term Residential Care Facility
NECG	National Emergency Coordination Group
NHI	Nursing Homes Ireland
NHS	National Health Service (United Kingdom)
NIAC	National Immunisation Advisory Committee
NNHES	National Nursing Home Experience Survey (Ireland)
NPHET	National Public Health Emergency Team
OECD	The Organization for Economic Cooperation and Development
PPE	Personal Protective Equipment
SA	Situational Analysis
SOG	Senior Officials Group
TUSLA	The Child and Family Agency
TD	Teachta Dála; member of the Dáil Éireann
WHO	The World Health Organisation
UN	United Nations

Chapter 1. Introduction

1.1 Introduction

Early on, during the initial outbreak of coronavirus in China, epidemiologists determined that older people were at greater risk of dying from the virus due to the fact that the human body's physiological ability to mount an immune response declines with age (The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team, 2020; see also United Nations, 2020). Many countries around the world, including Ireland, responded by issuing social distancing restrictions and recommendations, often specifically targeting older population groups (WHO, 2023; Comas-Herrera et al., 2023). Backed by the international medical and scientific establishment, policymakers would assert that distancing measures were implemented with the intention of protecting vulnerable older people from the virus, of preventing serious illness and death, and of avoiding a situation in which hospitals, in particular intensive care units, would be overwhelmed. In Ireland, where hospital bed occupancy was 15 percent above the European average *prior* to the pandemic, the latter point would be a particularly critical factor in the government's pandemic policies (O'Leary et al., 2021).

Prior to the rollout of the first vaccines in the spring of 2021, the Irish government oversaw one of the strictest and most sustained series of lockdowns in Europe. While the movements and social interactions of all Irish residents were severely curtailed, older people's lives were especially constrained. People over the age of 70 living at home were further advised to 'cocoon', to self-isolate, and older people living in nursing homes and other long-term care facilities were locked down in their rooms, unable to visit with family and friends. Despite the draconian measures, after a year of the pandemic and three distinct 'waves' or surges in cases, nearly 40 percent of deaths in Ireland had occurred in residential institutions[1] (HPSC, 2021c). Of deaths linked to outbreaks[2], 60 percent occurred in nursing homes (HPSC, 2021c).

Non-governmental groups at the international (e.g. International Federation on Ageing; United Nations), European (e.g. Age Platform Europe), and national, Irish level (e.g. Sage Advocacy; Alliance of Age Sector NGOs) have objected to the extended isolation measures for older members of the population on the grounds that they are discriminatory and ageist, that they violate older people's right to autonomy, and that they are harmful to the health and wellbeing of older people

[1] According to the definition provided by the Health Protection Surveillance Centre (HPSC), residential institutions include: community hospital/long stay unit, homeless facility, mental health facility and nursing homes. Source: HPSC, 2021c.

[2] An 'outbreak' of Covid-19 is defined for statistical purposes as: A cluster/outbreak, with two or more cases of laboratory confirmed COVID-19 infection regardless of symptom status. This includes cases with symptoms and cases who are asymptomatic; or, as a cluster/outbreak, with one laboratory confirmed case of COVID-19, and at least one additional case of illness with symptoms consistent with COVID-19 infection (as per the COVID-19 case definition). Source: HPSC website: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casedefinitions/covid-19outbreakcasedefinitionforireland/

even as they were designed to protect them. In Ireland as elsewhere, the government's pandemic response has become a flashpoint in domestic politics, with members of opposition parties contesting the coalition government's nearly every move (Horgan-Jones & O'Connell, 2022).

This introductory chapter sets out the context for the study, starting at something of a remove before bringing the focus back to the pandemic period. The first section details key elements in the historical development of Ireland's health and social care systems. An overview of Ireland's contemporary health and social care systems follows in the second section. In the third section, the immediate concern for the study—the public health response to the coronavirus—is set out through a brief chronology of the main events comprising the first fifteen months of the pandemic in Ireland (A more detailed and focused treatment is provided in *Chapter 4: A Chronological analysis and laying out of the 'situation' in four acts*). The fourth section provides an overview of the background to the project and details the research rationale and the study's main aims. The chapter ends by outlining the structure of the thesis.

1.2 A short history of care and welfare development in Ireland

From the early sixteenth century until it formally gained independence from Britain in 1922, Ireland was a British colony. Following Christianisation of the island around the 5th century, through to the British conquest and the Protestant Reformation in the sixteenth century, monasteries traditionally took on the care of the poor and the infirm (Timonen & Doyle, 2008). After the Reformation, the monasteries were disbanded and "for the next three centuries care for the old and poor was sporadic, wholly inadequate and often a reflection of the 'charitably disposed rich people' in the environs" (Timonen & Doyle, 2008: 78; citing O'Connor, 1995: 36). The ensuing centuries were marked by poverty and famine. The colonising British exploited the land's natural resources and its human labour force, while intentionally under-developing its economic and social welfare infrastructure (Brown, 2004). This was especially the case in western rural areas, a world away from the urban areas of Belfast and Dublin where the Anglo-Irish population was concentrated (Brown, 2004). In the nineteenth century, the Catholic Church was experiencing a resurgence, and as Fahey (1998) writes, this rejuvenation was linked to its emerging role as social service provider in many countries around the world:

> "The survival and expansion of Catholicism in the nineteenth century was due in part to the Church's extraordinary success in developing a role as a provider of mass social services. Catholic schools, hospitals, orphanages and other similar institutions multiplied and flourished and, in many instances, anticipated the development of similar services by emergent welfare states" (202).

The reshaping and expansion of religious congregations was the principal institutional development which enabled the Church to achieve this feat. In Ireland, a wave of religious founders emerged in the nineteenth century and set up scores of new orders and congregations. These were devoted to a mixture of social provision and evangelisation both for the poor and the middle classes. The novelty of this movement rested in part on its scale and on the extent of the social services which this scale allowed (Fahey, 1998: 203).

Having established itself as a key social service provider, as the state embarked on the beginnings of a modern system of welfare provision in Ireland, "the Catholic social services came to form as much an obstacle to reform as a means of promoting it. The Church supported vested medical interests in fighting off the extension of public health insurance from Britain to Ireland in the period 1912-18" (Fahey, 1998: 204). Entering the twentieth century and the establishment of the Irish Free State in 1922, and later the Irish Republic, the Church wielded considerable influence in the development of health and social policies at national level. More than policymaking, it was the ideological force guiding said policies.

In a fascinating paper, 'The curse of the Irish Hospital's Sweepstake: a hospital system, not a health system', Irish historian Mary E. Daly (2012) describes how the Irish Hospital Sweepstake, a lottery established in 1930 during the early years of Ireland's independence to raise funds for voluntary (almost all charity-based) hospitals, came to define the hospital-centric approach to Irish health care. She argues that the medical marketplace in Ireland incentivised acute care for two reasons. First, the Hospital Sweepstake, which operated not only in Ireland but also collected money from the Irish diaspora in the US and the UK, "provided a substantial amount of money that was available to fund the construction of hospital beds and to subsidise the running costs of voluntary hospitals; money that was not available to support out-patient or general practice services" (Daly, 2012: 4). In effect, the voluntary sector, funded to a great extent by privately raised funds, stepped in where the young, independent Irish state could not, ultimately supplanting it in terms of providing social services. The second important and related factor Daly cites for the early incentivisation of hospital care was the "influence of Catholic social teaching and the principal of subsidiarity. Catholic social teaching regarded the family as the primary provider of income and care, including medical care; the state should not assume responsibility for matters that are properly the remit of the family, they should only step in when the family failed in its role" (Daly, 2012: 5).

The Catholic principle of subsidiarity mentioned by Daly above was first described in abstract terms by Pope Leo XIII in his 1891 encyclical, and more explicitly invoked 40 years later by Pope Pius XI in his encyclical, *Quadragesimo Anno* (appropriately, 'the fortieth year'), 'On Reconstruction of the Social Order' (Pius XI, 1931). Published at a time when the liberal political order was under threat from socialist workers' movements, Pope Pius XI's encyclical sought to strike a delicate balance. It acknowledged the failures of capitalist systems in meeting the welfare needs of all citizens,

specifically the working classes, while at the same time vehemently denouncing socialism as an acceptable alternative. He positioned the Church as the natural arbiter between these two polarities, reasserting its moral authority amidst the social and political upheaval of the time. By advocating for subsidiarity as the organising principle for the 'reconstruction of the social order', the primacy of the family unit in caring for ageing and sick members, and the community in next order—over which the Church had strong influence in Catholic countries—was reinforced. The encyclical states:

> "As history abundantly proves, it is true that on account of changed conditions many things which were done by small associations in former times cannot be done now save by large associations. Still, that most weighty principle, which cannot be set aside or changed, remains fixed and unshaken in social philosophy: Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do" (Pius XI, 1931: Art. 79).

The encyclical instructed state authorities, "to let subordinate groups handle matters and concerns of lesser importance, which would otherwise dissipate its efforts greatly. Thereby the State will more freely, powerfully, and effectively do all those things that belong to it alone because it alone can do them: directing, watching, urging, restraining, as occasion requires and necessity demands" (Pius XI, 1931: Art. 80). As another Irish historian, Ruth Barrington (1987), writes in her history of the medical system in Ireland, the political dynamics in the country were such at the time that Pius XI's message was ripe for adoption:

> "In 1933, the Minister for Local Government and Public Health, Mr. S.T.O. Ceallaigh, announced in Geneva that 'in no country was this inspiring pronouncement (*Quadragesimo Anno*) read and studied with greater eagerness than in Ireland…the Constitution of 1937, the creation of Eamon de Valera, reflected closely the Church's teaching on the role of the state, the family and Christian marriage and recognised the special position of the Catholic Church as the church of the majority" (Barrington, 1987: 144-45).

With the adoption of the Irish Republic's Constitution in 1937, which John Charles McQuaid, Catholic Primate of Ireland and Archbishop of Dublin had a key role in drafting, the symbiotic relationship between the Church and State became legally enshrined. In the decades that followed, even as Ireland's health system became more modernised, Timonen and Doyle (2008) argue that the influence of Catholic social teaching and the subsidiarity principle can still be clearly discerned. They assert that the latter, "play a role in bringing about a bifurcated system where institutional care is increasingly regulated but formal home care remains the poor relation that is left unregulated in the mistaken belief that the 'traditional' channels and networks of family and community are still in position to perform effectively the role of 'regulator' in the new and more complex world where

private, public and voluntary sector providers are working alongside family carers" (Timonen & Doyle, 2008: 86).

In contemporary welfare regime analyses, Ireland's colonial history and the profound influence of the Church in the development of its social welfare systems renders it something of an odd man out. Ireland is not considered a welfare state in the post-war European tradition, rather it tends to be more closely aligned with the liberal regimes of the UK and United States. Through the political economy lens of Esping-Andersen's Three Worlds of Welfare Capitalism (1990), the development of Ireland's state institutions is characterised as loosely adhering to the corporatist-statist model, in which different sectors of the economy, different professional groups form powerful interest groups. Adshead and Millar write that:

> "Corporatist regimes are also typically shaped by the Church, and hence strongly committed to the preservation of traditional familyhood. Social insurance typically excludes 'non-working' wives and family benefits encourage motherhood. Day care and similar family services are conspicuously underdeveloped and the principle of 'subsidiarity' underscores the fact that the state will only interfere when the family's capacity to service its members is exhausted. The consequence for corporatist regimes was that hierarchical status-distinctive social insurance cemented middle class loyalty to a peculiar type of welfare state" (2003: 2).

The consequences of Ireland's colonial legacy for the (under-)development of its welfare institutions, the expectation that the family act as primary welfare provider, and the related and mammoth influence of the Catholic Church in funding, delivering and determining the structure and substance of social services in lieu of or in partnership with the state, can still be felt in the country's current system of care (Millar & Adshead, 2004; Adshead & Millar, 2003; Cousins, 1997; McLaughlin, 1993), as the next section goes on to address.

1.3 Ageing and care in Ireland in international context

Population ageing is a much-discussed topic among developed nations because of the significant impact it is having and will increasingly have on countries' economies, specifically on the sustainability of public financing for social protection and welfare systems. For the moment, Ireland is still a relatively 'youthful' country. In 2019, according to data compiled by Eurostat, Ireland's population had the lowest share of persons 65 years and older in the EU27 plus Norway, at 14.3 percent, and with just 3.4 percent of its population 80 years of age and older, had the second lowest share of persons in this age group after Slovakia (European Commission, 2021). Most countries report rates closer to 20 percent of the population made up of persons 65 and older, and between four and six percent of persons 80 years and older (European Commission, 2021). The reasons behind Ireland's relative demographic youthfulness, and the recent ageing of its population are complex,

interwoven with seismic social and economic changes the country has undergone in the second half of the twentieth century and the early decades of the twenty-first. Once high fertility rates, a consequence in part of the Catholic Church's power in shaping social policy, specifically related to women's reproductive rights, have dropped in recent years as the Church's moral authority—and its social and political authority—has waned and women's participation in the labour market has increased (Mahon, 1994; Inglis, 1998; 2008). The country's long-standing abortion ban, overturned in 2018, is indicative of the slow modernisation of the Irish state's approach to women's health (Quilty et al., 2016). Also contributing to Ireland's unusual demographics relative to its neighbours is the influx of young, working age migrants from other EU countries, and from the US, Brazil, and other South American countries in particular, many of whom have been attracted by Ireland's position as headquarter (and corporate tax haven) to many large, multinational companies following the country's economic boom in the mid-1990s (Ruhs & Quinn, 2009).

Ireland will not remain forever young, however. By 2070 in Ireland, the share of both individuals aged 65 and over and 80 and over is projected to increase to 27.5 percent and 11.5 percent, respectively (European Commission, 2021). This is one of the largest percent changes between 2019-2070 projected for any EU country. In addition to slowing birth rates, life expectancy for both women and men in Ireland has been steadily rising (European Commission, 2021), corresponding to improvements and innovations in medical therapies and care, and expanded access to healthcare—albeit from a low baseline— in recent decades. While women in Ireland—and across Europe—will continue to live longer than men according to the European Commission's (2021) projections, a degree of convergence between women and men's life expectancy is expected by 2070. For the time being and for the foreseeable future, however, women continue to occupy a greater share of the older age population, especially among the oldest old (European Commission, 2021).

While gains in life expectancy in recent decades is cause for celebration, those additional life years are not necessarily lived in good health (Colombo et al., 2011), and most older adults will require some form of social care or long-term care as they age, placing significant pressure on health and social care systems and on family members to finance and organise care. Public sector spending on health and long-term care varies widely globally. Even among the developed countries of Europe, the range of public expenditure on both is broad. According to Eurostat data, public spending on health care (including long-term nursing care) as a percentage of GDP ranged from 4 percent in Latvia to 9.7 percent in Sweden, with the EU average at 7.8 percent. Ireland's public expenditure on health care in 2018 was 5.3 percent (European Commission, 2021). Importantly, this figure was down from 8 percent in 2011, and up only marginally from 4.4 percent in 1990 (European Commission, 2021). This trend corresponds with the country's broader trends in economic growth, which experienced a surge in the so-called Celtic Tiger years of the mid-90s to mid-2000s, and a precipitous drop in the wake of the 2008 financial crisis and the years of Troika- and self-imposed economic

austerity that followed. No other country's trajectory took as sharp a downward turn in terms of public expenditure on health as Ireland's did from 2011 to 2018 (Economic Commission, 2021; Daly, 2019a).

Comparative data on public expenditure on long-term care is more difficult to capture and assess because the boundaries between the health and social components of long-term care expenditure are often blurry, definitions of long-term care as distinct from health care vary from country to country, and private funding sources, including out-of-pocket payments by individuals and families, are widely underestimated and underreported. According to the OECD's 2022 *Health at Glance*, public spending on long-term care as a percentage of GDP ranged from 0.2 percent in Greece to 4 percent in the Netherlands in 2019 (OECD/European Union, 2022). Ireland comes in below the median, spending 1.3 percent (OECD/European Union, 2022). However, the OECD figures likely overestimate the level of public expenditure on long-term care in Ireland. Moreover, concern about a lack of systematic, transparent, and reliable administrative data related to long-term care in Ireland has been voiced by researchers, advocacy groups and even some policymakers and must be considered when evaluating all such data (Wren et al., 2016; Smith et al., 2019).

The OECD defines long-term care as "a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help" (Colombo et al., 2011: 11). The range of services includes help with basic activities of daily living (ADL) and instrumental activities of daily living (IADL), as well as nursing care, preventive care, rehabilitative care, and palliative care (Colombo et al., 2011). This medicalised definition does not, however, do justice to the concept of care which is significantly more complex than levels of dependency and types of services. Daly and Lewis define 'social care' as, "an activity and set of relations lying at the intersection of state, market and family (and voluntary sector) relations" (Daly and Lewis, 2000: 281). In the Irish context, what the OECD defines as long-term care is usually referred to as 'social care', while 'long-term care' is used to refer to long-term care nursing care provided in an institutional setting. The term 'social care' is used in this thesis to denote all care services for older adults with care and support needs.

Social care services may be provided in a variety of settings, including in residential and adapted living facilities, ambulatory day care centres, or in individuals' homes. For reasons of both cost-efficiency and public pressure, EU Member States are increasingly aligning themselves with the policy of deinstitutionalisation, a term connoting a reduction in care provided in traditional 'closed' residential facilities in favor of care services provided in the home and in the community, intended to enable 'independent living' as long as possible (Mansell et al., 2007; Colombo et al., 2011; European Commission, 2018b). Yet there is evidence that governments in Europe have used deinstitutionalisation as a premise for retrenchment, for cutting funds to public institutional or

residential care without making adequate resourcing available for the formation of community-based alternatives (Ilinca et al., 2015). In addition, the indirect costs of community care are often neglected. These include poorer health of informal, family carers and lower rates of labour market participation for the still mostly women who provide family care (Carmichael & Charles, 1998, 2003; Schulz & Sherwood, 2008; Coe and Van Houtven, 2009; Daly, 2020).

In Ireland, the re-direction of funding and service expansion towards community-based health and social care and away from in-patient hospital care and residential long-term care—or nursing home care—is a core aim of the ten-year health and social care reform programme referred to collectively as 'Sláintecare', enacted with broad political backing in parliament in 2017 (Committee on the Future of Healthcare, 2017). The passage of Sláintecare was achieved after decades of stop-start efforts to reform the country's systems of care. And its implementation has been slow and fraught for a variety of reasons, including, according to some analysts, lack of adequate stewardship/ownership by government officials, territorialism among government agencies involved, immovable vested interests by the medical profession in particular, and fundamentally, a vague implementation strategy (Barry et al., 2021; Thomas et al., 2021).

1.4 Key features of Ireland's health and social care systems

The Department of Health (DOH) is the body responsible for governance, policy direction, and monitoring oversight of public health care services, and for allocating the health budget, including social care. The DOH's implementation arm, the Health Service Executive (HSE), is a separate institutional entity and is responsible for service management and delivery. Cash benefits such as the Carer's Allowance, meanwhile, are administered by the Department of Social Protection, as are tax relief schemes related to the provision of informal, family care. While the focus of this section is on providing an overview of the social care system for older adults, given the shared governance and funding stream of health and social care in the state, and the overlap between the two sectors along the care continuum, key aspects of the country's health care system are relevant and important to note, especially in the context of the coronavirus pandemic. In particular, the state's low acute and critical care capacity, which pre-date the pandemic, was stretched even further, becoming a focal point for policymakers and a driving force in shaping pandemic policy in the health and social care sectors (HSE; March 3, 2021)[3].

Ireland has a national health service, yet it is the only EU country that does not currently provide a universal entitlement to public health care. The overarching aim of the Sláintecare programme, described above, is to move the Irish health care system towards a universal health care model

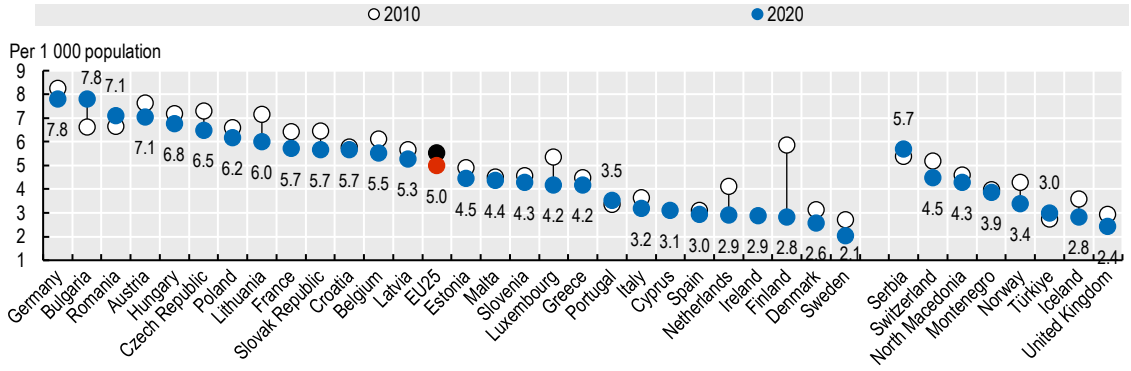
[3] To aid readability, texts included in this study as data, like this one published by the HSE, are cited in the text and in the reference list with full publication date. This was done to avoid confusion and provide a sense of chronology, as in many cases, multiple documents were published by the same author(s) in the same year, and often in the same month or week.

(Committee on the Future of Healthcare, 2017). For the time being, however, the population is divided into those who qualify for subsidised care and those who do not. A means tested 'medical card', targeting low-income individuals and families, entitles the holder to public primary and acute care, free of charge. Select population groups, such as children under six and people over the age of 70, are entitled to a 'GP visit card', a scheme granting access to free primary care. And the 'Long-term Illness Scheme' provides free prescriptions and medical aids/ appliances for people living with certain chronic conditions, irrespective of income level (OECD/European Observatory, 2021). Despite the numerous schemes subsidising the costs of care for specific groups, most of the population does not qualify for any of these. In 2021, around 32 percent of the population was covered by a medical card, and an estimated additional 10 percent of the population qualified for a GP visit card (McGlacken-Byrne et al., 2021), leaving nearly 60 percent of the population uninsured for public primary and hospital care. The analysis by McGlacken-Byrne and colleagues (2021) indicates that levels of coverage across these schemes remained largely stable in the first year of the coronavirus pandemic compared with levels observed in the years immediately preceding its onset, while waiting times for nearly every type of health care increased. During the pandemic, all treatment related to the coronavirus, including testing and (remote) GP consultations was made available to all residents free at the point of use (OECD/European Observatory, 2021).

Almost half of people resident in Ireland, 46 percent in 2021, purchase private, voluntary health insurance (VHI) schemes to supplement access to public services, which is characterised by long waiting times for primary and specialist out-patient care and non-emergency elective care, due in part to a widespread shortage of qualified health care professionals (OECD/European Observatory, 2021; Cullinan et al., 2020). VHI schemes grant policy holders faster access to private screening and diagnostic services, specialist services, and elective (planned) hospital treatment. Those who can afford to pay privately into VHI schemes have access to faster care, while those with medical cards, and those not covered by either public or private schemes, are left to wait for care, sometimes for several months, particularly for specialist consultation and elective procedures, creating a two-tier system of health care (McGlacken-Byrne et al., 2021). Ireland's so-called 'trolley crisis' is an annually recurring phenomenon in which patients seeking acute care are not admitted (allocated a bed) due to lack of available hospital beds but rather are placed on trolleys in ad hoc locations such as hallways (Burke, 2018; Ryan, 2018; Kapur, 2020). There is evidence to support a link between the trolley crisis and delayed discharges from hospital due to lack of sufficient and appropriate home- and community-based care (Walsh et al., 2020; Burke et al., 2023). This has resulted in older patients, many of whom are unable to return home because it is deemed unsafe given the lack of community supports, often having to wait several weeks for a place in a nursing home, and earning the derogatory designation of 'bed blockers' in social and news media (Cullen, 2017).

Public primary care and hospital care are severely constrained in terms of capacity and have been for many years. The number of hospital beds in 2020, as shown in Figure 1 below, was 2.9 per 1,000 population, the fourth lowest in the EU (OECD/European Observatory, 2021). In the years prior to the pandemic, hospitals regularly operated at 95 percent capacity, well above the level considered safe internationally (Cullinan et al., 2020).

Figure 1. Hospital beds per 1,000 population in OECD countries, 2010 and 2020 (or nearest year)



Source: OECD Health Statistics 2022; Eurostat Database (OECD/European Union, 2022:191).

As became clear during the pandemic, however, capacity constraints in public health care are more than a function of a lack of adequate physical infrastructure such as hospital beds or GP practices. Crucially, it is also a workforce issue. Ireland has a shortage of doctors and nurses, a problem that is difficult to solve in the short-term. The number of doctors was 3.3 per 1,000 population in 2019, among the lowest in the EU. The number of nurses is above the EU average of 8.4 at 12.9 per 1,000 population, yet this number has dropped in the past decade, forcing providers to recruit doctors and nurses from abroad (Cullinan et al., 2020; OECD/European Observatory, 2021). Interestingly, in her historical analysis of Ireland's health care system and the Irish Hospitals' Sweepstakes described above, Daly (2012) points out that for much of the twentieth century, Ireland had *too many* hospitals and too many hospital beds, to the neglect of all other forms of health and social care. While other services, both public and private, have been substantially expanded, and hospital capacity has been dramatically reduced, the paradoxical result is that even with capacity constraints, overcrowding, and chronic waiting lists and trolley crises, it is *still* a system skewed in favour of acute over community- and home-based care.

Social care in Ireland is supplied by a mix of public, non-profit, and private care providers (Doyle & Timonen, 2008; Timonen et al., 2012; Daly, 2019b). The financing and organisation of formal public long-term care services is the mandate of the Minister for Health, implemented by the Health Service Executive (HSE). Since 2009, long-term residential care is funded through the Nursing Home Support Scheme, or the 'Fair Deal' scheme (Committee on the Future of Healthcare, 2017). Eligibility for the Nursing Home Support Scheme entitlement is based on clinically assessed need, and financial contribution is based on an assessment of income and assets. In 2020, up to 30,000

individuals over the age of 65 were in receipt of nursing home care services under the NHSS (COVID-19 Nursing Homes Expert Panel, 2020), approximately four percent of the 65 and older population according to Census 2022 data (CSO, 2022). Of 576 nursing homes registered with the Health Information and Quality Authority (HIQA), 80 percent are privately funded and operated (COVID-19 Nursing Homes Expert Panel, 2020).

Unlike residential care, home care in Ireland is not a statutory responsibility of the state. It is funded on an annual, discretionary basis from the HSE's overall budget (Committee on the Future of Healthcare, 2017; Wren & Connolly, 2017). Home care services are not means-tested and allocation of a Home Care Package with a defined number of home help hours is granted based on assessed need, subject to availability. Because the Home Support Scheme is not demand driven, access to services is subject to availability and individual cases are prioritised based on the level of assessed care need (i.e., individuals with high care needs are, in theory, first in line for services), though anecdotal evidence points to the use of different forms of lobbying to jump the line. Home care services are administered and financed at the local health organisation level and are delivered by both public and private providers. In 2015, 47,500 persons received public home care services under the Home Help Scheme and an estimated 18,160 individuals received formal private home care, with an unknown number receiving both kinds of care (Wren et al., 2016). An additional 15,300 individuals were in receipt of a Home Care Package in 2015. The number of hours of care provided through these Home Care Packages is not available (Wren et al., 2016). Prior to 2018, the Home Help Scheme and Home Care Package Scheme were financed through different funding schemes, with Home Care Packages tending to target persons with more complex needs. These two schemes were merged into the Home Support Scheme in 2018.

Despite the increase in year-on-year spending, there are long waiting lists for publicly funded home care, which have only increased since the pandemic began in 2020. In many cases, older people waiting for care have already been approved for home supports but there are simply too few home care professionals to meet the need. In June 2019, the HSE effectively announced a 5-month freeze on the allocation of new home help hours as part of its measures to curb health sector spending (Kelly & Wall, 2019), despite most observers citing inefficiencies in other areas of the health sector and poor budgeting as the primary causes of over-spending (Care Alliance Ireland, 2018; Sage Advocacy, 2019; Timoney, 2018; Gloster, 2018). Analysts agree that the level of public funding allocated to social care, particularly to home-/community-based care, will continue to be insufficient unless it increases in line with demand (Mercer, 2002; Wren et al., 2017; Grotti et al., 2019).

Due to the demographic shift taking place in Ireland, the demand for Home Care Packages is projected to increase by between 44-66 percent by 2030 (Wren et al., 2017). Demand for the number of hours of home care is projected to increase by between 38-54 percent for the same period (Wren

et al., 2017). Yet between 2008 and 2017, the number of clients receiving home care services and the overall number of home care hours was reduced, corresponding to the 2008 economic crisis and subsequent austerity budgets, which included spending cuts for home care services. An uptick in both indicators has occurred since 2014, but neither the number of users nor the number of hours has returned to pre-recession levels (Age Action, 2019).

A 2019 report by the ESRI on the geographic supply of non-acute healthcare services in Ireland reveals significant inequalities in the supply of home care hours by county, inequalities that persist even after controlling for indicators of care need (Smith et al., 2019). The authors cite the lack of resource planning at national level and the high degree of autonomy granted local health authorities in deciding many aspects of non-acute service provision among the causes for these inequalities (Smith et al., 2019; Timonen and Doyle, 2008). Before the two schemes were merged in 2018, the prominence of the Home Help scheme versus the Home Care Package scheme varied significantly across local authorities (Smith et al., 2019).

A lack of statutory home care, and inadequate and unpredictable public funding has resulted in documented unmet care needs among older adults (Grotti et al., 2019). At the end of 2018 in the greater Dublin area alone, 3,359 persons over the age of 65 who were eligible under the Home Support Scheme, and who had been assessed and approved for services, were waiting to receive care (Gloster, 2018)[4]. The total number of people on waiting lists to receive home care nationally was 6,324 at the same time point (Gloster, 2018). Data provided to members of parliament in 2022 (Dáil Éireann, 2022), and which is not publicly available, cites comparable figures for 2022, with "more than 6,000" (Dáil Éireann, 2022) mostly older individuals waiting for public home supports in 2022. The 2018 figures were provided by the HSE following a Freedom of Information (FOI) request. Both figures likely underreport the actual level of unmet need because they do not account for those people who are in receipt of home help hours below the number of hours for which they were assessed, or who have care needs but who have not applied for care under the Home Support Scheme for a variety of reasons (Care Alliance Ireland, 2018; Donnelly et al., 2016).

As a direct result of the backlog in available home care services, older persons are ending up in acute care, spending weeks and sometimes months in hospital despite being well enough to return home with support (Age Action, 2019). Although the Department of Health and the HSE's official policy is one of deinstitutionalisation, most observers are of the opinion that the lack of a statutory

[4] Also in 2018, Care Alliance Ireland placed Freedom of Information (FOI) requests with the 9 HSE regions (also referred to as CHOs) for (1) data on the duration of the waiting period from assessment of care need to receipt of services, and 2) the gap between assessed level of care need and actual provision. Six of the 9 HSE regions responded to request (1). The average waiting time across the 6 regions was 3.3 months for low-priority clients. Four of 9 HSE regions provided an estimate for request (2). On average, there was a gap of 15 percent between assessed need and actual provision. These figures should be treated with caution as not all HSE regions provided data. The names of the HSE regions were anonymised in the Care Alliance report (Care Alliance Ireland, 2018).

entitlement to home care is resulting in institutionalisation, often unnecessarily and against people's preferences (Timoney, 2018). Without a sustainable and dedicated financing mechanism for home-/community-based care, the high levels of unmet need will not improve. In line with its stated aim of expanding home- and community-based services in recognition of the increase in demand for home care, the Sláintecare reforms include a planned overhaul of the home care scheme and the establishment of an entitlement to home care similar to the NHSS (Committee on the Future of Healthcare, 2017). Yet even before the onset of the pandemic, implementation of the home care scheme overhaul was stalled due to a lack of agreement on how to finance the new scheme, among other reasons. It was into this health and social care context of strained capacity in acute hospital care, an over-reliance on informal, family care to the neglect of publicly funded social care services, that the coronavirus exploded in the early months of 2020.

1.5 The first 15 months of the coronavirus pandemic in Ireland

On December 31st, 2019, the first cases of atypical pneumonia were reported to the local media by the Medical Administration of Wuhan Municipal Health Committee in China, and the news was picked up by the World Health Organisation's country office shortly thereafter (WHO, 2020). The international community on alert, governments, public health officials, and ordinary citizens around the world watched as the virus spread and Chinese cities and their residents were placed under lockdown. On the 9th of January 2020, Chinese authorities confirmed that the cases were caused by a novel coronavirus (WHO, 2020). On January 13, 2020, the first cases were reported in neighbouring Thailand, and what had for a short time been designated an epidemic, developed over the course of the next weeks into a pandemic, reaching Ireland on February 29th (WHO, 2020; BBC, 2020).

Owing to its relative geographical isolation from the rest of Europe, the island of Ireland (composed of the Republic of Ireland and Northern Ireland) reported its first case of coronavirus, or Covid-19[5], on February 29, 2020. The first person diagnosed with the virus on the island had flown from Italy to Dublin, and subsequently travelled to Northern Ireland by train (BBC, 2020). As the number of cases in the Republic rose and it was established that transmission of the virus had taken hold in the community, the government initiated a series of increasingly strict social distancing measures, ultimately announcing that a full lockdown of all but essential activities would commence on the 27th of March 2020, ultimately lasting until the middle of May (Department of the Taoiseach; May 1, 2020). Leading the health sector's response in the first months of the pandemic was Simon Harris, a member of Fine Gael, the governing party at the time, as Minister for Health. Following parliamentary elections in February 2020, a coalition government consisting of Fine Gael (liberal-conservative, Christian-democratic party), Fianna Fáil (conservative, Christian-democratic party),

[5] The term 'coronavirus' is used in the text to refer to the SARS-CoV-2 virus and the disease it causes, except when citing sources that use alternate designations.

and the Green Party (green, progressive party), was formed. Leo Varadkar, leader of the Fine Gael party, stepped down as prime minister (*Taoiseach* in Irish), replaced by Micheál Martin of Fianna Fáil. Under the new power sharing agreement, Stephen Donnelly—a member of Fianna Fáil—took over as Minister for Health on June 27th, 2020 (MerrionStreet, 2020). It is contextually important to note that Fianna Fáil and Fine Gael have been Ireland's two major political parties, trading places as the leading party in government since the early days of the Irish Republic. No other political party has lead government since 1932.

On May 18, 2020, Ireland began a tiered, five-phase process of easing restrictions, each phase lasting three weeks and subject to review by government, with the fifth and final phase commencing on August 10th (Department of the Taoiseach; May 1, 2020). For the latter part of August and early September, with the lockdown succeeding in significantly lowering all relevant public health metrics, the most stringent restrictions were lifted, and daily life for most residents returned to a period of relative normalcy, for a brief period.

Citing rapidly rising numbers of new cases, the government announced that on September 18, 2020, Dublin city and county would move to 'Level 3' of the "Resilience and Recovery 2020-2021: Plan for Living with Covid-19", the Government's short- to mid-term strategy for coping with the virus (Department of the Taoiseach; September 15, 2020). On October 6th, the rest of the country was moved to Level 3. A few weeks later, based on a continued increase in the numbers of new cases, hospitalisations, and renewed concerns over increasing community transmission rates of the virus, the government announced that the whole country would move once more to Level 5 restrictions, a second full lockdown, on October 21, 2020, for a period of six weeks, subject to the government's review (Department of the Taoiseach; October 19, 2020). Importantly, Ireland's second lockdown differed from the first in that educational institutions remained open, with face-to-face instruction continuing at primary and second level, and online learning and limited, 'essential', face-to-face instruction operating at third level (Department of the Taoiseach; October 19, 2020).

By the end of November 2020, the number of new cases and hospitalisations had fallen significantly, to the extent that Ireland was reporting among the lowest case numbers in Europe. In anticipation of the approaching Christmas period, the government announced that the country would move to Level 3, with restrictions eased across multiple domains at once, including retail, hospitality, and family gatherings, with some limitations (Department of the Taoiseach; November 27, 2020). Within a few weeks and just days before Christmas Day itself, a phased return to a Level 5 lockdown was announced in response to dramatically rising coronavirus cases (Department of the Taoiseach; December 30, 2020). Ireland was entering a third wave of the pandemic, arguably the most severe one yet, and at the end of March, 2021—the end of the period of observation and data collection for

the purposes of the research presented in this dissertation—the lockdown was still in place with minor modifications in the direction of loosening restrictions.

In Ireland as in other countries, older age groups have been disproportionately affected by the virus in terms of the number of cases reported and particularly their rate of mortality (HPSC; March 22, 2021a). According to data published at the end of March 2021, almost exactly a year after the HSE started reporting such data, out of a total of 4,588 fatalities in the Republic, men and women over the age of 65 accounted for 92 percent of all deaths attributed to the coronavirus; and 43 percent of all recorded deaths occurred among men and women 85 years of age and older (HPSC; March 22, 2021a) (See Appendix A, Table 4). Not only are older adults at greater risk of contracting the virus and at greater risk of developing a severe case, but the residential care settings which are home to 5 percent of Irish residents over the age of 65 and 22 percent over the age of 85[6], have been especially susceptible to outbreaks because of the way the virus is transmitted from person to person (COVID-19 Nursing Homes Expert Panel; August 19, 2020).

Other than private homes, workplaces, and other types of residential facilities, nursing homes for older persons in Ireland experienced the highest number of known clusters or outbreaks of coronavirus (HPSC; March 22, 2021b) (See Appendix A, Table 5). The majority of these outbreaks occurred during the first months of the pandemic, in March, April, and May of 2020, and again following a relaxation of restrictions in the lead up to the Christmas holiday in December 2020, and January, and February of 2021 (HPSC; December 11, 2020) (See Appendix A, Figure 4), events which feature prominently in the analysis of the discourses advanced in subsequent chapters. As in many countries, a number of Ireland's mitigation measures and public health guidance have specifically targeted older population groups, usually persons over the age of 65 or 70 years of age (AGE Platform Europe, 2020). In Ireland as elsewhere, public health officials and policymakers have framed the social and physical distancing restrictions as the only way to protect vulnerable members of society (Department of the Taoiseach; March 12, 2020).

The government's pandemic measures have not gone unchallenged, however. Notably, the Houses of Oireachtas Special Committee on Covid-19 Response, a parliamentary committee, was established in May 2020 at the height of the first wave and were critical of several aspects of the government's response in its final report, notably its handling of the nursing home sector (Houses of the Oireachtas Special Committee; October 6, 2020). To the chagrin of many committee members and civil society observers, the committee was dissolved in October 2020.

[6] Data from Census 2016, accessed online on Ireland's Central Statistics Office website: https://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/agr/

1.6 Background to the project, its rationale, and main aims

When the pandemic erupted in Ireland in March of 2020, I was halfway through the second year of the structured PhD programme with the Confirmation Report and Review process successfully completed (November 2019). My ethics application to the school's research ethics committee several months prior had been approved, and the recruitment and interviewing of participants was already under way. If this sounds like something out of the magical realist genre—a project revolving around the coronavirus pandemic proposed and begun before the coronavirus was a known entity—that is because the research project described above is different in almost every conceivable way from the project that I ended up carrying out.

The original project aimed to explore older persons' experiences accessing home care services in Ireland. It too was designed as a Grounded Theory (GT) study, but instead of analysing discourses, text-based data, the plan had been to conduct in-depth interviews with men and women with care needs who were either already receiving or who were in the process of applying for any number of home care hours per week. I was particularly interested in the intersection of gender and socioeconomic status and the role these elements of a person's identity played in how and why and to what effect a person seeks out formal home care services. I wanted to see what people's experiences might tell us about inequalities in the wider care system, the social and political mechanisms that reinforce those inequalities, and the norms and values underpinning it all. It was a project that was years in the making, developed out of my earlier work in research on long-term care and an interest in qualitative, GT research methodology.

In the course of my work experience conducting research on ageing and care I developed an interest in the ethics of care literature, in feminist critiques of care policy and care systems, and in the human rights literature—particularly the disconnect between achievements in the area of rights for persons with disabilities and the lag in advancing rights for older persons with care needs. I was aware that in Ireland, a statutory entitlement or right to home care did not exist despite years of advocacy and efforts at reform, and despite the right to independent living for older people being a hot button issue internationally. As I came to know the Irish system better, I discovered that while evidence existed that many people with care needs were waiting months if not years to be allocated home care hours—often insufficient hours at that—no rigorous qualitative research had been undertaken to date that focused on older people's experiences of home care and access to home care specifically. Motivated by a strong social justice research ethic, I wanted to draw attention and give voice to the people whose everyday lives were being directly affected by a chronically dysfunctional care system and the seemingly intransigent political actors and processes propping it up.

I was making steady progress on data collection when the Irish government announced the first pandemic measures around mid-March 2020, including the announcement that everyone, but

especially people over the age of 70, should self-isolate. In the first weeks, eyes glued to various newsfeeds, continuing to get work done was relegated to the bottom of the priority list for everyone in my circle. Slowly, however, after the university issued guidelines for continuing data collection over the phone or via online communication platforms (such as Zoom, Skype, Microsoft Teams), fieldwork became possible once more. However, I was faced with additional practical obstacles and a few significant ethical dilemmas.

First, recruiting participants and conducting interviews virtually with members of my target group posed significant challenges. Not necessarily because of their age and a commonly associated wariness of technology—in fact, many older persons have high levels of digital literacy—but because the people I was interested in speaking to, to be eligible for the study, would have had a certain level of physical and/or cognitive impairment requiring support/care. The interviews I had already conducted had clearly demonstrated the difficulty that hearing impairment, for instance, posed for some participants in their day-to-day communications, and this would likely only be heightened when speaking with a relative stranger, and a foreigner speaking English with a different accent at that. I had also found in my efforts at recruitment that making my pitch in person, allowing people to get a sense of who I am and what interacting with me might be like, was far and away the most effective strategy. In-person meetings were no longer possible, of course, and no one could say when things would return to 'normal'.

Ethically, I faced another set of challenges. Although technically I would have been able to meet a participant outside for an interview, I did not want to expose potential participants to the risk involved, or put anyone in a position where they felt pressured into participating given the risk and the fear, anxiety, and uncertainty that characterised those early months. In addition, my recruitment strategy involved first contacting a gatekeeper—a home care or community care service provider in most cases. It was well documented already in the early days of the pandemic just how overwhelmed care providers were, trying to deliver much-needed services in a crisis scenario, often short-staffed due to coronavirus outbreaks on top of pre-existing chronic staff shortages. As a researcher with a well-developed ethical sensibility, I felt strongly that I could not add my request for assistance with recruitment for a doctoral study to their workload. One of the cornerstones of research ethics—beneficence and non-maleficence—enjoins the researcher not only to do no harm but more pointedly, to have the interests and the welfare of participants as a primary goal of the research study. In carrying on with data collection under such circumstances, I would have been contravening this key ethical principle.

Over the course of a few sober conversations with my first supervisor, we talked through various options. The first was to stay the course, suspend data collection and wait and see how things developed in the hopes that I could pick up some months later where I had left off. In her wisdom,

my supervisor cautioned that we were in uncharted and uncertain waters and that there was thus no guarantee that I could resume my work within the next six months. The other option was to shift gears, to choose another topic, design a new research project and move ahead. I chose to do the latter, and while it was a difficult decision—I was thoroughly invested in the original project intellectually, psychologically, and in terms of my time and labour—it has also carried certain rewards.

First has been the opportunity to make an original contribution to the scholarship by analysing a situation unfolding in real time, a truly unexplored topic perfectly suited to GT. Secondly, and perhaps more importantly from my perspective, it allowed me to continue to do what I value most about research, to be *critical* of those in power, where being critical means challenging conventional bases and sources of knowledge, and crucially, as part of that exercise, giving a voice to the less powerful. Thirdly, the shift in focus has given me the opportunity to expand my methodological skill set. While both projects were designed to apply GT, I apply a different variant in my final project than I had proposed to use in my original study, as well as a different ontological/epistemological framework (see *Chapter 3: Methodology* for a detailed discussion). The methods are also different—where in-depth interviews formed the basis of my data in the original project, text-based documents—one type of discourse—constitute the body of data in the research presented here. It has given me a sense of flexibility and confidence in terms of my capabilities as a researcher, and not unimportantly, a sense of myself as someone who is adaptable, resilient. It has also reinforced in my researcher brain that one must always consider the core question being asked and to build the theoretical and methodological framework around it, rather than vice versa.

Ireland's official response to the coronavirus pandemic raises compelling questions about Irish society's attitudes towards older people and its values around care, norms that are deeply embedded in the state's history, in its social and political structures and processes, and in its health and social care systems and institutions. First conceived of in the early months of the pandemic in the Spring of 2020, this study, rooted in a Critical Realist (CR) ontological framework and utilising a blended GT methodology, analyses official government discourses emerging in Ireland around older people and their care in the first 15 months of the pandemic (January 2020-March 2021). While a flood of important research has been published and is ongoing on the pandemic in Ireland and on the government's response, the work presented here constitutes the first large scale discursive analysis focusing on constructions of older persons and their care, and the wider significance of these constructions for Irish social care policy. The key questions I sought to answer in undertaking this research include: how have older persons and their care been constructed and represented in the official discourses over the course of the coronavirus pandemic in Ireland? Which are the actors and actants involved in this situation, and what is their relationality and positioning vis-à-vis one another? Where does (decision-making) power lie in this situation, and who and what are the silent actors and actants, the underrepresented, the marginalised?

1.7 Mapping the structure of the thesis

This introductory chapter has provided important context for the research undertaken as part of this study. The remaining chapters build on one another to develop the theoretical contributions of the thesis step by step. **Chapter 2: Literature review** engages with the international literature on select concepts identified through abductive reasoning in the course of the data analysis. The literature review chapter is divided into two parts. Part I provides an overview of the empirical evidence on the impact of the pandemic on older people, on their physical and mental health, and their social connectedness and daily lives. This literature suggests that pandemic restrictions have had a deleterious effect on overall health and wellbeing, but the extent and scope of the impact is not yet known. Part II of the review engages with the theoretical literature on concepts of vulnerability and autonomy, structured dependency and the management of societal risk, and theories of crisis and temporality. A key insight from the theoretical literature is that vulnerability, rather than an individual trait, can be created, or exacerbated, by state institutions. **Chapter 3: Methodology** positions the research as a Critical Realist study applying a blended GT methodology to the analysis of discourses, and reflects on the reasons for selecting this particular combination of ontological, theoretical and methodological approaches. The chapter also engages with the concept of researcher reflexivity, a central tenet in all qualitative research methodologies. **Chapter 4: A chronological analysis and a laying out of the 'situation' in four acts** is the first of three core chapters presenting the study findings. Chapter 4 sets out to familiarise the reader with the events, with the actors/actants, and the interactions between them—the collective social action—occurring in the discursive situation. The dominance of the biomedical model of health and care, espoused by a core group of experts, and the centralisation of 'emergency' decision-making power in the executive branch, are critical points here. Where Chapter 4 addresses the 'who' and the 'what' of the 'situation', Chapters 5 and 6 mine the data to explicate the 'how' and the 'why' and are structured around the two main conceptual strands to emerge from the data analysis. **Chapter 5: Silences and absences: a focus on actors/actants** analyses the multiple ways in which older people are made vulnerable discursively, foremost in their near complete exclusion from the official discourses, except as a 'group' to be talked about and acted upon by other actors and non-human actants, notably the virus. **Chapter 6: Continuities and discontinuities: a focus on institutional and temporal elements** sees the virus construed in paradoxical ways in the discourses, on one hand as a justification for continued inadequate capacity in the care sector and poor outcomes for older persons with care and support needs during the pandemic, and on the other hand as a force for change and reform in the future. The final chapter, **Chapter 7: Conclusions**, draws the findings and the literature reviewed together to propose a new and grounded theory as to the mechanisms underlying the particular constructions of older people in the official discourses in Ireland during the pandemic.

Chapter 2. Literature Review

2.1 Introduction to the review of the literature

The purpose of reviewing and referring to the scholarship within the framework of a Grounded Theory (GT) study is different in at least one important way from its role in other qualitative methodologies, and indeed in projects taking a positivist, quantitative approach (Charmaz, 2006; Corbin and Strauss, 2008; Timonen et al., 2018). According to GT, the established literature does *not* serve as the basis for the formulation of research questions, for the articulation of hypotheses to be tested, or as the source of a theoretical framework with which to approach data collection and analysis. In a GT study such as this, the overarching research question, while undoubtedly informed and influenced by the researcher's experience and knowledge, is intentionally broad and exploratory, leaving the door open for discovery and for the data to guide the theoretical thrust of the findings. As described in greater detail in *Chapter 3: Methodology*, the GT researcher, guided by the principle of abduction, engages with existing theory and research throughout the process of data generation and analysis to help explain and make sense of the data and to drive the analysis forward towards the development of new theory (or at the least, towards refining conceptual links between emergent categories) (Timonen et al., 2018).

While conducting my analysis, I regularly engaged in abductive reasoning, reading into specific literature as I went through the various stages of coding. This helped me in coming to grips with certain phenomena I was encountering in the data, and at various points in better understanding historical and more recent political and social developments relevant to the situation under study. A more concerted effort to conduct a series of more comprehensive albeit highly targeted reviews of the literature came only after I had completed the bulk of the analytic work. The literature(s) targeted for this more in-depth review were selected based on the main conceptual categories emerging from my data. These include: the constructions of older people as vulnerable and dependent in the context of the pandemic response; the concept of 'risk' and how—and by whom—risk [in this case the coronavirus 'crisis'] is defined and distributed in society; and reacting to the absence of older people's voices in the official discourses, what have been their experiences of the pandemic, and to what extent have their perspectives been investigated and reported on in the scholarship to date (see Appendix F, Figure 8 for 'mind map' of conceptual categories). The 'mini' reviews of these emergent concepts were integral to reflecting on, developing more fully, and tying together the ideas presented in *Chapter 7: Conclusions*.

In accordance with GT, the review carried out is narrative in nature. I looked to the literature to help tell the story of the data rather than to gain an overview of everything written about the respective phenomena or concepts. Using a series of key terms, I searched Scopus, PhilPapers, and Google

Scholar[7]. The literature reviewed is interdisciplinary, drawing on authors from the fields of sociology, anthropology, philosophy, political science, and the health sciences.

2.2 Structure of the review

The review is structured to draw out the linkages between core concepts, with each section building on the one(s) preceding it. The review is divided into two main parts, with the Part I providing an overview of empirical evidence available in the scholarship on older people's experiences during the pandemic. The focus then shifts; Part II of the review expounds on theoretical/conceptual frameworks that I abductively engaged with in the course of the study.

2.2.1 Part I: Empirical evidence on older persons' experiences of the pandemic

The first part of the review lays out the empirical evidence captured by review of literature regarding older adults' experiences of the coronavirus pandemic. As will become apparent in Chapters 4-6, while older people are talked about *ad nauseam* in the official discourses, their perspectives and their experiences of the pandemic and of governments' pandemic measures are largely absent. Reviewing this literature brings older adults' experiences into conversation with the discursive data collected as part of this study, and also serves to highlight the limitations of the extant literature in this regard.

There is increasing evidence that the social distancing measures imposed in most high-income countries, which in some cases specifically targeted (and continue to target) older age groups, has led older people to report feelings of isolation and loneliness, as well as diminished access and utilisation of health and social care services, with associated negative impacts on physical health, mental health, and wellbeing indicators. However, it is also evident that the impact on older persons has not been uniform or entirely clear-cut, with some studies reporting instances where older people welcomed the protectionist measures, particularly in the early stages of the pandemic, and other studies providing evidence of higher levels of resilience among older adults relative to other age groups. An added wrinkle is that the majority of empirical studies are cross-sectional in nature, capturing just one point in time in the lives of participants experiencing the pandemic, a highly dynamic phenomenon.

2.2.2 Part II: Theoretical/conceptual frameworks

The first section in Part II of the review is concerned with the British sociologist Peter Townsend's theory of the structured dependency of older people (1981). It then moves to a brief discussion of sociologist Ulrich Beck's (1992) ground-breaking characterisation of modernity as a *risk society*.

[7] According to a systematic comparison by Martín-Martín and colleagues (2019), Google Scholar and Scopus databases provide the best combination of breadth and depth of coverage in the humanities and social sciences, slightly preferable to Web of Science (in combination with Google Scholar).

Beck, building on Townsend, offers a theoretical framework for understanding how governments and the institutions of state simultaneously manage and create risk—including notably 'crises' situations such as the coronavirus pandemic—and by extension how they contribute to the construction of vulnerabilities across society. A thought-provoking sub-section of the literature on risk and structured dependency deals with the issue of what scholars of critical time studies have termed 'crisis time', and of temporality as a tool or a 'technology' of those in power, concepts that have direct relevance for my findings. The latter part of this section discusses how governments 'managed' the risk posed by the coronavirus to older people and to society at large during the first waves of the pandemic.

The third section is devoted to a close engagement with the ways in which vulnerability in older age has been defined and theorised by diverse authors from various fields, including Goodin (1985) and Fineman (2008). A key division quickly emerges between scholars like Fineman (2008), who ascribe to an ontological, or universal understanding of human vulnerability, and Goodin (1985) and others who propose a structural conception of vulnerability, where certain individuals and groups are *made* vulnerable through their interactions with social institutions. More recently, authors like Rogers, Mackenzie, and Dodds (Rogers et al., 2012b; Mackenzie et al., 2014), working from a feminist bioethics perspective, have critiqued Fineman and the ontological viewpoint to propose a conception of vulnerability as relational, as constructed through interactions with others, with social norms, and with institutions.

These different conceptions of vulnerability have important implications for how we think about older members of society, and for what we believe is owed to vulnerable members of society, and whether dependence (care need) brought on by vulnerability precludes an individual retaining their autonomy. The fourth section discusses the links between vulnerability, dependence, and autonomy. A brief conclusion to the chapter summarises the main points/concepts of interest revealed by the review of the literature.

Two short provisos before continuing to the review. First, it should be noted that by engaging with the literature on risk and vulnerability, I am interested only in making sense of the discourses around these concepts. I am not adjudicating the 'objective' level of older people's risk or vulnerability during the coronavirus pandemic or otherwise, nor am I making any value judgements regarding an 'appropriate' level of risk. Second, I do not review or discuss in detail the contextual literature on care policies in Ireland in this chapter. To a limited extent and focusing on its most relevant aspects, I provide contextual information in *Chapter 1: Introduction*, but to do so comprehensively here would take up the entire chapter. Analyses of Ireland's health and social care policies have been admirably taken on by others with greater depth of expertise (see for example, O'Shea & Hughes, 1994; Walsh et al., 2015; Wren & Connolly, 2017; Barry et al., 2021).

2.3 Part I: Empirical evidence on older persons' experiences of the pandemic

A great deal has been written and published about the pandemic and its impact on older people, internationally and through an Irish lens. This literature includes analyses of multi-country, nationally representative longitudinal studies such as SHARE, the Survey of Health, Ageing and Retirement in Europe (SHARE-ERIC, 2021) and TILDA, The Irish Longitudinal Study on Ageing (Ward et al., 2020, 2021), also smaller-scale cross-sectional survey-based studies, reviews of the evidence, and to a more limited extent, qualitative interview-based studies with specific groups of older people themselves.

Most of the core findings or takeaways from the coronavirus era literature are not entirely surprising or particularly revelatory. After all, that social isolation and loneliness are risk factors for poorer mental, cognitive, and physical health among the older population, as are low take-up and accessibility of health and social care services, was well-established prior to the emergence of the coronavirus, even if the precise causal mechanisms have always been less clear (Courtin & Knapp, 2017; Coyle & Dugan, 2012). Likewise, inequalities across a broad range of health outcomes by income, SES, race and ethnicity, gender, age, and pre-existing health conditions demonstrated by the most recent evidence largely adhere to patterns observed pre-pandemic (Green et al., 2021; Mishra et al., 2021). What is more novel, although it perhaps should not come as a surprise given the heterogeneity of the population, is the diversity of older people's reactions and attitudes to the social distancing and self-isolation measures, and the self-reported qualitative impact these have had on people's lives. What emerges is a complex story, a study in contrasts and contradictions. Many older individuals reported feeling isolated and lonely, while others found the situation empowering and regenerative in certain ways, demonstrating considerable strength and resilience. And while some people expressed frustration and anger with the perceived ageist and paternalistic measures, others expressed gratitude for and derived comfort from what they viewed as protective measures and the concern for their wellbeing of policymakers and society at large. Also notable, if again not necessarily surprising, is the paucity of qualitative studies—internationally as well as in Ireland—designed with a view to capturing the experiences of older adults living at home and especially of those living in residential care facilities, in their own words.

2.3.1 Older adults' experiences of the pandemic

Most of the literature to date focusses on the impact of the pandemic on older adults across a range of outcome measures/indicators and is derived from quantitative survey-based studies. In an early review of the available international evidence on the mental health effects of the coronavirus pandemic on older adults, Vahia and colleagues (2020) determined that there was evidence to suggest that older people were not "experiencing disproportionately increased negative mental health consequences commensurate with the elevated risks they faced during the first few months of the COVID-19 pandemic" (Vahia, 2020: 2254).

Multiple studies from a diverse group of countries cited by Vahia et al (2020) demonstrated that some older people exhibited greater resilience in terms of mental health outcomes relative to younger age groups. For example, a survey carried out by Czeisler et al (2020) and published by the American Centers for Disease Control and Prevention (CDC) found that of 933 participants aged 65 years or older, significantly lower percentages reported experiencing anxiety disorder (6.2 percent), depressive disorder (5.8 percent), or trauma- or stress-related disorder (TSRD) (9.2 percent) than participants in the younger age groups (Czeisler et al., 2020). By comparison, participants aged 18 through 24 years, 49.1 percent reported anxiety disorder; 52.3 percent, depressive disorder; and 46 percent, TSRD. Of 1,911 participants in the 25 through 44 age group, 35.3 percent reported anxiety disorder; 32.5 percent, depressive disorder; and 36 percent reported TSRD. Lastly, of the 895 participants aged 45 through 64 years, 16.1 percent reported anxiety disorder; 14.4 percent, depressive disorder; and 17.2 percent reported experiencing TSRD (Czeisler et al., 2020).

Czeisler and colleagues' findings are in keeping with other cross-sectional studies from Spain (González-Sanguino et al., 2020), the US and Canada (Klaiber et al., 2020), as well as a longitudinal study of community-dwelling older adults from the Netherlands, which found that although levels of loneliness increased following the onset of the pandemic, mental health outcomes did not change significantly (van Tilburg et al., 2021). As Vahia and co-authors (2020) point out, however, there are a few important limitations of these studies that must be kept in mind and that should be addressed by further research. First and most obvious among these is their timing, capturing as they do only the first months of the pandemic, and apart from a few longitudinal studies, providing only a snapshot of older people's self-reported mental health. Another limitation is the dearth of studies investigating the pandemic's mental health impact on older persons living in residential care facilities, a group at especially high risk from the virus itself and from the lockdown measures.

Two studies using longitudinal data collected by TILDA, and published approximately a year apart, provide a sense of how the picture changed as the pandemic wore on. In their first analysis published after the onset of the pandemic, Ward and colleagues (2020) analyse self-reported survey data on loneliness[8] and social isolation[9] among community dwelling adults over 70 years of age, collected as part of TILDA's 5th Wave in 2018. They also include more current administrative data from the Irish voluntary organisation ALONE, which set up a dedicated helpline for older people struggling

[8] TILDA definition of loneliness: "Emotional loneliness is the subjective assessment of an individual's satisfaction with the quality of their social relationships. It is the feeling of loneliness an individual experiences and while most often understood to be the emotion association with social isolation (Steptoe et al., 2013), loneliness can also be present among highly socially integrated individuals (McHugh et al., 2017)" (Ward et al., 2020: 4).

[9] TILDA definition of social isolation: "TILDA uses a measure of the size of an individual's social network to measure social isolation. The size of social networks is measured using the Berkman-Syme Social Network Index (SNI) (Berkman & Syme, 1979)" (Ward et al., 2020: 11).

with isolation and loneliness during the pandemic. According to the survey data collected pre-pandemic, 71 percent of older adults in the survey sample hardly ever or never felt lonely, with 24 percent reporting feeling lonely some of the time, and five percent feeling lonely often (Ward et al., 2020). Higher socioeconomic status and living with others were shown to be protective factors against loneliness (Ward et al., 2020). In terms of social isolation, 63 percent of those surveyed felt most or moderately socially integrated, indicating regular social contacts. Men were more likely than women—25 percent versus 19 percent—to be in the most integrated group, which may reflect the fact that women are more likely to live alone, especially among oldest age groups. According to the data, both loneliness and social isolation were associated with poorer quality of life, with loneliness being a more significant determinant (Ward et al., 2020).

The authors conclude that despite loneliness often being associated with older age groups, older adults in the sample show considerable resilience, with the majority maintaining strong social networks and participating as active members of their communities (Ward et al., 2020). The data from ALONE, however, collected during the early months of the pandemic in Ireland amidst social distancing measures and specifically the 'cocooning' guidelines issued for adults over the age of 65, provide an early picture of the detrimental impact of the measures on users of the organisation's helpline. ALONE reported a significant increase in the numbers of calls per day from people expressing suicidal ideation when the helpline was first launched in March 2020 to June 2020 (from 2-3 calls per week to 3-4 calls per day) (Ward et al., 2020). Similarly, as the weeks passed, more older people called in to the helpline stating that they were dealing with physical pain, with 42 percent requesting support with physical health and personal care. In addition, many callers reported deferring access to health care services due to anxiety about the coronavirus, and some even reported not seeking medical attention following a fall (Ward et al., 2020). ALONE also reported that the majority of people calling in were living alone (76 percent between March and June), and had chronic conditions, indicating that older people in these groups may be more vulnerable to isolation (Ward et al., 2020).

The second report from TILDA, published a year later (Ward et al., 2021) and based on survey data collected during the pandemic, found dramatic increases in loneliness and other outcomes compared to the 2018 data. Average loneliness scores more than doubled, with women and older adults living alone reporting the highest loneliness scores, while those who completed third level education reported feeling the least lonely on average (Ward et al., 2021). Loneliness continued to be associated with poorer physical and psychological wellbeing as well as premature mortality. The data on accessing health care services revealed that almost one third of those over the age of 60 (the target population for the 'cocooning' guidelines) reported delaying or altogether avoiding needed medical care (Ward et al., 2021). Finally, and with critical implications for women in particular, the analysis documented a more than double increase in persons over 60 years of age taking on a caregiving role, from six percent in 2018 to 15 percent during the pandemic (Ward et al., 2021). These two reports

provide valuable information about (community dwelling) older adults in Ireland; not just about the impact the pandemic has had on self-reported loneliness, social isolation, and health care utilisation, but also about the vulnerability of certain groups within the older age population to changes in their daily lives and social networks brought about by the government's physical distancing measures. It is also important to note that the data sample excludes older people living in residential care, a group which experienced the most drastic enforced isolation measures during the pandemic.

A longitudinal qualitative study (Brooke & Clark, 2020) employed semi-structured interviews to explore older adults' (70 years of age and older) early experiences of household isolation and physical distancing in the United Kingdom and in the Republic of Ireland. Taking a phenomenological approach, the authors determined that many of the interview participants had internalised the discourse on older people's heightened risk and vulnerability to the virus, especially in the earliest stages of the pandemic, which were marked by perhaps the greatest levels of uncertainty and anxiety in society at large. The analysis showed, however, that as the weeks and months went by under lockdown, many of the older individuals employed coping mechanisms to deal with feelings of anxiety around catching the virus and the dominant discourses around older people, including distancing themselves from the stereotypes associated with older 'vulnerable' people, and limiting their own exposure to developments in the news and other media (Brooke & Clarke, 2020).

A mixed methods study from the Netherlands, where physical distancing measures were comparatively relaxed in the European context, serves to emphasise the diversity of experiences within the older age population. The study is notable for the inclusion in its sample of a broad range of population groups initially considered to be 'socially vulnerable' in the face of the pandemic (see de Vries et al., 2022, p.124, for authors' definition of social vulnerability), including older adults living in residential care facilities as well as in the community, older adults with mental health problems, and their formal and informal caregivers (de Vries et al., 2022).

Overall, older people 70 years of age and older who were living independently were "not found to be a socially vulnerable group as a whole, despite their physical vulnerability to the virus" (de Vries et al., 2022: 130). According to the quantitative component of the study, 73 percent of those surveyed living independently did not need extra help, 78 percent felt 'happy', and 86 percent felt 'calm' (de Vries et al., 2022). For those participants living in residential care facilities, the maintenance of daily structure and care relationships (virtually but also in-person) was critical to well-being. According to the study, informal, family caregivers, "observed from a distance how the health of their loved ones deteriorated. They expressed concern that behavioural and affective disorders worsened in the period that visitation was not allowed" (de Vries et al., 2022: 132). The authors report that while older residential care residents experienced a level of 'calm' and 'rest' during the lockdown, "the further expectation of remaining cut off from contact with loved ones was unbearable for most" (de

Vries et al., 2022: 132). The study's authors underline the importance of continuing services and supports as mediating factors in counteracting the negative effects of physical distancing and isolation measures on older people's wellbeing. It is notable that research of this kind, funded by the Netherlands Organisation for Health Research and Development, was able to proceed under the circumstances, and might serve as a good practice example for the deployment of rapid research to inform policy in times of crisis.

Two further studies from the Netherlands argue that 'loneliness' encapsulates a complex set of emotions and experiences and that research, and indeed policy, must take this nuance into account when considering the effects of physical isolation on older adults (van Tilburg et al., 2021, 2022). The studies, conducted by the same group of researchers, are among the few to distinguish between different dimensions of loneliness. The authors apply Weiss's (1973) framework to investigate older adults' experiences of emotional, social, and existential loneliness[10] (van Tilburg et al., 2021, 2022). Both studies use The Longitudinal Aging Study Amsterdam, comparing data collected in 2019 with data from the first and second waves of the pandemic in 2020, respectively. The earlier study found that while rates of loneliness increased, mental health outcomes remained mostly stable. While participants did not seem to be experiencing social loneliness as a result of the physical distancing measures during the first wave, there were already indications of a significant increase in emotional loneliness (van Tilburg et al., 2021). The later study, capturing data during the second wave, reinforced the earlier study's findings and found that levels of emotional loneliness in particular rose further. Having a partner or living with others offered some protection, but even among those, rates of emotional and existential loneliness were raised.

Two studies from the US (Austin, Texas) and Portugal, respectively, focus specifically on the experiences of older adults living alone during the pandemic (Fingerman et al., 2021; São José et al., 2022). The US study, using self-reported survey data from 226 individuals aged 69 years and older, provides evidence on the role social contact plays in older adults' emotional wellbeing (Fingerman et al., 2021). Fingerman and colleagues found that older adults' wellbeing was negatively impacted by a lack of or reduced *in-person* contact specifically. Virtual interaction was not a satisfactory substitute for the majority of those surveyed. The authors found that "in fact, telephone contact among those who lived alone was associated with higher levels of negative affect, and specifically with loneliness" (Fingerman et al., 2021: e118). The authors conclude that older adults living alone may be at greater risk of loneliness and social isolation as a result of government issued distancing measures (Fingerman et al., 2021).

[10] van Tilburg et al. (2021; 2022) define emotional, social, and existential loneliness as follows: "*Emotional loneliness* originates from situations in which the relationships' quality or intimacy one desires has not been realized. *Social loneliness* originates from the absence of being embedded in a broader group of contacts. *Existential loneliness* is a sense of meaninglessness in life (Weiss, 1973)" (van Tilburg, 2021: e249).

The qualitative, semi-structured (telephone) interview-based study carried out by São José and colleagues (2022) in Portugal looks closely at the impact of the home isolation measures on older adults' daily lives and activities. Adopting the sociology of everyday life as their framework (see also Sztompka, 2008, and Neal & Murji, 2015), the researchers find that most of their 23 participants, aged 65 and older, experienced the home confinement during the first lockdown as a series of losses in multiple areas of everyday life. These included the loss of activities outside the home, of face-to-face social interactions, and of independence more generally. A sense of imprisonment, and of a specific physical loneliness, an absence of touch and affection, was expressed by many of the interview participants. Just one participant found the home confinement to be a 'pleasant' experience.

The same authors describe a clear gender and socioeconomic dimension to the impact of home confinement. Women tended to report feeling a loss of independence as a result of being unable to carry out activities outside the home, such as grocery shopping. In the Portuguese context, older people living alone tend to live in urban apartments with limited access to outdoor space and are more likely to belong to lower socioeconomic groups (São José et al., 2022). For the authors, these findings indicate that the home confinement measures exacerbated pre-existing social inequalities, a finding that is held up by research from other countries **(**Green et al., 2021**)**.

Cipolletta and Gris's (2021) conducted semi-structured interviews with 30 adults between the ages of 72 and 94 in Northern Italy. Their qualitative study of older people's experiences and coping strategies during the first wave of the pandemic further demonstrated that older people's experiences and ways of coping varied widely, and that while some individuals were able to draw on existing social networks and personal resources to cope with the enforced isolation and resulting loneliness, for others, pre-existing experiences of social isolation and weak social ties were exacerbated (Cipolletta & Gris, 2021). Like the study by São José and colleagues (2022) from Portugal, Cipolletta and Gris's analysis provides evidence that some older people were more vulnerable to the effects of physical isolation than others, and that often, these vulnerabilities emerged along existing lines of social inequalities among older age groups.

In Ireland, a qualitative, exploratory study by a team of researchers based at Trinity College Dublin provides the country's most in-depth investigation of how community dwelling older people experienced the pandemic restrictions (Phelan et al., 2021). Conducting interviews with 20 older men and women aged between 59 and 92 years of age, Phelan and colleagues' (2021) findings provide evidence of the significant negative impact that multiple lockdowns have had on the physical and mental health of older adults in one eastern region of the country. Despite the detrimental effects of the pandemic measures, Phelan and colleagues (2021) also found many of the older people interviewed displayed remarkable resilience, citing support from their social networks as instrumental in their coping with feelings of isolation and loneliness. The authors conclude that

participants' social capital, specifically the social capital they had access to as members of their respective communities[11], was a crucial mitigating factor.

Beyond the impact on participants' health, the study by Phelan and colleagues (2021) provides important insight into the myriad ways in which the pandemic disrupted the everyday lives of the interview participants, altered their senses of identity, and moved some to reflect on their age, their vulnerability, and on their own mortality differently, or in some cases, for the first time. Relatedly, the study reflects on how several participants processed the temporality of the pandemic in relation to their own lives, demarcating between their lives *before* and *since* the pandemic (Phelan et al., 2021).

Also from the Irish context, a report published by the Alliance of Age Sector NGOs (Gilbert, 2021), an umbrella organisation of NGOs working in the ageing and social care sector, sought to provide early anecdotal evidence on the experiences of older people living in the community. The report is explicitly framed as a countermeasure to the lack of consultation and perceived marginalisation of the voices of older people, of family members, of care professionals, and of advocates in the government's response to the pandemic and especially to the 'cocooning' guidelines. The report, titled "'Telling It Like It Is': What older people told us about their experience of Covid-19, and what Ireland should do about it", distances itself from what its authors call 'formal research', claiming instead to be one of the only initiatives to have considered what older people themselves have to say about their experiences. The report "contains little in the way of formal research and data. It aims to tell it like it is, directly, as our staff, volunteers and members heard it from older people themselves" (Gilbert, 2021: 8). The authors set themselves apart from the 'experts' and the reams of statistical data they produced, ubiquitous during the pandemic, and from policymakers, with both groups perceived as having side-lined older people's voices. The views of its authors aside, the report draws on member organisations' interactions with older people through their various care and support services, and the information in the report is the result of "what older people told us during the pandemic" and "what we observed" (Gilbert, 2021: 8). In keeping with what 'formal research' has told us, the Alliance's report found a diversity of experiences and reactions to the pandemic measures, but that for most, the extended periods of isolation had negative effects on their wellbeing:

> "Many expressed gratitude for the protection measures that were put in place, and for the support and consideration that many communities excelled at. But they also voiced frustration, anger, worry and concern about the unintended or unforeseen consequences of the protection measures. As lockdown followed lockdown, it turned out that, for many older people, and despite their resilience, the side-effects of Covid-19—loss of confidence and

[11] Phelan et al. (2021) refer to the OECD's definition of social capital: "networks together with shared norms, values and understandings that facilitate co-operation within or among groups" (OECD, 2001:103).

> capacity, loneliness, isolation, anxiety, depression—were and are as harmful as the disease, and perhaps more so" (Gilbert, 2021: 4).

If we now have something of a sense of how older people living in the community experienced the pandemic, it is striking how little evidence is available on the experiences of people living in residential care facilities. A cross-sectional, nationally representative survey-based study from Sweden (Johansson-Pajala et al., 2022) is one of the few exceptions. Investigating anxiety and loneliness among older people living in residential care as well as those receiving home care services, Johansson-Pajala and colleagues (2022) aim to fill a clear gap, stating that "despite a large body of research on the pandemic, there is little research on its effects on subgroups of older people, including those living in RCF [residential care facilities] and those receiving HCS [home care services]" (2). The authors found that among both groups, feelings of loneliness were more commonly expressed than feelings of anxiety, and that experiences of loneliness increased as the pandemic progressed (Johansson-Pajala et al., 2022). They also determined that both anxiety and loneliness were more prevalent among the survey participants living in residential care than among those receiving care at home (Johansson-Pajala et al., 2022). In their discussion, Johansson-Pajala and co-authors (2022) urge social care providers to better balance the risk of infection from the virus with the risks of isolation and loneliness for care recipients.

In Ireland, HIQA, the HSE, and the Department of Health jointly operate the National Care Experience Programme, which deploys a suite of surveys annually, including the National Nursing Home Experience Survey (NNHES). In 2022, the NNHES included *one* open-ended question on the coronavirus experience—the penultimate question—in a 52-question battery conducted as part of structured, face-to-face interviews with nursing home residents. Staff at the randomly selected, nationally representative 53 nursing homes were asked to identify potential participants based on their "having the physical, psychological, cognitive, and social capabilities required to take part in the interview", raising concerns about selection bias (HIQA, 2022: 15). Of 1,055 residents deemed eligible to participate, 718 residents ended up taking part (68 percent of eligible residents). Residents were asked, "Do you have any comments about how the COVID-19 pandemic affected the care you received here or your overall experience here during that period? If so, please elaborate" (HIQA, 2022: 39). While residents overwhelmingly reported being satisfied with the quality of care received, the cleanliness of the facilities, the nursing home staff, and so on, there are glimpses of the struggle to cope with the stringent and long-lasting lockdowns that nursing home residents were subject to, and especially the inability to see family members, as can be discerned even from the short shrift accorded the responses in the report (see Table 1 below) (HIQA, 2022).

Table 1. Overview of responses to Question 51 in the National Nursing Home Experience Survey, 2022

Theme	Feedback received	Illustrative quote
Quality of care	Comments were typically positive about the care received during the COVID-19 pandemic. Residents frequently described the care received during that time as being good, the staff being attentive and the situation being well handled. Some references were made to missing visits from family, but residents said they understood why precautions were taken.	"They did their best to keep COVID out and were very strict about it. The staff were very good and they did what they were told as well."
Visiting	Comments related to restrictions on visits and their impact on the resident. Residents also noted how they coped.	"No visitors allowed but I used my phone."
Spiritual care	Comments related to the psychological impact of the restrictions, including feeling alone, isolated, and uncertain.	"I was isolated myself and that was discomforting."
Medical care or condition	Comments referred to receiving vaccinations for COVID-19, getting COVID-19 and its impact, and symptoms experienced.	"I was quite tired when I had COVID and have backache since."

Source: National Nursing Home Experience Survey 2022, Table 10 (HIQA, 2022: 42).

A mixed-methods study by a team of researchers at University College Dublin in Ireland analysed the impact of the pandemic on residents, family members, and nursing home staff (Sweeney et al., 2022). The study was carried out in two phases and consisted of an online survey after the first wave of the pandemic, administered to residents, family members, and staff; followed by interviews with family members of residents after the second wave. The study revealed the "extreme" negative impact of the pandemic on all groups surveyed and is one of the only studies to place an emphasis on the relational nature of care in the context of the pandemic and residential care settings (Sweeney et al., 2022).

2.4 Part II: Theoretical/conceptual frameworks

2.4.1 Structured dependency theory and the distribution of risk

It is apparent from engaging with the literature presented above that states' social policies—in reaction to the spread of the coronavirus but more pointedly in the many years and decades prior—have played a role in determining how older individuals experienced the pandemic. As several authors in the previous section point out, it is neither adequate nor accurate to portray the impact of the pandemic on older people as a consequence of individual behaviour or disposition, or indeed as determined by factors such as age, health, and personal, financial and social resources. Rather, the effects should be viewed through a macro-level lens, through the lens of intersecting social inequalities, which long pre-date the pandemic and which have developed as a result of state and regional economic and social programmes. While the evidence has certainly shown that some groups of older people are more vulnerable to the coronavirus, the discourse cultivated around older people

as a vulnerable group *en masse*, and the restrictions following on from that discourse, were far from inevitable even if it often felt that way to members of the public and to policymakers and the experts themselves. Peter Townsend's (1981) structured dependency theory provides an illuminating framework for understanding just how social policy—and the people who enact it—'create' dependency, and by extension vulnerability, among older members of the population.

Townsend authored several foundational works in the fields of social gerontology and the sociology of ageing (see Townsend, 1954, 1957, 1962) and remains a hugely influential scholar to this day (Walker, 2009). While his research focus changed and evolved over the course of his career, his overwhelming contribution was to question and to elucidate the structural framework within which ageing, 'old age', and our expectations of and attitudes towards older people are rooted (Townsend, 1981). His early work was a marked departure from the predominant approach at the time, which he describes in the following way:

> "This emphasis on trying to explain individual ageing within a structure, and especially class structure, which was accepted without question, rather than trying to explain that structure, its interrelationships and its development, as a necessary precondition in the exposition of a theory about ageing and the aged, was shared by most social gerontologists. It was derived from neo-classical economic theory and the associated thinking of those working within the tradition of functionalism in sociology, as well as the more descriptive and empirical traditions of social work and social administration" (Townsend, 1981: 6).

It is in his 1981 paper, which appeared in the very first issue of the journal *Ageing & Society*, that he articulates his theory of structured dependency of the elderly (Townsend, 1981). His central argument is "that society creates the framework of institutions and rules within which the general problems of the elderly emerge, and indeed, are manufactured" (1981: 9).

Townsend's contextualisation of individual ageing within the broader liberal economic consensus dominant in post-Second World War Europe and North America, made plain that social norms around working life, retirement (including retirement age thresholds), care for older people as the responsibility of family members, women as 'natural' caregivers, and state institutions known as 'nursing homes', which stepped in when families 'failed' in their duties, were 'manufactured' by those in positions of power in order to uphold the capitalist means of production (Townsend, 1981). The arbitrary and enforced retirement age of 60 plus, which most of the developed world has adhered to since the creation of the welfare state—and which, incidentally, keeps creeping upwards as demographic ageing is causing countries to re-evaluate their spending on growing numbers of 'dependent' older people—renders an individual a non-earner, dependent on private savings and/or state benefits. In a nod to Foucault's *Discipline and Punish* (1977), which examined the exercise of power in state institutions, Townsend argued that the institution of the nursing home—which

developed out of Victorian era 'workhouses' for the poor—were, in their early incarnations at least, very clearly sites of punishment for families who transgressed against social norms of care as a private, family matter, rather than a public, state one (Townsend, 1962, 1981).

Another of Townsend's important insights is his definition of the social rather than physical or mental dependence of older persons. Writing about the social dependence of older people-as-inmates created within the walls of the nursing home-as-institution (in the tradition of Goffman (1961), and Foucault (1977), Townsend outlines how constraints built into the organisation of the institution and the formal expectations on them induce staff to "take an unduly pessimistic view of residents' capacities" (1981: 17) and create dependence where it otherwise might not exist or develop. It is remarkable that, writing in the 1980s, Townsend goes on to describe a situation that has only become more pronounced in the ensuing decades in nearly all high-income countries, namely, the reduction of funding for long-term care beds in publicly funded hospitals. This has resulted in the complex and difficult task of caring for severely disabled older individuals falling to underqualified nursing home staff, who also need to accommodate the needs of residents who are not wholly dependent. As a result of the expectation on staff to balance different levels of care need, Townsend writes:

> "The majority of residents in Homes are placed in a category of enforced dependence. The routine of residential Homes made necessary by small staffs and economical administration, and committed to an ideology of 'care and attention' rather than the encouragement of self-help and self-management, seems to deprive many residents of the opportunity if not the incentive to occupy themselves and even of the means of communication" (1981: 20).

If Townsend's structured dependency theory gives us the framework for understanding how older people's dependence is 'manufactured', Ulrich Beck's grand theory of the *risk society* helps us understand how older individuals' dependence on others for care and support and their vulnerability to multiple named and unnamed risks, is a self-inflicted condition of modern society (Beck, 1992, 2006).

In Beck's own words, "Modern society has become a risk society in the sense that it is increasingly occupied with debating, preventing and managing risks that it itself has produced" (Beck, 2006: 332). In their introduction to Beck's seminal 1992 book 'Risk Society: Towards a New Modernity', Scott Lash and Brian Wynne outline Beck's contribution as bringing a critical reflexivity to our understanding and study of the post-industrial, modern era, an era characterised by global rather than local or regional risks and existential threats, most prominently the risk posed to all humanity, irrespective of traditional class divisions, of ecological disaster brought on by man-made climate change (Lash & Wynne *in* Beck, 1992). Lash and Wynne write:

> "…the dominant risk paradigms have been able to surround themselves with the appearance (and self-delusion) of critical pluralistic debate and learning, through the growth of a plethora

> of disciplines, sub-disciplines and schools of thought vigorously competing for ascendancy and recognition in the interpretation and 'management' of the risks of modern technological society. […] A small group of sociologists and anthropologists from beyond the cultural pale of this hegemony have made three observations in particular. First, such physical risks are always created and effected in social systems, for example by organizations and institutions which are supposed to manage and control the risky activity. Second, the magnitude of the physical risks is therefore a direct function of the quality of social relations and processes. Third, the primary risk, even for the most technically intensive activities (indeed perhaps most especially for them), is therefore that of social dependency upon institutions and actors who may well be - and arguably are increasingly - alien, obscure and inaccessible to most people affected by the risks in question" (Lash & Wynne in Beck, 1992: 4).

Beck's theory of a risk society is relevant to the research undertaken in this study for several reasons. First and foremost, it illuminates how 'risk' is produced, distributed, and managed in society through social institutions, especially the institutions of state. His call for reflexivity in analysing our modern, globalised society forces us to consider phenomena like the coronavirus pandemic, and the broad-ranging 'crises' it gave rise to—not least the crisis in care— as something other than a given or as a necessary eventuality. Beck's work also summons important questions and insights into the role of experts in defining and managing risk, such as the risks posed to members of the public and especially older people, that we have seen play out in response to the coronavirus pandemic 'crisis'. In his 1992 book, Beck proposed five core theses of his theory. The first is of particular relevance here:

> "Risks such as those produced in the late modernity differ essentially from wealth. They induce systematic and often irreversible harm, generally remain invisible, are based on causal interpretations, and thus initially only exist in terms of the (scientific or anti-scientific) knowledge about them. They can thus be changed, magnified, dramatized or minimized within knowledge, and to that extent they are particularly open to social definition and construction" (Beck, 1992: 22-23).

The main thrust of Beck's thesis is that the unprecedented complexity of the modern world, in which global social processes operate in such a way as to render precise causal mechanisms elusive, means that causal mechanisms are open to interpretation and thus can only be constructed. Certain groups with certain knowledge and in certain positions of power can thus dominate the discourse and determine consensus interpretations of events. As Lash and Wynne put it in their introduction, "Reflexivity is excluded from the social and political interactions between experts and social groups over modern risks, because of the systematic assumption of realism in science" (Lash & Wynne *in* Beck, 1992: 4). Miranda Fricker's theory of epistemic injustice—in which certain groups are discriminated against and made vulnerable in their capacity as *knowers* or knowing subjects—has strong echoes in Beck's work (Fricker, 2007).

2.4.2 Older people and the management of risk during the coronavirus pandemic

In the first months of the pandemic, as governments around the world confronted the 'novel' situation posed by the coronavirus, in almost all cases implementing restrictions on people's movements, deploying resources to control the spread of infection, and ramping up capacity in acute care settings, researchers from a wide array of disciplines monitored and provided analyses of government's responses in real time. A website developed by the International Long-term Care Policy Network at the London School of Economics, called 'LTC Responses to Covid-19'[12], collected data, commissioned country reports, and produced 'living reports' in an effort to provide comparative, up to date information on how government responses in the area of long-term care were taking shape (Comas-Herrera et al., 2023). The trove of information available on the site, together with other, later analyses by researchers, indicate that the pandemic response in different countries was heavily determined by respective countries' existing care infrastructure and established governance processes (Comas-Herrera et al., 2023; Daly et al., 2022; Unruh et al., 2022).

Unruh and colleague's comparative analysis of the response in Ireland, the United States, United Kingdom, and Canada, a cluster of liberal welfare regime countries, found that while the countries faced similar challenges, such as scaling-up testing capacity, and implementing timely and appropriate containment measures while confronting shortages of health and social care workers, PPE, and other medical technologies and infrastructure, the substance of the response differed significantly. The authors identify "differences in health system organization and financing, political leadership and governance structures" as critical factors determining respective countries' responses (Unruh et al., 2022: 427). Ireland's poor health infrastructure, specifically its low numbers of acute and intensive care beds, is cited as a key consideration in its government's decision to enforce a national lockdown in the early stages of the pandemic (Unruh et al., 2022). The country's strong centralised government, its relative small size, and a close alignment between policymakers and scientific experts in terms of public messaging, made the country-wide lockdown possible, according to the authors. This is in particular contrast with the case of the United States, where the large size of the country, the power of individual states to make their own policy, and widespread mistrust of 'expert-elites', led to an uneven enforcement of and compliance with social distancing (Unruh et al., 2022).

Another comparative paper by Mary Daly and colleagues (2022) looks specifically at the care home policies of the Danish, English, German, Italian, and Spanish governments. The authors observe a clear clustering of countries, which are embedded in the institutional context of their long-term care systems. Evaluating the response in care homes in terms of the timing and duration of lockdowns, testing policy, and the supply of PPE, the authors find that Denmark and Germany adopted a

[12] The website of the 'LTC Responses to Covid-19' initiative: https://ltccovid.org.

proactive approach, while England, Italy, and Spain demonstrated substantial weaknesses leading to delayed and inadequate responses (Daly et al., 2022). Again, the authors point to the adequacy and efficiency of social care systems pre-pandemic as the deciding factor. They conclude that "differentiating the countries are the resourcing of the sector, the regulation of LTC and care homes, and the degree of vertical (and to a lesser extent horizontal) coordination in the sector and between it and the health sector" (Daly et al., 2022: 48).

The research cited above provides valuable health policy analysis of the ways in which countries' approaches to managing the pandemic risks in the care sector were constrained by their respective structural and process-related conditions. The overall message is not especially surprising, but it is telling. Two papers by M. Daly (2022), and by F. Daly and Claire Edwards (2022) take a more theory-driven approach to analysing how care was conceptualised and managed during the pandemic. M. Daly's (2022) contribution centres around how European countries responded to the pandemic "in regard to the types of care need that were recognized, the resources committed, the actors/agency that were supported or taken for granted and the values underpinning the responses" (1). What she discovers is that while care was prominent in public rhetoric and discourses, investment by states remained inadequate, care for children and older adults was 're-familialised', and social care was relegated to a position of secondary importance behind medical, specifically acute hospital care (Daly, 2022).

F. Daly and Edwards (2022) meanwhile, conducted a discourse analysis of Ireland's parliamentary Special Committee on Covid-19 Response to examine discourses about care. Their analysis is grounded in feminist care ethics and their findings echo M. Daly's (2022) above. Of particular interest, they find that informal care was eclipsed in the discourses by a focus on the formal health care system, and that gendered inequalities in the provision of care in the home and in formal care settings went largely unacknowledged. Notably, Daly and Edwards (2022) find that the voices of those with care needs are excluded, silenced. Both contributions see governments' responses as reversions to old practices and values in which public and private responsibility for social care, as opposed to medical, clinical care, is clearly demarcated. An important takeaway from these discussions is that the pandemic served to highlight the low societal value broadly afforded social care. Ethicists Smith and Upshur (2020) argue that in order for governments to learn from the lessons of the pandemic, it is necessary to recognise that underlying the inadequacies and failures of the institutional response is a moral failure: "Unless we appreciate that we have a defect in our collective moral attitude toward remediating the conditions that precipitate the emergence of outbreaks, we will never truly learn" (1).

2.4.3 Temporality, times of 'crisis', and the exercise of power

Following neatly on from Townsend's structured dependency theory, and Beck's theory of modernity as a *risk society*, this section engages with the concept of time as a fundamentally political and social

phenomenon and temporalities of crisis as sites of power. Recent contributions to critical time studies by Wigen and colleagues (2022) and Valkenburg (2022) are particularly relevant as they investigate the discursive work that temporal 'technologies' accomplish in times of crisis, specifically pandemics, and theorise the role of temporality in creating epistemic oppression, buttressing hegemonic ways of *knowing* and *being in time*, respectively. The discussion then moves on to engage with a number of papers that theorise how time has been constructed and used in the context of the coronavirus pandemic. This discussion barely scratches the surface of a broad and deep literature on time and temporality, nonetheless it affords important insights for the development of my analysis in Chapters 4-6 and *Chapter 7: Conclusions*.

Einstein's Theory of Special Relativity revolutionised our understanding of how time functions in the physical world. In simplest terms, his theorem proved that time is not absolute but relative, that the rate at which it passes depends on one's frame of reference (Einstein, 1905). 'Temporality' in the social sciences is used to express the ways in which human beings think about and relate to time, its duration and passage. While the passage of time is an objective feature of the physical world, how human beings interact with it, how we perceive and define time, and how we choose to organise ourselves and our institutions temporally, in relation to time, is socially constructed and interpreted (Valkenburg, 2022).

As Kirtsoglou and Simpson (2020) write, "the apprehension of time as duration is always mediated by representations and epistemologies that are systematic and shared" (2). In other words, how we experience time as individuals is influenced by social and political norms and values and the cultural symbols we attach to them. This, in turn, reinforces certain temporal epistemologies to the extent that they go largely unquestioned in everyday life. For example, the assumption that time is linear and that events are fixed in the past, present or future is disputed by various subaltern ontological frameworks. Valkenburg puts it succinctly: "Time is thus both a constituent of social life and produced through social life. This simultaneously foundational and contingent position renders it a primordial site for the exercise of power" (442). Foundational because time is an inexorable and inescapable aspect of our reality, and contingent because, returning to Einstein, how we perceive time depends on our frame of reference. More pointedly for Jarvis (2022), time is political: "Time, […] is both producer and product of political intervention. It is constitutive of political identities, processes, and actions. And it is constituted, at least in part, precisely through political processes and actions" (27).

If we accept that time is socially constructed and temporalities inherently political, it follows that different temporal frames will privilege certain epistemologies over others. In a recent paper on temporality and epistemic (in)justice, Valkenburg writes,

> "The power-wielding role of time has been a central topic in critical thought. In the thought of Elias, as explained by Nowotny (1992: 427), time is primarily a relational symbol by which groups connect multiple trajectories of change. The power to choose which symbols are chosen precisely and which changes are connected is a vital asset in defining those groups themselves. Defining the symbols a group thinks by, in effect, defines the preferred epistemology of the group" (2022: 442).

Drawing on Portschy's (2020) engagement with Foucault's writings on the relationship between time, knowledge and power, Valkenburg (2022) continues:

> "Time is eventful and relational. In this relationality, time orders the sequence of events and defines simultaneity and co-presence. Time is an example of what Foucault calls 'dispositives': institutional and cultural structures that afford and constrain action, thought and knowledge. As one of those structures, time is dispersed through the whole body of social life. There is thus a fundamental relation between time and power" (442).

Foucault's neologism of a 'dispositive' (*dispositif*) (like an 'apparatus' but decidedly not an apparatus because an apparatus connotes something rigid, machine-like), a structural mechanisms through which power is exercised in the social body (Foucault, 1978, 2021), is useful for thinking about time and temporality as a channel through which power relations are enacted, reinforced, and through which they change and shift.

'Capitalist time', or time managed according to the principles of a capitalist economic and social order, is an oft-cited and oft-critiqued example of a dominant form of time connected to a dominant epistemology, one with direct relevance for this study. Within the framework of capitalist production management, time is quantified and commodified in highly specific ways (Adam, 2003; de Sousa Santos, 2014; Valkenburg, 2022). Feminist sociologists have long pointed to the intersectional oppression of women and of racial and ethnic minorities under capitalist economic systems, with an extensive literature on the ways in which members of these identity groups are excluded from traditionally (white, heterosexual) male spaces, activities, and roles, and disadvantaged as a result (see for example Acker, 1988; Fraser, 1997; Daly, 2002; Calasanti, 2010; Tronto, 2013). The dominant epistemologies of capitalist, neoliberal systems exclude social reproduction or reproductive labour, and the *time spent* on such labour, long considered 'women's work', from its economic models, and likewise relegate people beyond a certain chronological age— 'retirement age'—to 'unproductive' status within economic and social welfare systems.

2.4.4 Temporalities of crisis

The coronavirus pandemic is often referred to as a 'crisis'. The term denotes an event defined by distinct temporal associations and boundaries (Roitman, 2016). Coming from the ancient Greek word

'*krinô*', meaning, variably, to separate, to choose, to cut, to decide, to judge, the root of the modern word 'crisis' "suggests a definitive decision" is underway (Roitman, 2016: 20). First appearing in the medical writings of Hippocrates to refer to the precise point at which a patient's illness takes a turn—for better or for worse—'crisis' has since come to be widely used to describe periods of social, political, and economic upheaval, as well as environmental and biological events, among other phenomena.

In her book *Critical Theories of Crisis in Europe: From Weimar to the Euro*, Roitman (2016) unpacks how it has come to be that a term whose original meaning refers to a finite episode is now ubiquitously used to refer to drawn-out, unending situations: "How did crisis, once a signifier for a critical, decisive moment, come to be construed as a protracted historical and experiential condition? The very idea of crisis as a condition suggests an ongoing state of affairs. But can one speak of a state of 'enduring crisis'? Is this not an oxymoron?" (6). Recalling Beck's notion of modernity as a risk society, Roitman (2016) argues that 'crisis' does important discursive work in the formation of contemporary political and historical narratives, in a social and political age in which 'risk' is created and simultaneously managed by state institutions. She clarifies that the point is not to question whether a crisis is 'real' or not, but rather, "to observe crisis as a blind spot, and hence to consider the ways in which it allows certain questions to be asked, while others are foreclosed" (Roitman, 2016: 30).

Work by Baraitser and Brook (2021) examines temporalities of care in the UK National Health Service (NHS). Starting from the premise that care is a temporal practice as much as it is a material one, they analyse the meaning of 'waiting' in relation to chronic health and the 'care crisis' confronting the NHS. Baraitser and Brook (2021) argue that references to chronicity and the care crisis conceal institutional failures of health systems and services. They draw on Cazdyn's (2012) concept of 'the new chronic' politics governing the modern field of medicine. According to this new politics:

> "Medicine does not operate in a realm that is separate from politics and culture, but comes together with political and cultural discourses to manage rather than cure disease, paralleling global capitalism's aims for a continual state of crisis management that perpetuates the inequalities of the now. […] Cazdyn suggests that if we want to understand a system and make some form of significant change beyond symptom management, we have to look away from what appears to be the immediate crisis and towards the permanent crisis that is at work even when the system is functioning well" (Baraitser & Brook, 2021:6; see also Cazdyn, 2012).

This point is elaborated in depth by Fraser (2016) in her paper 'Contradictions of Capital and Care'. Fraser asserts that "the 'crisis of care' is best interpreted as a more or less acute expression of the

social-reproductive contradictions of financialized capitalism" (99). Moving from the crisis of care to the financial crisis of 2008 and its aftermath, White (2015) takes up a similar line of argumentation in analysing the reaction by European state and regional institutions in the wake of the financial crisis as 'emergency politicking', "in which actions departing from conventional practice are rationalised as necessary responses to exceptional and urgent threats" (300).

2.4.5 Temporalities/use of time during the coronavirus pandemic

Updating his theory of 'emergency politics' to account for widespread narratives of 'urgency' and 'emergency' during the coronavirus pandemic, White writes, "Fast-moving conditions offer a warrant for cutting out chains of delegation and re-claiming power in informal networks. The diffusion of power across many institutions – what Alexander Hamilton once called the 'plurality of the executive' (Hamilton et al, 1787 /2008, no. 70) – creates an elaborate system inviting centralisation and de-institutionalisation in times of stress" (White, 2021: 80). Another salient point offered by White (2021) is the feature of emergency politicking that sees it "…rationalised as unchosen and unavoidable in substance and timing...It is characterised by heightened executive activity – what one may call doing – coupled with heightened disavowals of agency, i.e., the capacity to choose freely between options" (85). Jarvis (2022) would seem to concur with White's (2021) analysis, writing that the ways in which the official discourses in the UK employed specific narrative times was fundamental to the UK government's response, and served to side-line alternative responses. While it did not necessarily structure the substance or content of the response, the narrative of 'urgency' and 'emergency' "was employed to legitimise a range of economic, social and political initiatives introduced by Johnson's administration" (Jarvis, 2022: 33).

If official discourses were imbued with urgency, Wigen and colleagues (2022) note a paradox that was widely expressed by members of the public during early lockdowns: "At global and national levels, crisis declarations continued to spur feelings of acceleration and haste, whereas people's everyday lives kept slowing down, till the point of stopping completely" (1). Wigen et al identify a loss of agency as one of the consequences of this sense of disorientation or 'feeling of temporal discontinuity', which amounts to a desynchronisation between 'crisis time' and 'social time' (2022). Just as a lack of control over our physical bodies in a spatial sense constitutes a diminishing of our agency, so too can a lack of control over time and how we go about our lives. (Wigen et al., 2022).

2.4.6 Understanding 'vulnerability'

Vulnerability as a concept has long been the focus of bioethicists working within the field of research ethics. Following on from a series of egregiously unethical clinical studies carried out on both sides of the Atlantic in the early to mid-twentieth century, and in reaction to the horrors perpetrated against Jews, Roma, homosexuals, and people with disabilities by doctors in Nazi concentration camps, there was a push to develop guidelines for ethical research practice in many countries and at supranational level on justice grounds. Landmark documents like the Helsinki Declaration (World Medical

Association, 1964) and the Belmont Report (The National Commission for the Protection of Human Subjects, 1979) established standards for ethical research with human subjects that form the basis for research in the medical and social sciences to this day. The documents are premised on the assertion that all human research subjects are potentially vulnerable and must be protected from harm or injury to their wellbeing and/or interests. In research ethics, harm comes in the form of unethical practices on the part of medical/clinical researchers, an explicit recognition of the way in which knowledge/expertise is endowed with authority/power and creates a power imbalance, rendering certain groups vulnerable at the hands of others—a manifestation of Fricker's (2007) theory of *epistemic injustice*. In addition to recognising the potential vulnerability of all research subjects, the documents go further, noting that certain members of the population are particularly vulnerable and in need of special protections. The authors of the Belmont Report make the following case for designating specific vulnerable groups:

> "One special instance of injustice results from the involvement of vulnerable subjects. Certain groups, such as racial minorities, the economically disadvantaged, the very sick, and the institutionalized may continually be sought as research subjects, owing to their ready availability in settings where research is conducted. Given their dependent status and their frequently compromised capacity for free consent, they should be protected against the danger of being involved in research solely for administrative convenience, or because they are easy to manipulate as a result of their illness or socioeconomic condition" (The National Commission for the Protection of Human Subjects, 1979: 9)

The Helsinki Declaration is less specific, stating only: "Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm" (World Medical Association, 1964: 2). Yet both documents played an important part in expanding the scope of the vulnerability concept by arguing that certain groups were *especially* vulnerable and in need of special protections. Rogers and colleagues contend that, "These two early codes set in train a tension about the scope of the concept that continues to resonate in current debates" (Rogers et al., 2012a: 2). Should vulnerability be conceived of as *ontological* condition, as proposed by the feminist philosopher Martha Fineman (2008), primarily as a universal truth, an intrinsic part of what it means to be human and to be embodied? Or is vulnerability first and foremost *context-specific*, are certain individuals, certain groups more vulnerable than others as a direct result of their social, political, and economic environment? And what are the implications of both conceptions on who bears responsibility for shielding people from the harms they are vulnerable to? Is it the individuals themselves, their families, their communities, or is it the state? an individual trait or is it a socially imposed condition and what are the implications in terms of who bears responsibility for protecting those deemed vulnerable from harm? The ensuing debates around vulnerability have sought to answer these questions, among others.

Goodin, writing in the mid-eighties, conceives of certain individuals and certain groups as particularly vulnerable. He viewed vulnerability as "susceptibility to harmful wrongs, exploitation, or threats to one's interests or autonomy" (Rogers et al., 2012a: 3). If my actions threaten the interests of someone else, that person is made vulnerable as a result of my behaviour. For Goodin, that relationship gives rise to a moral duty and a special responsibility to protect the vulnerable from harms to their interests (1985: 34). Goodin's 'vulnerability model' turns on inequalities in the balance of power between individuals and groups within society, but crucially, it also extends to state actors and to the provision of welfare services aimed at protecting vulnerable individuals whose interests are in danger of being harmed or exploited by social conditions, including government policies. Goodin emphasises that it is not just the vulnerability or 'special need' of others that brings about a special responsibility to protect them, but also the 'special ability' of the *non*-vulnerable to help that compels them to do so (34). Furthermore, his model of vulnerability recognises that the form that responsibility takes, and the actors bearing the 'special duty', will differ from one socio-political context to another. He ascribes this to 'cultural relativity', which I would argue is more appropriately characterised as a consequence of varying social norms and structural conditions: "Where there is no collective provision for the care of the aged, a special duty falls upon their children to do so; to the extent that communities now make adequate collective provision to meet the needs of the aged (through pensions, etc.), these special duties fall away" (Goodin, 1985: 35).

Walker (1998) and more recently Dodds (2014) have critiqued Goodin's model for failing to consider that the relationship between vulnerability and responsibility is bi-directional. In other words, vulnerability gives rise to responsibility, yes, but responsibility can also generate vulnerabilities depending on how—and to whom—they are assigned. Just as vulnerabilities are socially constituted, so too are responsibilities, and the assigning of responsibility and the forms that protecting the vulnerable take are determined to a large extent by social norms and socially constructed understandings of vulnerability and dependency (Walker, 1998). Dodds (2014) takes Walker's argument further, elaborating what she calls *pathogenic vulnerabilities*: "Social and legal institutions designed to reduce dependency or to promote self-responsibility may pathogenically exacerbate the vulnerability of the dependent or his care provider if those institutional arrangements fail to address the complex relationships between dependency and vulnerability" (197).

Martha Fineman, feminist legal scholar and philosopher, tackles the issue of vulnerability from a different angle, making the case for an ontological understanding of vulnerability in her landmark 2008 paper 'The vulnerable subject: Anchoring equality in the human condition'. The title of the paper is telling. For Fineman, unpacking the concept of vulnerability is part of a larger project to theorise a new way of thinking about equality. She writes, "The vulnerability approach I propose is an alternative to traditional equal protection analysis; it is a "post-identity" inquiry in that it is not focused only on discrimination against defined groups, but concerned with privilege and favor

conferred on limited segments of the population by the state and broader society through their institutions" (Fineman, 2008: 1). Fineman's aim in proposing her vulnerability approach is to help usher in social and legal policies that are more responsive to our common vulnerabilities. Fineman and Goodin (and colleagues) differ in their approach to vulnerability, and while both are ultimately interested in what the societal *response* to vulnerability is and should be, their different conceptions of how people become or are made vulnerable lies at the heart of their respective proposals for what societies should do to shield against vulnerabilities.

In recent years, vulnerability has received considered theoretical treatment from within the field of feminist bioethics. In their introduction to a special issue on vulnerability in the *International Journal of Feminist Approaches to Bioethics*, editors Wendy Rogers, Catriona Mackenzie, and Susan Dodds (2012a) characterise the conceptual work that still needs to be done:

> "While the idea that vulnerability is a universal feature of our embodied humanity is important for bioethics, it is also crucial not to lose sight of the contingency and context-specificity of many kinds of vulnerability, and their origin in social and political structures, rather than in biological forces. Another important challenge is to develop an account of the duties involved in responding to vulnerability that avoids stereotyping and paternalism and is consistent with the principle of respect for individual autonomy" (3).

In developing her vulnerability approach, Fineman applies Peadar Kirby's (2006) concept of "assets" conferred by state institutions to help envisage what a state that is more responsive to people's vulnerabilities might look like. For Kirby, 'assets' are, "advantages, coping mechanisms, or resources that cushion us when we are facing misfortune, disaster, and violence. Cumulatively these assets provide individuals with 'resilience' in the face of vulnerability" (Fineman, 2008: 13; see also Kirby, 2006). According to Kirby, social institutions provide four different types of assets: physical assets, human assets, social assets, and environmental assets (Kirby, 2006: 55-59; see also Fineman, 2008: 13-15). Fineman argues that "Together with the concept of the vulnerable subject, understanding the state's relationship to asset-conferring institutions gives us a vocabulary for arguing that the state should be held accountable for ensuring equality in response to individual and institutional vulnerability" (2008: 15).

Another important contribution by Fineman is her analysis of vulnerability within the prevailing capitalist/neoliberal economic system, which celebrates the 'liberal subject'—the rational adult (male) with his full faculties intact, the 'productive' member of society at his most *in*vulnerable. She heralds instead the 'vulnerable subject', wanting to "claim the term 'vulnerable' for its potential in describing a universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility" (Fineman, 2008: 8).

While most scholars from the fields of bioethics, sociology, and philosophy who have come after Fineman agree to a large extent with her view of vulnerability as a universal condition, and as a relational phenomenon, a significant criticism has been that her analysis of vulnerability, even as it focusses on and seeks to address systemic inequalities, does not go far enough in creating a practicable framework for protecting the most vulnerable individuals and groups in society. If the root causes of socially constructed vulnerabilities are not addressed, if social conditions remain such that certain people are discriminated against or are otherwise marginalised, then bestowing special protections for such groups is necessary. Guidry-Grimes and Victor (2012) give an apt summation of this point: "Although we agree that frailty is a ubiquitous feature of humanity, we want to avoid positing vulnerability as a "natural fact," since doing so would minimize or obliterate the need for special protections for certain individuals (see Luna 2009, 128)" (Guidry-Grimes & Victor, 2012: 127). Also at issue is the disconnect between the concept of ontological or universal vulnerability in moral philosophy terms, and in political terms. As much as one might agree with Fineman that the designation of vulnerability based on an individual's identity category (or intersecting categories) lends itself to a view of vulnerability and dependence that is negative, stigmatised, and that diminishes autonomy, there exists a chasm between what is philosophically sound and right and what seems actionable in the 'real world'. Bozzaro, Bolt, and Schweda (2018) put it this way:

> "The major issue with a broad understanding of vulnerability is that it leads to a 'naturalization' of the concept by suggesting that it is normal or natural for everyone to be vulnerable. While this may be true from a philosophical point of view, such a generalized concept of vulnerability lacks discriminative utility when it comes to singling out specific groups of people that deserve particular ethical attention" (2018: 235).

In Western countries, a negative view of vulnerability and dependence is deeply entrenched to the extent that the viability of Fineman and others' vision of vulnerability as universal and relational is in doubt. Nothing less than a paradigm shift is needed, in line with what Tronto proposes within her ethics of care framework (1993, 2013). It is part of the same debate between those who engage in identity politics and those who argue in favour of universal equality frameworks. Nancy Fraser described the discourse between these two camps as "the widespread decoupling of cultural politics from social politics, of the politics of difference from the politics of equality" (2001: 21).

Pointing out the limitations of existing conceptions, Rogers, Mackenzie, and Dodds (2012b) propose a taxonomy of three different kinds of vulnerability: inherent, situational, and pathogenic vulnerability. Their aim is to enable a more nuanced distinction between different sources and kinds of "more than ordinary vulnerability" (2012b: 24). For Rogers and colleagues, *inherent* vulnerability, as the name suggests, addresses those "sources of vulnerability that are inherent to the human condition and that arise from our corporeality, our neediness, our dependence on others, and our affective and social natures" (2012b: 24). According to the authors, an individual's inherent

vulnerability depends on various factors, including their gender, age, health status, and disability, as well as on the social supports available to them, and their own resilience. *Situational* vulnerability refers to "vulnerability that is context-specific, and that is caused or exacerbated by the personal, social, political, economic, or environmental situation of a person or social group. Situational vulnerability may be short term, intermittent, or enduring." (Rogers et al., 2012b: 24). As an example, if a person, a family, or an entire community is forced to flee their homes because of an environmental disaster, they may be exposed to short-, mid- or long-term situational vulnerability depending on whether they have financial assets to draw on, are able to access home insurance, government assistance, and so on.

Importantly, Rogers and colleagues (2012b) state that their different kinds of vulnerability are overlapping—thus pre-empting the obvious criticism that what they describe as inherent vulnerabilities can also be situational, including notably so-called inherent vulnerabilities due to health status, disability, and age. Inherent and situational vulnerabilities can be either *dispositional* or *occurrent.* Pregnancy and giving birth, for example, are dispositional vulnerabilities for all women of childbearing age—there is a certain risk of harm to the woman regardless of external factors. However, they can also be occurrent in that the level of risk varies significantly depending on external factors such as the quality of pre- and post-natal care available, their socioeconomic status, the social supports they have to draw on, and so on. As for Goodin and Fineman and others, in Rogers, Mackenzie, and Dodds's view, "inherent and situational vulnerability give rise to specific moral and political obligations: to support those who are occurrently vulnerable; and to reduce the risks of certain individuals, groups, and populations to avoidable occurrent vulnerability (2012b: 25). And any such intervention has as its background aim to "enable or restore the agency of vulnerable persons or groups" (2012b: 25). The third kind of vulnerability Rogers and colleagues define, *pathogenic* vulnerability, occurs when interventions do not support the person or group's agency, engendering instead new or compounded vulnerabilities (2012b: 25).

2.4.7 Linking vulnerability, dependence, and autonomy

In a 2018 paper, Bozzaro and colleagues take up the question of whether older people as a group or category constitute a vulnerable group. Reviewing the bioethics literature on vulnerability, they distinguish between the two main conceptions of vulnerability in the field as 'broad' and 'restrictive', respectively. A broad conception refers to universal or ontological vulnerability, championed by Fineman (2008) among others. Restrictive conceptions by contrast are ones that define vulnerability as context-specific susceptibility to harm, leading to dependence on others and thus to limited capacity for autonomy for those groups of individuals considered vulnerable (Bozzaro et al., 2018).

Bozzaro and co-authors then distinguish further between two types of restrictive conceptions of vulnerability that appear in the literature, namely harm- or welfare-based, and consent- or agency-

based conceptions (2018: 234). They elaborate: “Harm- or welfare-based definitions of vulnerability focus on individuals’ interests concerning their own welfare, that is, their overall flourishing as human beings. They describe as vulnerable those who are more susceptible to frustrations of these welfare-interests and therefore prone to incurring additional harm for one reason or another” (Bozzaro et al., 2018: 234-235). The authors give the example of pregnant women, and of children and adolescents, as groups made more susceptible to harm due to their particular health and developmental statuses, respectively.

The authors contrast the latter with consent- or agency-based conceptions of vulnerability, which “concentrate on individuals’ agency-interests, that is, their interest in living in accordance with their own fundamental values, preferences, principles, and goals in life. They consequently define as vulnerable those who are relatively or absolutely incapable of realizing such a (more or less) self-determined way of life and therefore are prone to being wronged” (235). Examples provided of vulnerability from this point of view include young children and persons with mental disabilities, “Since they lack the full capacity to form, express, and enforce their own will and make informed decisions, they are more susceptible than others to manipulation, deceit, and force, preventing them from deciding and acting according to their own preferences and values” (Bozzaro et al., 2018: 235).

Importantly, the authors clarify that the two types of restrictive concepts of vulnerability are not mutually exclusive, rather they “highlight different reasons for and aspects of vulnerability that may actually coincide or even interact” (Bozzaro et al., 2018: 235). In some cases, harm to a person’s agency-interest will also result in harm to their welfare-interest, and vice versa. But this is not necessarily the case, and indeed in some situations, harms to or frustrations of one’s agency-interests can be said to safeguard one’s welfare-interests: “Thus, paternalistic decisions usually have the normative structure of infringing upon certain individuals’ agency-interests for the sake of protecting or safeguarding their own welfare-interests” (Bozzaro et al., 2018: 235). This is an important point to consider in the context of the coronavirus pandemic and government measures that aimed to ‘protect’ older persons.

Bozzaro et al (2018), recalling the work of Luna (2009), Rogers and colleagues (2012b), Guidry-Grimes and Victor (2012), and Dodds (2014), recognise that restrictive conceptions of vulnerability in bioethics have significant limitations also. Firstly, that they risk labelling individuals or groups vulnerable as ‘helpless’ without taking account of intra-group variability. Secondly, that they risk creating the pathogenic and compounded vulnerabilities discussed by Rogers et al (2012b), Guidry-Grimes and Victor (2012), and Dodds (2014) in particular: “restrictive concepts can promote widespread paternalism in an attempt to prevent others from harm and meet their needs. This may lead to a systemic stigmatization of and discrimination against certain groups that can ultimately even reinforce vulnerability” (Bozzaro et al., 2018: 235). Thirdly, Bozzaro and colleagues state that

some of the consent- or agency-based conceptions open themselves to criticism because they "define vulnerability only in terms of a failure to attain or retain full autonomous agency, whereby autonomy is defined as the individual's capacity of rational self-determination. Critics have argued that such an understanding of autonomy is founded in a reductive, rationalistic, and individualistic view of the person as an isolated rational agent that requires a disavowal of his embodiment, of emotions, and of his embeddedness in social relationships" (2018: 235). This seems to be the key point on which scholars of bioethics seem to agree and argue convincingly for: the need for concepts of vulnerability, dependence, and autonomy that are *relational*.

Determining that prior bioethical discussions of the relationship between ageing and vulnerability all take as their point of departure a problematised understanding of ageing that cannot be generalised, Bozzaro and colleagues turn to an anthropological, phenomenological examination of the concept, grounded in the individual experience of ageing, citing the tremendous variation and diversity in how people experience getting older, and indeed in how people age from an 'objective' medical point of view. Bozzaro and colleagues argue that "old age should not, in and of itself, be used as a marker of vulnerability, since ageing is a process that can develop in a variety of different ways and is not always associated with particular experiences of vulnerability" (2018: 233). The authors draw on qualitative interpretive interviews conducted by Finnish scholars Sarvimäki and Stenbock-Hult (2016) with older persons on the meaning of vulnerability. Sarvimäki and Stenbock-Hult interviewed 14 people between the ages of 70 and 96 years of age who were residing at home, in assisted living facilities ('serviced housing') and in nursing homes. Their core finding is that the people interviewed experienced a deeper or deepening sense of vulnerability as they aged (Sarvimäki & Stenbock-Hult, 2016). While vulnerability was mostly perceived as a negative, associated with losses physical, psychological, and social, vulnerability and protection was also considered in a positive light by some, as a strength (Sarvimäki & Stenbock-Hult, 2016). These findings resonate with Christine Straehle's work (2017), which calls for a closer examination of morally salient forms of vulnerability, and for distinguishing between what she calls the *harm to interest* account of vulnerability and more positive forms of universal vulnerability. "Some kinds of vulnerability affect the capacity to live autonomously and thereby the basis of self-respect, but at least one kind can foster our individual autonomy and thereby our sense of self-respect—the vulnerability we experience in loving relationships" (Straehle, 2017: 33).

Bozzaro and colleagues offer their own analysis of Sarvimäki and Stenbock-Hult's data, using it as a springboard for proposing their own 'combined model of vulnerability' (2018: 238). They identify vulnerability from the perspective of the older persons interviewed as a series of *changes* or processes. First, the onset of bodily impairment, frailty, resulting in a heightened sense of one's physical body and embodiment. Second, a fundamental change in the way time is experienced: "Growing older means that the past becomes ever longer while the future of one's own lifetime

becomes ever shorter" (Bozzaro, 2018: 237). Third, Bozzaro et al perceive that vulnerability entails changes to one's status in society, involving a growing estrangement from rapidly evolving social and cultural norms, a feeling of isolation and loss as the 'familiar world', and the people who populated it, fade away and disappear (2018: 237). For Bozzaro and colleagues, then, a combined model of vulnerability recognises both that vulnerability is universal and not specific to older people specifically, but also that ageing as a process is likely to involve certain heightened forms of vulnerability, which vary for every individual. It is this acknowledgement of nuance, and the different types and degrees of vulnerability we face as we age, which marks out Bozzaro and colleagues' main contribution: "the combined model takes vulnerability not as an absolute parameter separating the vulnerable from the non-vulnerable but rather as a gradual matter of increasing or decreasing likelihood of incurring harms or wrongs. As human beings, we all share the fundamental experience of vulnerability, albeit to varying degrees depending on our specific situations and circumstances" (2018: 238). The authors' call for nuance is appealing, but once more, while the philosophical implications are evident, the implications for praxis are more ambiguous. The question of how such a 'combined' concept of vulnerability might be incorporated into policies aimed at older adults—or indeed over the life course— in a way that fosters welfare-interests and agency-interests, is not convincingly answered.

Guidry-Grimes and Victor (2012), building on their and others' assertion that vulnerability can be compounded by the design and delivery of social services and that social institutions can create pathogenic vulnerabilities, detail how medical labels and diagnoses can lead to the internalisation of vulnerability and threaten one's self-conception and identity. The authors draw on Ian Hacking's (1999) concept of an *interactive kind* to suggest interactive-kind modelling as a useful conceptual tool for illuminating how labelling an individual or a group signals to others how the labelled person or group should be treated, and how such labelling can compound vulnerabilities (Guidry-Grimes & Victor, 2012: 126). They write:

> "Moreover, the actions of the labeled and the actions of others toward the labeled persons result in a looping effect (i.e., feedback loop) between the label and the classification itself. The characteristic of an interactive kind is being the sort of thing that, when labeled, is aware of labels and responds to them. This awareness is one that is 'shared and developed within a group of people, embedded in practices and institutions to which they are assigned in virtue of the way in which they are classified' (Hacking, 1999: 104)" (Guidry-Grimes & Victor, 2012: 128-129).

Using the example of premenstrual dysphoric disorder (PMDD), the authors describe how women suffering from a range of symptoms associated with menstruation, are stuck between biological (medical) and social constructionist modelling of the phenomenon. Where the former pathologises such symptoms and presents women with a diagnosis of PMDD, the latter claim that the symptoms

are a woman's natural response to her social circumstances (Guidry-Grimes & Victor, 2012). These models, according to Guidry-Grimes and Victor (2012), are presented as an either-or proposition, a binary, when what would be useful for women experiencing such symptoms would be to recognise the feedback loops between biological, social, and psychological factors.

> "To admit that women could become conditioned to respond biologically to oppressive social situations, particularly if these general sentiments are magnified by personal or professional stress, does not undermine the explanations given by either model. What this means is that we may need to have a different model that brings these two into conversation with each other, so we can see the bigger picture of how these different kinds of factors engage with one another and affect the lives of women who receive a medical label. In modeling the interactions among biological, psychological, and social variables as different kinds of looping effects, we can begin to get a firmer grasp on how such looping effects shape the social institution of medicine; we can track, for instance, how medical labels shift over time" (Guidry-Grimes & Victor, 2012).

Eilenberger and colleagues' (2022) more recent contribution brings Guidry-Grimes and Victor's (2012) paper on the mechanisms at work and implications of assigning labels to vulnerable groups into direct relevance for the discussion of older people's enforced vulnerability in the coronavirus era. Eilenberger et al (2022) draw on Judith Butler's work on vulnerability and precarity (2004, 2009) to make explicit what Guidry-Grimes and Victor's concept of interactive kinds leaves implicit, namely that vulnerability "is not an individual disposition but rather a socially produced label that is assigned to people and assumed by them on the basis of their embodiment. In other words, vulnerability is relational" (Eilenberger et al., 2022: 42). Butler writes:

> "Vulnerability might take the form of excitability, susceptibility, longing, delight, fear, anxiety, or dread, but whatever form it takes, it is already and from the start a relational predicament" (Butler, 2021: 177).

Eilenberger and colleagues' (2022) main contribution, then, is to extend the notion of vulnerability as a relational concept and describe, taking a phenomenological lens, what the experience of being labelled a 'vulnerable senior' is for older individuals. They use the term 'unrealizables', introduced by Jean-Paul Sartre (2003) and deployed also by Simone de Beauvoir (1996), to encapsulate the experience of "being labelled from the outside by others" (Eilenberger et al., 2022: 44). The concept of an 'unrealizable' describes the tension that we experience as we age. "In aging, we need to accept a reality that is properly ours but that comes from outside and remains ungraspable for us. There is an indissoluble tension between our inner conviction that we remain who we always have been and the objective certainty of being considered old. This objective certainty, this unrealizable, forms the other side of our situation" (Eilenberger et al., 2022: 44). According to Eilenberger and co-authors,

the label of vulnerability foisted on older persons during the pandemic has brought vulnerability's inherent relationality as a concept to the fore:

> "Almost two years into the global coronavirus crisis, we are starting to realize how pandemic rhetoric has reinforced the entanglement of age and vulnerability. It has led to novel practices of naming, of separating those who are to be protected from those who do not need protection. Older people, however, are not passive bodies that merely endure their being labelled; they are actors in a process of becoming who respond to their new "identity" in diverse ways—through appropriation, negotiation, or rejection. While they cannot escape the label of the vulnerable senior, they still have the conditioned freedom to take it up and interpret their own situation through it (or to reject it). This does not take away, of course, the effects of disempowerment and marginalization that labels such as "vulnerable senior" frequently entail" (Eilenberger et al., 2022: 50).

Elizabeth Ben-Ishai (2012) provides an interesting framework for thinking about how some state interventions, even when they claim to foster autonomy and self-determination, do the opposite because they fail to consider the social context within which they operate that perpetuate relations of domination and inequality. She uses the term 'new paternalism' to describe such interventions which marked a new approach or philosophy of social policy, and which emerged from the welfare reforms in the United States, United Kingdom, and certain European countries in the 1990s and 2000s. She uses the conservative academic Lawrence Mead's definition of new paternalistic social policies:

> "According to Mead, 'these measures assume that the people concerned need assistance but that they also need direction if they are to live constructively' (Mead, 1997: 2). The relations of power involved in new paternalistic measures are configured, in part, by this claim regarding the need for direction: Mead suggests that the poor are specifically lacking in some capacities, including that of autonomy" (Ben-Ishai, 2012: 155).

Ben-Ishai then goes on to describe two case studies of new paternalistic interventions emanating from the welfare reform legislation passed in 1996 in the US, the first a workfare programme, and the second a pregnancy prevention programme (2012). She describes how, in both cases, the designers of the programmes and the staff tasked with implementing them perpetuated the intersecting systems of class and gender oppression by insisting on a set of classist and sexist assumptions about the needs, behaviours and dispositions of poor people with regard to employment and to family planning, assumptions that are clearly informed by a conservative, neoliberal ideology (Ben-Ishai, 2012). Ben-Ishai reflects that, "New paternalist accounts of autonomy emphasize the attainment of an individualistic sense of self, bolstered neither by familial relationships nor relations of care, tellingly both feminized configurations of social relations" (2012: 152).

The pandemic measures enacted in Ireland to safeguard older people from the perceived risks posed by the virus should not be equated with the 'new paternalistic' interventions described by Ben-Ishai above. The latter refer to a particular era in social policy in specific country contexts and are concentrated in the policy area of poverty alleviation. Nonetheless, her work is relevant here because there are parallels between the 'new paternalism' she describes and the paternalism and ageism of the 'cocooning' measure and visitor restrictions in nursing homes and long-term care facilities. In both cases, a set of assumptions underpin these policies, assumptions about how people want to live their lives and what they define as a good life. Such policies negate individuals' diverse experiences and stifle a relational conception of their autonomy.

2.4.8 Conclusion

The first part of this review, which has reviewed the empirical literature on the impact of the pandemic on older people's lives, tells a mixed story. It offers evidence that the measures imposed by governments have affected both older people's mental and physical health, disrupting their access to social networks and to vital health and social care services, and leading to multiple forms of isolation and loneliness. It has also served to highlight the resilience of some. The evidence indicates that these effects have not been equally distributed, exacerbating existing socio-economic and gender-based inequalities, and institutional differences across countries. Ultimately, due to the cross-sectional nature of much of the research, the extant literature is unable to tell us what the full impact of the pandemic has been on older people's lives, as only longitudinal data can do so. The paucity of qualitative research is also problematic, as qualitative studies are better able to capture the complexity and nuance of lived experiences.

The second part of the review engaged with theoretical contributions on the concepts of structured dependency of older persons, 'risk' and temporality as 'manufactured' or created phenomenon in modern societies, and the complex conceptions of vulnerability. These literatures link nicely with one another in that they highlight the role of structural conditions and state institutions in generating vulnerability in people, rather than merely as reactors to the vulnerabilities of individuals. The contributions on vulnerability also caution against taking too narrow or restrictive a conception of vulnerability, arguing that unless they account for relational approaches to autonomy, agency, and dependency, they may render those made vulnerable as helpless, as lacking agency.

The review of the literature indicates an important gap in terms of understanding how older people's vulnerability is constructed discursively in the context of the coronavirus pandemic. The focus of this research study is intended to address that gap by asking, how were older people constructed through policies and discourses engaged in by the Irish state during the coronavirus pandemic? In the course of the empirical research for this project, I identified key established theoretical perspectives regarding dependency, risk, vulnerability and temporality that offer useful frameworks

for understanding how older people were constructed through coronavirus pandemic policies. The empirical analysis in Chapters 4, 5, and 6 engages with these theoretical frameworks *abductively* as I conduct a GT analysis of texts emanating from the official discourses related to older people and their care during the pandemic in Ireland. The next chapter describes the theoretical and methodological frame of the study.

Chapter 3. Methodology

"Yes. I can't imagine how it might work. However, the universe is not limited by what I can imagine."

— Hilary Mantel, on whether she believed in an afterlife, *Financial Times,* 2022

3.1 Introduction

This chapter sets out the methodological and theoretical framework for the research presented in subsequent chapters. The first section outlines the theoretical and methodological framework underpinning my research design. The second section discusses my chosen methodology of GT in greater depth, the rationale for selecting this approach, and details the methods I employed. The third section provides an overview of the data collection and data analysis process. Finally, the last section is a reflection on the importance of reflexivity for my research project, and my positionality. Throughout, I have endeavoured to be as transparent as possible and as methodical as possible in recording the whole endeavor—warts and all.

3.2 The theoretical - methodological framework

In the sociology and social science methodology courses I have had the opportunity to sit through, 'ontology' and 'epistemology' were concepts that were covered cursorily and then quickly pushed to the side, with the result that the words floated around in my head, their definitions, and implications aggravatingly opaque and more than a little daunting. This changed when early into the PhD, I picked up Michael Crotty's "The Foundations of Social Research" (1998) on the recommendation of a colleague. Around the same time, I was reading more deeply into the literature on GT and discovering the extent to which its evolution as a theory and methodology was intertwined with the wider postmodern, post-positivist, interpretivist turns in philosophy and the social sciences in the second half of the twentieth century (Glaser and Strauss; 1967; Clarke, 2009; Clarke, 2005; Charmaz, 2009).

I started to understand why it mattered which ontological and epistemological assumptions underpinned one's research, and why it seemed to matter more to researchers applying qualitative methodologies than to those using quantitative approaches. If one assumes, as most quantitative research does, that there is one 'true' and objective version of the world, including social phenomena, then there is little need to explain one's ontological/epistemological approach. It was in reaction to this singlemindedness and this unwillingness to consider that other people, other groups of people, other cultures might perceive, might interpret the world differently, that post-positivist scholars (sometimes referred to as anti-positivists) broke away and asserted their own interpretivist school of

ontology (Weber, 1922; Mead, 1926, 1934; Dewey, 1929). It is not by accident that this movement in the social sciences coincided with broader emancipatory movements happening around the world, including the feminist movement, the fight for civil rights for minorities and formerly colonised peoples, and so on (Crotty, 1998; Clarke, 2005). But when one is establishing one's position against and in reaction to a hegemonic authority—in this case the positivist school of scientific inquiry—then the burden of proof, so to say, is on the upstarts. Although qualitative research—together with mixed methods—is much more widely accepted today within academic and scholarly circles, the more 'serious' scholars in the fields of economics, political science, and even sociology often look down their noses at qualitative research.

In this study, I combine a constructivist epistemology (our knowledge of the world is co-constructed) with a Critical Realist (CR) ontology (there are aspects of the world that are independent of our experiences, although we cannot observe them entirely). CR theory was developed by the philosopher Roy Bhaskar as a rejection of and response to the 'epistemic fallacy' in philosophic logic, which assumes that *how we perceive the world* is *how the world is* (Bhaskar, 1978; Oliver, 2012). CR sets a distinctly postmodern, post-positivist course, straddling the divide between objectivist and interpretivist ontologies. It has been described as an 'ontological bridge' between the "positivist's search for evidence of a reality external to human consciousness with the insistence that all meaning to be made of that reality is socially constructed" (Oliver, 2012: 372).

A key contribution of CR to the ontological debate is its view of reality as structured and yet dynamic, ever-changing. Bhaskar contended that our social world functions much like the natural world in that social phenomena can be deconstructed into progressively more basic stratified layers (Oliver, 2012). According to Bhaskar and CR, reality is made up of natural and social objects and structures with particular 'generative mechanisms' that induce said objects to behave in certain ways that make events occur (Hoddy, 2019: 112; Bhaskar, 1978). According to CR, reality is stratified into three domains: 1) *The domain of the real* is made up of natural and social objects, structures and their mechanisms, mentioned above; 2) *The domain of the actual* is made up of 'events', or what happens when these mechanisms are activated; and 3) *The domain of the empirical* is comprised of our perceptions and experiences of these events (Bhaskar, 1978; Hoddy, 2019). Within CR's ontological/epistemological paradigm, it is assumed that while there is an objective reality, human beings cannot observe or know this reality completely and objectively; instead, we construct meaning through our daily confrontations with others and with existing structures and processes. As we move from our perceptions and experiences towards the *domains of the actual* and *the real*, what is objectively 'real' becomes increasingly difficult to access and to apprehend, and we are never able to so fully, precisely because our starting point is our subjective reality (Hoddy, 2019).

CR is a more appropriate fit for this research project than a purely interpretivist ontology. While I am of course interested in how the actors in the discourses construct meaning, and in considering what their individual perspectives and biases are, that is not my central interest. Instead, my primary interest is in what these constructions tell us about, how they can bring us closer to understanding, the complex interactions of age, gender, class, and disability—underpinned by the exercise of power—in our society. In this study, certain structural conditions and processes are the 'social objects' in CR's domain of the real. To a large extent, such social objects exist independently of individual experience or even awareness. For example, the way in which access to and quality of health and social care in Ireland is distributed is not a function of individuals' perceptions or experiences but rather follows discernible, 'real' patterns that are underpinned by relations of power, and by the state's approach to care and to social welfare more broadly. Furthermore, Ireland's political and legal systems, its social history—notably, its colonisation by the British and struggle for independence, the legacy of the Catholic Church—and more immediately the coronavirus and the pandemic, exist independently of individual experience and exert an influence even if we are not fully conscious of them or fully understand the dynamic processes at work.

3.3 Grounded Theory and its compatibility with Critical Realism

Grounded Theory is the chosen methodology for this research because of its ontological congruence with CR. More specifically, in recent years, a number of scholars have outlined the compatibility between a critical realist ontological approach and so-called 'second generation' or 'successor' GT variants (Oliver, 2012; Hoddy, 2019; Clarke, 2005; Charmaz, 2006). Barney Glaser and Anselm Strauss' (1967) classic Grounded Theory methodology called for the researcher to be a 'blank slate' and for findings to emerge inductively, uninfluenced by existing scholarship or the researcher's pre-existing knowledge and biases. Strauss would eventually break with Glaser's rigid interpretation of GT that emergent theory must be 'grounded in the data' and in the data alone and would go on to wholeheartedly embrace the theory of symbolic interactionism, which views the researcher as a co-constructor of knowledge and meaning within the research process (Strauss, 1978; Corbin and Strauss, 2008). In doing so, Strauss paved the way for second-generation GT scholars who modified and adapted the foundations of GT to suit their ontological positions and research interests, recognising that being a blank slate is neither realistic nor desirable. Sociologists Adele Clarke and Kathy Charmaz are two notable successors to Glaser and Strauss, known respectively for their development of the Situational Analysis and Constructivist variants of GT (Clarke, 2005; Charmaz, 2006).

In later versions of Grounded Theory, the value of applying abductive logic and reasoning—looking outside of the data, to the literature for example, to help explain observed phenomena—in combination with an inductive approach, has been firmly cemented (Charmaz, 2006; Oliver, 2012;

Timonen et al., 2018; Timmermans & Tavory, 2012). According to Charmaz, abduction "entails considering all possible theoretical explanations for the data, framing hypotheses for each possible explanation, checking them empirically by examining data and pursuing the most plausible explanation" (Charmaz, 2006: 188). Similarly, 'retroduction', a form of abductive reasoning, is the core analytical tool used by critical realists. As the researcher moves from the domain of the empirical towards the domains of the actual and the real in an attempt to understand the social phenomenon under investigation, retroduction encourages the researcher to first ask: "what must be the case in order for the following to be true?" (Oliver, 2012: 379). This act of reflecting on the existing body of evidence on a topic comes before the researcher attempts to abstract causal mechanisms from the observed phenomenon or to link any such abstraction with empirical evidence (Oliver, 2012). The process of abduction used in second generation versions of Grounded Theory corresponds neatly with retroduction in CR—essentially, both concepts compel the researcher to look around, to dig into what is already known, and ask the question: "what makes this phenomenon possible?", "what must be true?" (Oliver, 2012: 380).

Grounded Theory—specifically Charmaz's Constructivist (social constructionist) GT—is well suited to making sense of how individual action and interaction operate within the complex relations, processes and structures that constitute our society, making it a good methodological fit for this study (Charmaz, 2006). The appeal of Charmaz's approach in this case is its emphasis on the importance of social constructions for understanding wider truths about society. According to Charmaz, "knowledge rests on social constructions" Charmaz, 2009: 130). I am less concerned in this study with analysing individual experience, or in the 'knowing subject' as the unit of analysis (Clarke 2008). If that were the case, I would rather align the research with a phenomenological epistemology and would likely apply interpretive phenomenological analysis (IPA) as my methodology (Smith et al., 2022).

Instead, the aim of my research project is to understand constructions of older people in their social context, to make sense of the actions, interactions, and processes whereby these constructions come into existence. GT guides the researcher to do exactly this by inducing a focus on tracing actions, interactions, and processes in the data, and by guiding the researcher to apply abductive reasoning so that a credible picture of social constructions in context takes shape (Corbin & Strauss, 2008). Because of its emphasis on building new theory, GT is well suited to exploring under-researched or novel phenomena (Corbin & Strauss, 2008; Charmaz, 2006), criteria my research fulfills, at least in part. Ageism and ageist constructions of older people have existed since at least ancient times (see Small, 2007) and certainly existed in pre-pandemic Ireland, yet examining the constructions of older persons in the context of the pandemic, provided an opportunity for fresh, original analysis and potentially new theory development.

3.4 Choosing a successor Grounded Theory variant

When initially considering which variant of GT to apply as the methodology in this study, I looked first to Adele Clarke's Situational Analysis (SA) (Clarke, 2005). The key feature of SA that sets it apart from other variants of GT (Clarke explicitly describes SA as an extension of Straussian and Constructivist GT), is the designation of *the situation* under inquiry as the central unit of analysis, rather than the individual or the action/social process, as in antecedent versions of GT published by Strauss and Corbin (1990, 1998; Corbin & Strauss, 2008). In other words, according to the theory behind SA, there is no such thing as 'context' because context, or the 'conditions of possibility' implicated in the situation of inquiry, is *itself* the researcher's central focus (Clarke 2005, 2009). SA, perhaps more than any other second-generation GT approach, is deeply rooted in Anselm Strauss's social worlds/arenas theory and in Foucauldian discourse theory (Clarke, 2005, 2009). Following Foucault (1972), Clarke argues that to more fully understand how our reality is constructed, we must go beyond the 'knowing subject' to consider non-human elements as entities capable of agency (Clarke, 2005, 2009, 2019).

SA seemed to be a good fit for what I was setting out to investigate at the time. Writing my project proposal and embarking on data collection approximately three months into the pandemic in Ireland, there was a clear 'situation' developing that I could track and analyse in real time, namely, the government's pandemic response as it related to older people and their care. There was evidence already at that early stage of the pandemic that on average, older people were at higher risk of getting sick, and of getting sicker, than younger adults or children, and a clear narrative was already developing around older age and the coronavirus. And even in the very first brainstorming sessions with my first supervisor, as I was deciding to shift topics, it was clear that 'the virus' would make for a compelling non-human actant to contemplate.

What I did not anticipate was just how overwhelming it would become to try to keep a firm grasp of all the moving parts, all actors, actions, interactions, and processes that were constitutive of the unfolding 'situation'. I had begun by mapping the different actors implicated in the situation, as prescribed by the first stage of Clarke's SA methodology (Clarke, 2005). It rather quickly became clear that I would have to narrow my focus so that I could do justice to the material. The sheer volume of discursive material produced during the period of study and the variety of media—text, video, audio—exchanged by means of various channels, including social media of course, made it difficult if not impossible for one researcher, working alone, within the time and resource limits of a PhD thesis, to effectively manage all the data implicated in the situation. Also, I became fascinated early on with how older people were being constructed by the different actors and non-human actants involved in the situation. I found then-Taoiseach Leo Varadkar's—arguably the most powerful

person in the country, the leader of the government, a key state institution—first addresses to the public about coronavirus and the pandemic, and the narrative that he was propagating in his speeches around vulnerability, and around the state's duty and society's obligation to protect, to *care* for the vulnerable, particularly intriguing (see Appendix D, Documents 1 & 2). This protectionist, paternalistic narrative, the excess of (rhetorical) concern for vulnerable groups, flew in the face of what I knew at the time about the *context* of the Taoiseach's speech, namely, the criticism levied at the Irish care system over the years for its many shortcomings, the inattention that genuine efforts at reform had been met with by a sequence of governments.

Wanting to know more about the context and the social dynamics underpinning these emerging constructions, I decided to shift from a consideration of the 'situation' as the central unit of analysis to a focus on social constructions of older persons in the official government discourses, and on tracing the actions, interactions, and processes in same. Using SA in the first stages of the project as an entry point for coming to grips with the analysis of an emergent, evolving, and unique situation, I moved forward applying Charmaz' Constructivist GT (Charmaz, 2006), all the while carrying SA's emphasis on power relations—on which actors are *not* present in the discourses, on silences and absences—with me (Clarke, 2005) (see Appendix E for SA mapping). Oliver, citing both Clarke and Charmaz, draws the two variants under the same umbrella in this respect:

> "Most contemporary approaches [of GT] now move 'beyond the knowing subject' (Clarke, 2009: 200) to consider the absences, silences, hidden positions and structural discourses echoing through individual accounts. They recognise that 'what we see, when, how and to what extent we see it are not straightforward...actions, interpretations and influences may be unstated or go unrecognised. Our task is to make it explicit in our analyses' (Charmaz, 2009: 130)" (Oliver, 2012: 382).

In reflecting on the methodological approach I have taken, I was initially concerned about the blending of different GT variants, concerned that it would be a mark of failure, of having ill-considered my methodological options at the start and not being able to fully realise a SA approach. I became more comfortable with the idea when my second supervisor reminded me of the principle of *pragmatism* in GT (Timonen et al., 2018). Practising pragmatism in GT has its roots in the Pragmatist sociological tradition of, among others, John Dewey (1929) and George Herbert Mead (1934), both of whom were important thinkers in the post-positivist landscape that gave rise to classical GT (see section on GT and CR compatibility above). Pragmatist sociologists placed a premium on theory being useful and workable, arguing that if a given theory or claim did not explicitly contribute to social progress, then it must not be worth much. Applying this principle to the practicalities involved in actually *doing* GT and the decisions research work involves (Timonen et al., 2018), I started to think of the different methodologies as toolkits – the 'problem' or question

had changed, and so the tools would have to change also. This often occurs when one sets out to do exploratory research, as, by definition, little is known about the area under study when one first sets out, and adaptations and modifications of the research design, methodology and methods are common if not expected. The researcher's interpretation of the data can lead them in different direction—there is no one way to proceed (Clarke, 2009).

3.5 Discourse analysis – theory and method

To complicate matters somewhat, this study applies Constructivist GT methodology to analyse discursive data—the study's method. Clarke clarifies that an interest in discourse extends not just to analysing textual forms of language, but equally to "visual images, symbols, non-human things/material objects, and other forms of communication", and is more than just a method (2005: 148). Discourse analysis in the social sciences has its roots in twentieth century French poststructuralist philosophy, most notably in the work of the French philosopher Michel Foucault and his writings on the analytics of power (Foucault, 1972; Clarke, 2005). While much of the qualitative research done by sociologists and anthropologists in prior decades of the late nineteenth and twentieth centuries centred on "grasping the native's point of view, his relation to life, to realize his vision of his world" (Malinowski, 1922: 25, cited in Prior, 1997: 64), Foucault argued for the need to go beyond the 'knowing subject', beyond the individual and the individual's point of view, to investigate the social relations and collective social actions that constitute and are constitutive of social life (Foucault, 1972; Prior, 1997; Clarke, 2005). Foucault pointed to the utility and importance of analysing discursive materials in doing so (Foucault, 1972).

Jaworski and Coupland define discourse as, "language use relative to social, political and cultural formations—it is language reflecting social order but also shaping social order and shaping individuals' interaction with society" (1999a: 3). Interpretivist assumptions about how we understand the world around us, specifically a social constructionist understanding of reality stand at the core of discourse analysis (Clarke, 2005). Norman Fairclough (1999: 203-205, cited in Clarke 2005: 151) identifies theoretical, methodological, historical, and political reasons for studying discourses:

a) Theoretical: Discourses constitute one important form of social action. The work that language does in the world is worthy of understanding on its own terms;
b) Methodological: Texts constitute a major source of evidence for grounding claims about social structures, relations and processes;
c) Historical: Texts are sensitive barometers of social processes, movement and diversity, and textual analysis can provide particularly good indicators of social change;

d) Political: Discourse analysis emerges from the critical project. It is increasingly through texts (notably but by no means only those of the media) that social control and social domination are exercised (and indeed negotiated and resisted).

Critical discourse analysis, "examines the structure of spoken and written texts in search of politically and ideologically salient features which are constitutive of the (re)produced power relations without often being evident to participants" (Jaworski & Coupland, 1999a: 497). Jaworski and Coupland, (1999b) developed an overview framework (see Figure 2) outlining in broad terms four different foci that research projects employing discourse analysis can have. Although most projects will be hybrids and will engage in multiple forms of analysis of the discursive materials, Jaworski and Coupland's typology turns on the assumption that in designing their research, analysts will have to make a conscious decision to foreground one or another substantive feature of discourses in their project (1999b: 7, cited in Clarke, 2005: 154).

Figure 2. Jaworski and Coupland's Overview Framework of the Genres and Foci of Discourse Analysis, adapted by Clarke

1. Sequence and structure of speech and conversation: **A focus on form**
   ⇒ The formal organization of speech and conversations is the research object.

2. Negotiating discourses in social relationships/interaction: **A focus on discursive interaction**
   ⇒ How discourses actually enter into social action/interaction is the research object.

3. Producing identities and subjectivities through discourse: **A focus on subject making**
   ⇒ How particular discourses are taken into account in changing identities and subjectivities is the research focus.

4. Producing power/knowledge, ideologies and control through discourse: **A focus on the situation of production**
   ⇒ How discourses are produced, by whom, with what resources, and under what conditions, are the research foci.

Sources: Jaworski and Coupland, 1999b: 7; Clarke, 2005:154.

This research project falls primarily into the fourth category, "Producing power/knowledge, ideologies and control through discourse: A focus on the situation of production", although it may also venture at times into analysis of the 2nd and 3rd kind as well (see Figure 2). In this research, I am concerned with the discourse which has been constructed during the Coronavirus pandemic around older people and their care. I am concerned with who is creating the discourse, how they are doing so, and with what goals and consequences. I am less concerned with the meaning conveyed by the discursive material per se, and more so with what it reveals about the social processes and the exercises of power and authority at work in the implicated social world/arena (Clarke, 2005). Prior writes that, "a representation should be understood not as a true and accurate reflection of some

aspect of an external world, but as something to be explained and accounted for through the discursive rules and themes that predominate in a particular sociohistorical context" (1997: 70).

Grounded Theory has been widely used as a methodological toolkit for carrying out discourse analysis precisely because it is well suited to analysing social relations and processes—essentially social action—in context (Corbin & Strauss, 2008). Indeed, Anselm Strauss, one of the founders of Grounded Theory, belonged to the American school of sociology which emerged from the University of Chicago known as symbolic interactionism (Clarke, 2005), and his social worlds/arenas theory influenced Grounded Theory's emphasis on context for analysing and explaining social phenomena (Strauss 1978, 1982; Clarke, 2005). Symbolic interactionism was the brainchild of pragmatist philosopher George Herbert Mead (Crotty, 1998). The three core assumptions at the heart of symbolic interactionism were outlined by Herbert Blumer as follows: "that human beings act towards things on the basis of the meanings that these things have for them; that the meaning of such things is derived from, and arises out of, the social interaction one has with one's fellows; that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (1969: 2; cited in Crotty, 1998: 75).

3.6 Data sampling

Following the tenets of Grounded Theory, my sampling of the data was initially purposive and then theoretical in nature (Corbin & Strauss, 2008; Timonen et al., 2018). Although I initially considered doing a comparative study, due to the sheer volume of documents being published daily, I soon decided to concentrate my data collection and analysis squarely on Ireland, on a combination of the 'official' channels operating in the country with relevance for the pandemic and older persons. Specifically, that included any communication coming from online government sources. This included the websites of relevant governmental departments, foremost the Department of Health, the Department of the Taoiseach (Head of Government/Prime Minister), the Health Service Executive (HSE), the Health Information and Quality Authority (HIQA), and last but certainly not least, from the expert body established to advise the government on the public health implications of the pandemic, the National Public Health Emergency Team (NPHET). In fact, NPHET's terms of reference and governance structure documents, and subsequently the group's daily (sometimes multiple times a day) postings, published on the website of the Department of Health, served as an important starting point. I also included a selection of key documents from non-governmental organisations that contributed to important alternative narratives to the discourses around older people and their care during the pandemic. These included documents produced by Nursing Homes Ireland, the Irish Human Rights and Equality Commission (IHREC), and the Irish Council for Civil Liberties (ICCL).

During the data collection period, while I would systematically check the websites of the main data sources I was using every week or so, I also frequently identified new data sources as I was reading and coding data that I had already captured. The establishment of the parliamentary Special Committee on Covid-19 Response in the summer of 2020 and the appearance of key representatives from the above groups before the Committee, led to my inclusion of the transcripts from relevant hearings as well (see Appendix C, Table 10). In terms of the type of discursive materials I looked at, I focused to a great extent on digital, text-based material published on governmental websites. In a few instances, I included digital visual images that appeared in government campaigns or that were included in government strategies or action plans. It should be noted that apart from one print document (providing HSE-issued guidelines to the public on social distancing), all texts included as data were digital. In most if not all cases, the documents were only available in digital form. The pre-pandemic ubiquity of the Internet as a source of information and a means of communication was reinforced by the pandemic, with many institutions essentially going 'paperless'. Indeed, the fact that so much of the information issued by the government to the public was only available online has potentially far-reaching implications for (older) persons with lower levels of digital literacy, and for those who do not have access to personal computers and other devices.

The data were coded with a view to identifying emergent categories and developing theory (Corbin & Strauss, 2008; Timonen et al., 2018). These emergent categories and, increasingly, my immersion and increasing familiarity in the situation surrounding the research, informed the direction of subsequent data collection in what is referred to in Grounded Theory as theoretical sampling (Corbin & Strauss, 2008; Timonen et al., 2018). Interestingly, even though only about five percent of the 65 and older population (according to latest census data available, 2016) reside in residential care homes, as the pandemic evolved and outbreaks in nursing homes exploded, this care setting dominated the official discourses and the context in which older people were being referred to. One of the emergent categories or concepts that I defined early on was, 'Nursing homes as embodied spaces: Constructing vulnerable older persons as functions of their care setting' (see *Chapter 5: Silences and absences*).

In March 2021, a year into the pandemic in Ireland and approximately eight months into data collection, I experienced a moment of panic when the transcript of a Houses of the Oireachtas (parliamentary) Joint Committee on Health debate referred to a series of debates in the Dáil Éireann (lower house and principal chamber of parliament) on the coronavirus and wide-ranging government measures to respond to the pandemic. Feeling like I might have overlooked a whole swathe of data, I discussed whether to include the Dáil debates with my first supervisor. The conclusion we came to was that while I might consider including segments from the most relevant, significant debates—which I did ultimately do—that as my focus to that point had been on sources emanating from the government's executive branch, and on specialist committees set up explicitly with the mandate to

investigate the coalition government's response, less attention to the Dáil, to the legislative branch, was justified.

In terms of the timeframe set for data inclusion, the start date is the date of the first official communication pertaining to the coronavirus (end of January 2020). As the pandemic was a rapidly evolving situation when I began my data collection, it was not possible at the time to set an end date for the inclusion of sources. At the time of this writing, in April 2023, fully three years after it first began, the pandemic is still with us. Most restrictions on travel/mobility and social activity have been lifted, but subsequent waves have continued to impact the health and social care sectors, including hospitals, long-term care facilities, nursing homes, and community-based services for older individuals. That said, in and around March 2021, following the arrival of the coronavirus vaccines and the rollout of the government's vaccination programme, which prioritised older people, and especially older people in nursing homes, as a 'vulnerable' group, I started to get the sense that no truly compelling, new concepts of relevance for my research aims were emerging from the data and that I was close to a theoretical saturation of the data (Timonen et al., 2018; Ritchie et al., 2014). While I undoubtedly could have continued to collect valuable data and expand the scope of the project as long as the pandemic continued (indeed continues), the question of feasibility and what was possible within the timeframe and the resources of the PhD also began to play on my mind around that time. Satisfied that I had achieved theoretical saturation—even if I had not managed to include every single text of interest—I brought my data collection phase to a close at the end of March, 2021. A list of the texts included as data in this study is provided as an appendix (see Appendix G, Table 13).

3.7 Data analysis

Textual (and the few visual, image-based) data sources were uploaded into the NVivo qualitative data management tool for coding. Data published as free text on websites was copy-pasted into Microsoft Word files and then uploaded into NVivo. The NVivo tool was used as a repository of all data sources and facilitated the coding and constant comparison of data. It also aided in the storing of memos and in linking memos to relevant segments of data. To the extent possible, data analysis occurred in tandem with data collection to facilitate the constant comparison of data and the focus on emergent theory that is so fundamental to Grounded Theory methodology. I carried out data coding in the following stages: open coding, coding for concepts, and theoretical coding (Charmaz, 2006). In the first stage of coding, the aim was to 'open up' the data and get a feel for it while starting to think about possible conceptual links across the texts, giving labels to these emerging categories (Charmaz, 2006; Timonen et al., 2018; Corbin & Strauss, 2008). In most cases, I would first scan a document or a segment of text to determine whether it merited including. Often, I could tell simply by reading the title and knowing its authorship/ provenance that it should be included. Thus, my first

close read of a text usually coincided with my open coding of it. In the second stage of coding, I focused on using the process of constant comparison to identify patterns and connections between these categories.

Constant comparison involves the juxtaposition of multiple segments of data to aid in the identification of conceptual similarities and differences. In the latter stages of data collection, when I felt quite confident that I was encountering many of the same codes and concepts across different data sources, I no longer carried out a full-scale open coding of new data but rather used my index of emergent categories—or a more advanced version of my code list—to code the newly captured data, all the while staying alert to the possibility of novel concepts emerging. In doing this work, and in preparing for the final stage of coding, I refined the emergent categories further, distilling them into two main categories or concepts around which I structured my two analytical findings chapters (see *Chapter 5: Silences and absences* and *Chapter 6: Continuities and discontinuities*). The first of these is 'silences and absences', reflecting the striking absence (and conversely the dominance) of certain actors and actants from the discourses. The second is the concept of 'continuities and discontinuities', which speaks to the interesting effect the pandemic—'the virus'—has had in a temporal sense, on the state's approach and attitude towards older people and their care.

The last stage of coding, theoretical coding, involves a refining of conceptual categories and of the relationships between them, which is then formulated into a central, explanatory theory (Corbin & Strauss, 2008). Timonen and colleagues refer to this step as a "theoretical integration of the categories" (Timonen et al., 2018: 7).

> "Even grounded theory's traditional concept of saturation has been reframed to embrace the fluidity of knowledge creation. It is now rarely presented as a fixed point at which truth has been extracted from the data. All theory is modifiable (Glaser, 1998) and analysis stops when 'you don't think you have missed much of anything. You think these are the most important elements. (Of course there are many others, but they don't seem to "make a difference" to the stories you would tell)' (Clarke, 2003: 571)" (Oliver, 2012: 378-379).

While the emergent theory must be grounded in an inductive analysis of the data, throughout the analysis I also relied on abductive reasoning to inform the formulation of conceptual categories and the relationships between them, returning to the literature and to my own knowledge of the situation under investigation (Charmaz, 2006; Corbin & Strauss, 2008; Timonen et al., 2018). In the final stage of analysis, the emergent concepts and theory I developed informed a series of narrative reviews of the literature (see *Chapter 2: Literature Review*). Engaging with the literature—abductive reasoning in successor variants of GT—anchored my findings in the existing scholarship and helped me to

refine my theoretical contribution and the reflections presented in the final chapter of this dissertation (see *Chapter 7: Conclusions*).

3.8 On reflexivity, my role as researcher, and my positionality

If we assume a constructivist epistemological position, it follows that the role of the researcher in the research process, as a co-constructor of knowledge, is central to every aspect of the project. As Grounded Theory has evolved as both a theory and a methodology, the call among the community of GT practitioners for researchers to adopt a reflexive research practice has become stronger and stronger. This emphasis on 'reflexivity' is not only a natural byproduct of GT's evolution away from its founders' original insistence on pure inductive reasoning (the source of the researcher as 'blank slate'). It has also developed in response to criticism from researchers from the positivist schools of inquiry—usually quantitative researchers—as well as from within the qualitative community itself, that qualitative research methodologies are lacking in scientific rigour, particularly in terms of how they account for the 'validity' and 'reliability' of research findings (Golafshani, 2003).

While this provoked efforts on the part of certain authors to come up with ways to make aspects of the qualitative research process more systematic and to approximate measures associated with quantitative methodologies, for example 'triangulation', 'member checking', 'inter-coder reliability' (essentially, to introduce processes in qual that mimic quant approaches) (Onwuegbuzie & Leech, 2007; Cho & Trent, 2006), Kathy Charmaz, together with Adele Clarke of the Situational Analysis variant of GT, and others, were of a mind that different research paradigms call for different approaches, and that qualitative research needed to forge its own path. The concept of researcher reflexivity, involving a high degree of transparency in terms of documenting and presenting the researcher's thought processes, biases, and the details and messiness of the research process, has become a cornerstone of achieving rigour in qualitative research, consistent with the theoretical impetus and aims of doing qualitative research (Charmaz, 2008, 2009; Clarke, 2009, 2019; Whittemore et al., 2001; Cho & Trent, 2006). In her contribution to Holstein and Gubrium's (2008) *Handbook of Constructionist Research,* Charmaz is explicit about the fact that in her constructionist version of GT, "research always reflects value positions" (Charmaz, 2008: 402) and that the following assumptions are fundamental to her approach:

> "My constructionist approach makes the following assumptions: (1) Reality is multiple, processual, and constructed—but constructed under particular conditions; (2) the research process emerges from interaction; (3) it takes into account the researcher's positionality, as well as that of the research participants; (4) the researcher and researched coconstruct the data—data are a product of the research process, not simply observed objects of it.

> Researchers are part of the research situation, and their positions, privileges, perspectives, and interactions affect it (Charmaz, 2000, 2006; Clarke, 2005, 2006)" (Charmaz, 2008: 402).

Focusing on points (2) through (4) for my purposes here, it is perhaps useful to briefly consider each in turn as it relates to my research process. While my project does not, by design, include research participants (see point (2) above), the centrality and importance Charmaz and Clarke both give to 'interaction' between actors within the research process as part of the 'post-modern' or 'interpretive' turn in GT still applies (Charmaz, 2008; Clarke, 2005; Clarke et al., 2018). In my case, the research process resulted from my interactions as researcher first and foremost with my supervisors, as well as from interactions, discussions with colleagues, with external experts (for example, during seminars, conferences attended). As solitary an undertaking as the PhD can feel at times, it is by no means conducted in isolation or in a vacuum. My regular conversations with and emails to and from my supervisors, the written feedback they provided and my reflections on and incorporation of their feedback, were of enormous significance in terms of guiding the overall process. Charmaz's points (3) and (4) speak to the positionality of the researcher and the understanding and active recognition that as (co-)constructors of the data, their views, their experiences and perspectives, and their values are all inextricable from the findings emerging from the study. It is perhaps worthwhile to reflect here at some length and in some detail on what I bring to this project as an individual.

I come from a privileged background and have encountered few significant external obstacles to academic and professional success. I am white, cisgender, heterosexual, I was raised by highly educated parents who, while they struggled financially in the early days of their marriage and in our first years as a family, the struggle was that of professionals working their way up the career ladder. I grew up in prosperous suburbs of Boston and Washington DC, attended a prestigious public secondary school, and went on to earn my undergraduate degree in English Literature from an elite, private liberal arts college. I know that I am extremely privileged. I also know that I carry my family's history very close to my chest, and that it is a constant check on that privilege.

My mother grew up in post-war Hungary, in the country's Northern Great Plains region, close to the border with Romania. Her drive and ambition and the access she had to a quality, free education, propelled her first to a career in academia in Budapest, then to Germany, where she met my father, a first generation American with German roots. They married and she moved to the US to be with him, forgoing a comfortable and prestigious career in Hungary to start over and raise children in a new country, a new language, without the support of family. We spent every summer of my childhood with my Hungarian grandparents, and while I loved being with them and with my mother's extended family, even to a young child the difference in the standard of living between Hungary in the 80s and 90s and where we lived in the United States was stark. As her parents grew older, they relied on my mother for financial and practical support, and to arrange for private home care, despite the physical distance between them.

My father's parents were German Jewish refugees who settled in Los Angeles in 1946 after spending four years in the Philippines, one of the few countries still granting visas to Jews in 1939 when my grandfather finally conceded that he would have to leave Germany. My grandparents arrived in California with little economic but considerable social and cultural capital, and despite early struggles to adjust and adapt, they made a comfortable life for themselves and for my father, their only son, in the boom years of American post-war prosperity. When they were older and my grandmother developed Alzheimer's disease, eventually requiring 24-hour care, my grandfather refused to admit her to a nursing home and paid out of pocket for private carers. She died at home, as did he a few years later, both with the continuing support and care of private home carers.

I inherited a strong sense of social justice from both of my parents, and both sets of grandparents, and as a teenager took great pride in being a 'liberal' in the American sense of the word, without knowing much about what that label meant. At university, I chose English Literature as my major or concentration because I liked to read and write and had some facility in both, and harbored faint ambitions of being a writer, but there was no great passion driving the decision. It wasn't until my final year that a real intellectual curiosity was sparked. I took two classes that were formative, the first a senior colloquium with the theme 'literary monsters', and the second a seminar on postcolonial literature, which introduced me to the works of Edward Said. For the first time, a resonant condition was articulated for me: 'otherness'. This concept of otherness, of how we construct people who are different from us as 'others', how we construct our own social identities, and the purpose this 'othering' serves in society, felt incredibly consequential at the time, though from where I sit now, it seems self-evident. Given my background, I have never felt wholly at home anywhere, or as part of any one group. All my professional and educational pursuits in the intervening years were extensions of this basic but fundamental idea. In graduate school at The University of Edinburgh, I studied international health policy with a minor in medical anthropology, learning about systemic health inequalities, the social determinants of health, and Foucault's theories of biopolitics and biopower, among many other things.

It was in my work as a researcher at an international research institute in Vienna, where I was based for the five years before starting the PhD, that my focus first turned to questions of ageing and care. Early during my tenure there, I did desk research for my team's contribution to the European Commission's annual Social Situation Monitor series. The theme of that volume was the 'indirect costs of long-term care' (Rodrigues et al., 2013). In reading the literature for my contribution, the complex interactions between gender, socioeconomic status, and care were clearly articulated for me. In addition to the empirical evidence, I was introduced to important schools of thought and theoretical work in the field, including feminist care ethics, notably the work of Joan Tronto, and intersectionality. I developed a particular interest in qualitative research over the next several years,

contributing to studies on community-based care for people with dementia, quality in care from the perspective of care workers, and (long-term, social) care within the framework of human rights. I became increasingly 'critical' of the status quo in terms of Western neoliberal societies' approaches to ageing, care, and care work, and increasingly frustrated by some of the research I was being tasked with, which included large scale European projects, and which often seemed like little more than box-ticking exercises to boost partners' publication lists, and study designs that only allowed for rushed qualitative research.

It was then that I decided to pursue the PhD, choosing Trinity primarily because I found the work of my first supervisor to be the kind of work I wanted to do. Thought-provoking, 'critical' without being ideological, serious about theory, and methodologically rigorous. The wide-ranging reading I did particularly in the first two years of the PhD greatly expanded my familiarity with the Irish care system and its sociopolitical and historical context, deepened my methodological and theoretical (in Sociology especially) knowledge base considerably, and cemented my alignment with critical feminist research.

In terms of my chronological age and life experience, I am young relative to the ages of the people whose lives and experiences I am in interested in studying. I have no direct experience myself of what it means to 'get old' and to 'be old' in our societies, to have long-term care needs or to provide for those needs. That said, I have seen what getting old and being old looks like up close, and it is increasingly apparent to me that I myself am getting older, ageing, and that this process happens over the entire course of one's life, even if we do not notice or choose to ignore it when we are 'young'. I have talked about it with family members and friends, and I think a great deal about what will happen when my mother and father, who live a transatlantic flight away from both their children, inevitably require care. For the past three years (with periodic interruptions due to the pandemic) I have also been a volunteer at a weekly social club for older adults in Dublin.

While I do not engage in any research activities with the group, talking with members, hearing about their daily lives and their resilience, and above all their eagerness to engage with me and with each other, to be sociable, has undoubtedly influenced my perspective. This is a large part of the reason I feel strongly about the value of qualitative research—it requires the researcher to enable participants to speak for themselves, to provide rich, experiential data about *their* lives as *they* see it. It is the researcher's role to fill in the necessary context, to draw connections—in the case of a constructivist epistemological approach in any case—between the lived experiences of individuals and the conditions that exist around them, and to constantly reflect on what they themselves as researcher and co-constructor of meaning, bring to the work.

Charmaz writes, “We construct research processes and products, but these constructions occur under pre-existing structural conditions, arise in emergent situations and are influenced by the researcher’s perspectives, privileges, positions, interactions and geographical locations” (Charmaz, 2009: 130). I’ve gone to some lengths here to give an account of my positionality as I see it, not only because it is *de rigueur* for any social constructionist GT research endeavour, but because I see a direct line between my positionality—the importance of my early relationships with older members of my family, how I relate to and make sense of my own family history, and my exposure and sensitivity to the relational complexities of care from a young age—and the life choices I have made as an adult, including the decision to do a PhD and specifically *this* PhD, so vividly.

My background, my views, my perceptions, my experiences bring a sense of purpose to my research. I am motivated by a desire to change societies’ approach to ageing and to care for the better. This of course is ‘better’ as *I* see it, a vision that includes health and care as public goods, universal access to health and social care services, and more rather than less state intervention to redress inequalities in access to care services across the life course. It also involves a move away from a biomedical, patriarchal, and paternalistic approach to health and social care, towards a broader conception of health and wellbeing, and the realisation of quality care as the right of every individual. I recognise that my convictions are ideologically influenced, and that as much as they motivate me, they also bias me in my focus and in my analysis in this study. I recall asking myself regularly if I was ‘picking’ on certain actors, or indeed if I was lingering on, following certain branches of the discourses over others because I was being guided by my ideological and political views. The only conclusion that I can draw is that, yes, I very likely was, and no other researcher would have followed the same path I have, made the same analytical decisions, developed the same theoretical framework that I have. However, throughout the process, I kept checking, kept asking myself: am I overlooking something important because of preconceived ideas that I have formed, because of my biases, my experiences? And I regularly took a second, or a third look to make sure that I had given the data its due consideration.

3.9 Challenges faced over the course of the PhD

Several challenging circumstances had—to varying degrees—an impact on the progress of this dissertation. First, the change in topic, mentioned earlier, extended the timeline of my PhD considerably and was a difficult adjustment initially. Second, as I was researching and writing about coronavirus and the pandemic, I was also experiencing the pandemic restrictions along with everyone else. At certain points, this living and working under the cloud of the coronavirus and the inability to escape it, negatively affected my mental state and my ability to concentrate on the research at hand. With the encouragement of my first supervisor, I allowed myself to take time away from working on the PhD every now and then. Then in January 2021, I contracted coronavirus myself and the virus

set off certain sequalae that resulted in my developing a form of ‘long Covid’. I went off the student register on medical grounds for one term (six months), returning in September 2022 to complete the PhD. Lastly, coming back in September, my primary supervisor, Virpi Timonen, moved institutions, remaining in a co-supervisor role, however, and Catherine Conlon came on board as co-supervisor. In the end, I was most fortunate to have them both providing guidance and feedback in the final year of the PhD.

As the above and previous sections clearly show, the research process leading to this dissertation was not always a wholly smooth one, but then it never is, nor should we expect it to be. Qualitative research is messy, but through the practice of reflexivity we can start to understand the ways in which we bring ourselves, a great deal of ourselves, into the process and what it means for our contributions to the scholarship. In this dissertation, without setting out to do so but as a result of a series of decisions guided by the principle of pragmatism, my methodological contribution is the blending of SA and Constructionist GT to manage and make sense of a unique and fast-moving situation.

Chapter 4. A Chronological Analysis and Laying Out of the 'Situation' in Four Acts

4.1 Aims and Structure

As defined in greater depth in the *Chapter 1: Introduction* and *Chapter 3: Methodology*, the questions I am trying to answer using blended variants of Grounded Theory (Clarke, 2005; Charmaz, 2006), include: How have older persons and their care been constructed and represented in the official discourses over the course of the coronavirus pandemic in Ireland? Which are the actors and actants involved in this situation, and what is their relationality and positioning vis-à-vis one another? Where does decision-making power lie in this situation, and who and what—if any—are the silent actors and actants, the underrepresented, the voiceless? In this chapter, my aim is to lay out the situation under investigation. My understanding of the 'situation' is informed by Clarke's (2005) SA variant of Grounded Theory, which posits the significance of context, or the 'conditions of possibility', considering it to be indivisible from the central unit of analysis. Although I did not ultimately employ the SA methodology to its fullest extent, my engagement with the ideas underlying the approach, especially in the early stages of data collection when I was coming to grips with the contours and dynamics of the unfolding phenomenon, meant that I considered context to be more than merely background information within this study—integral to understanding the dynamics of the situation under investigation.

I will lay out the evolving situation between January 2020 and March 2021 in four *Acts*. Each Act is bounded by the evolving narratives that emerged from official discursive texts. The division of the evolving situation in Ireland into four acts does not imply that these periods are analytically distinct, stand-alone periods within the situation. Rather, the actors and actants and the discourses emerging in each act build on and are interrelated with the one(s) that precede it. In fact, as one might expect, many of the actors and actants—the key players in the situation—remain consistent as we move chronologically and discursively through the four acts. It is their relationship with and position vis-à-vis one another that we can see change and evolve. The decision to structure this chapter into four acts proceeded from a need to provide the reader with a narrative frame within which the 'situation' can be clearly laid out in all its complexity.

The four Acts are designated as follows. *Act I: Responding to an 'unprecedented' crisis*, will address the time period from when the Irish government first initiated its official response to the pandemic, at the end of January 2020, marked by the first meeting of the country's expert advisory committee, The National Public Health Emergency Team (NPHET) for Covid-19 on the 27th of January, to the establishment of the Special Parliamentary Committee on Covid-19 Response (hereafter the 'Special Committee') on the 6th of May, 2020. *Act II: Coming under criticism and 'learnings'*, picks up where Act I left off at the beginning of May with the establishment of the Special Committee and ends with

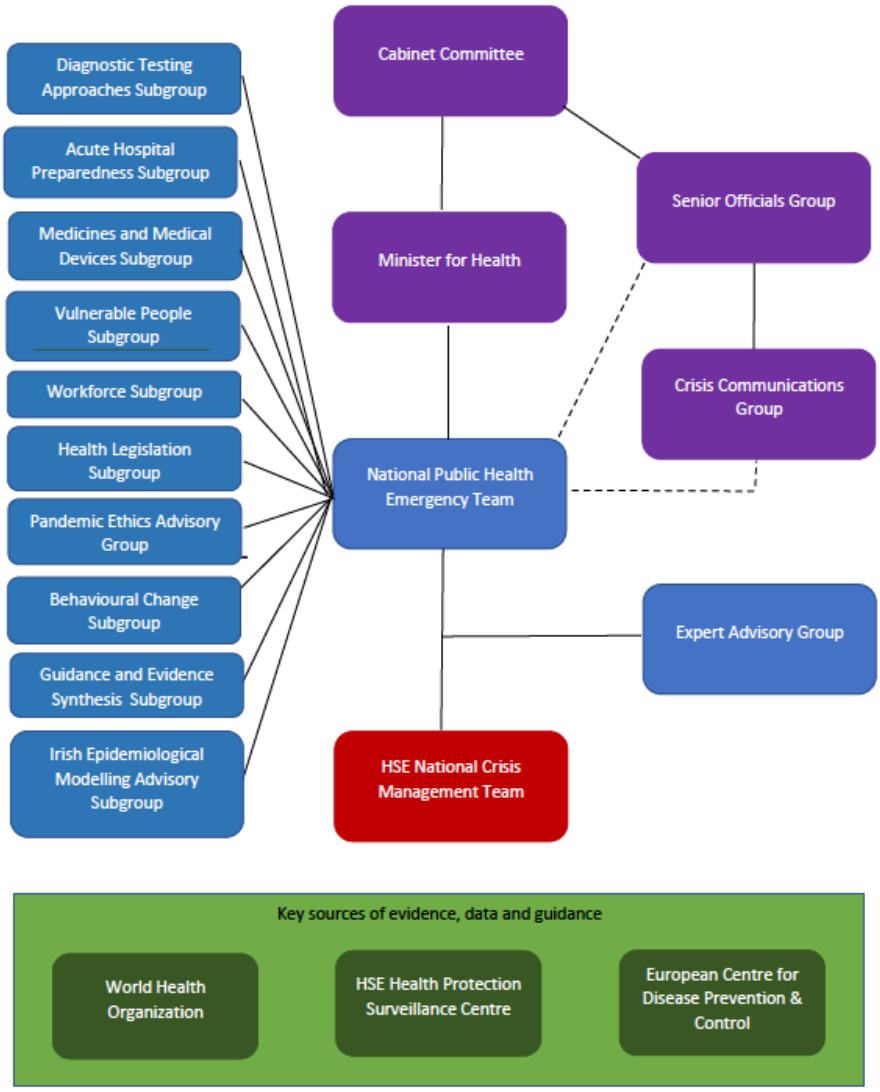
the beginning of the 'second wave' in Ireland, marked by the announcement on September 15th, 2020 that Dublin would move to Level 3 restrictions that same week. *Act III: Navigating a second wave and the bid to 'save' Christmas*, begins with the announcement of Dublin's move to Level 3 on September 15th, and ends with the announcement on November 27th, 2020 that restrictions would be eased for the Christmas period. Lastly, *Act IV: Only the vaccine can save us now* addresses the period from early December, 2020, to early March, 2021, when rising cases and mortality rates would force the government to announce a lockdown days before the Christmas holiday, and would keep the country in lockdown while attempting to deliver the vaccine to the country's most at-risk population groups, including older people. As is evident, the four Acts are not determined by equal periods of time, rather by key discursive moments emerging from the data.

4.2 Act I: Responding to an 'unprecedented' crisis [January 2020 – May 2020]

On January 27th, 2020, the NPHET for Covid-19 held its first meeting (NPHET; January 27, 2020). National Public Health Emergency Teams have been formed in the past by the Irish government during times of public health crisis, for example, during the H1N1 (swine flu) pandemic in Europe in 2009. The NPHET became the chosen mechanism for coordinating the health sector's response to the pandemic crisis (NPHET; June 26, 2020). In terms of its governance structure, it sat within the Department of Health and performed its duties at the request of the Minister for Health. NPHET was an expert advisory body and as such, was not endowed with decision-making authority *de jure*. As became clear over the course of the analysis in this study, however, at certain points during the pandemic, NPHET was handed *de facto* decision-making power by the executive branch.

Interestingly, while the government opted to form a National Public Health Emergency Team for Covid-19 to coordinate the response to the pandemic, this was not the only structure available to them. As recently as 2017, the government adopted a framework for strategic emergency management at the national level. The framework's central structure or body to be convened in a national emergency is the National Emergency Coordination Group (NECG), consisting of representatives from all governmental agencies/departments, and to be led by the agency deemed most relevant in any given emergency (Department of Defence, 2017). In 2017 and 2018, NECGs successfully coordinated the government's responses to the national emergencies wrought by Storms Ophelia and Emma (Murphy, 2020). In addition to severe weather, one of several national emergency scenarios outlined in detail in the strategy document is a pandemic/influenza (Department of Defence, 2017). In the case of the coronavirus pandemic, then, the Minister for Health at the time Simon Harris, could have convened a NECG and set in motion the strategic emergency management framework with the Ministry for Health as the lead agency. For reasons that remain unclear the government opted instead to utilise the NPHET mechanism to coordinate its response, a mechanism which grants members of the Taoiseach's cabinet direct oversight (see Figure 3) (O'Toole, 2020).

Figure 3. Overview diagram of Ireland's governance structure for responding to the coronavirus pandemic



Source: NPHET (June 26, 2020: 3).

According to a document outlining the NPHET for Covid-19's governance structure (see Figure 3 above), recommendations from NPHET are "communicated to the relevant parties to inform policy and operational approaches, depending on the nature of the emergency. Key to this is the role of the Minister for Health, who receives recommendations and updates for consideration in terms of health policy and further consideration, if needed, for a wider cross-Government approach" (NPHET; June 26, 2020: 4). The NPHET is chaired by the Chief Medical Officer (CMO) of the Department of Health (DOH). At the beginning of the pandemic, Tony Holohan—by training a physician specialised in general practice with a master's degree in public health—held this position until he took a temporary leave of absence for personal reasons on July 3rd, 2020. He resumed his post as CMO and chair of NPHET on October 5, 2020. In the interim, Deputy CMO Ronan Glynn, himself a qualified public health physician, occupied the role.

A document published on NPHET's governance structure by the group in June 2020 (NPHET; June 26, 2020), states that NPHET membership is made up of representatives—primarily government officials and civil servants—from the health and social care sectors. Specifically, members were drawn from the Department of Health (DOH), the Health Service Executive (HSE), the Health Protection Surveillance Centre (HPSC), the Health Information and Quality Authority (HIQA), and Health Products Regulatory Authority (HPRA) (NPHET; June 26, 2020: 4) (See Appendix B, Table 7 for further details). In addition to representatives from governmental agencies, four individuals with relevant professional expertise in non-governmental positions were also represented in the group (NPHET; June 26, 2020: 4) (See Appendix B, Table 7). Membership of the group remained largely static from the time it was established in January 2020, adding a few additional members as additional expertise was required, but without major changes to the composition of the core group (NPHET; June 26, 2020: 4). On the recommendation of the body's own Chair and Chief Medical Officer, Tony Holohan, and the decision of the Minister for Health, NPHET for Covid-19 was gradually stood down between February and March 2022, as it was determined that the group was no longer needed in its existing form (NPHET; February 17, 2022).

According to the document outlining its governance structure, "The NPHET's membership is multi-disciplinary and multi-sectoral in line with best international practice" (NPHET; June 26, 2020: 4). On closer inspection it becomes clear, however, that what the authors of the document understand to be 'multi-disciplinary' and 'multi-sectoral' is quite limited. Within the medical sciences, there is admittedly a diversity of disciplines and specialisations represented. Persons with expertise outside that field, however, are severely underrepresented, as evidenced by the positions and institutional affiliations of the 32 members of the group, presented in Table 2 below (see also Appendix B, Table 7). As the NPHET is the only body with an explicit mandate for providing expert advice and recommendations to government on its pandemic response, from the outset, the Irish government's response to the pandemic has been led by biomedical experts. In addition to limits to the multi-disciplinarity of the group even within the health and social care sciences, the claim of multi-sectorality is also overstated. Notably, representatives from other governmental agencies, and from other sectors of society and the economy are severely underrepresented in the makeup of the main NPHET group. Except for four experts drawn from outside government agencies, neither the private/voluntary sector nor civil society organisations are represented in the core NPHET group, a fact that is particularly striking when one considers the outsized role of private and voluntary service providers in the provision of healthcare and social care in Ireland.

Table 2. Position and institutional affiliation of the main group of NPHET for Covid-19.

Position	**Institution**
Chief Medical Officer	Department of Health (DOH)
Director, Resources Division	DOH
Deputy Chief Medical Officer	DOH
A/Sec, Acute Hospitals Division	DOH
A/Sec, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division	DOH
Deputy Chief Medical Officer	DOH
A/Sec, Primary Care Division	DOH
Director, National Patient Safety Office	DOH
A/Sec, Social Care Division	DOH
Head of Health and Wellbeing	DOH
Special Advisor to the NPHET (Infectious Disease expert)	DOH
Chief Bioethics Officer	DOH
Deputy Chief Medical Officer	DOH
Head of Communications	DOH
Medical Assessor	Health Products Regulatory Authority (HPRA)
Interim Director	Health Protection Surveillance Centre (HPSC)
Chief Executive Officer	Health Information and Quality Authority (HIQA)
Deputy Chief Executive and Director of Health Technology Assessment	HIQA
National Clinical Director for Health Protection	HPSC, Health Service Executive (HSE)
Chief Clinical Officer	Health Service Executive
Asst. National Director, Public Health	HSE
Deputy National Director of Communications	HSE
Asst. National Director, Office of Emergency Planning	HSE
Lead for Integrated Care	HSE
Director of Public Health Medicine	HSE
National Director, Community Operations	HSE
National Director, Acute Operations	HSE
National Clinical Lead, Critical Care Programme / Consultant in Anaesthetics, Intensive Care Medicine	HSE / Beaumont Hospital
President	Irish College of General Practitioners (ICGP)
President	National University of Ireland Maynooth
Director / Consultant Virologist	National Virus Reference Laboratory (NVRL) University College Dublin
Consultant Infectious Diseases / Professor of Medicine	St. James's Hospital / Trinity College Dublin

Source: NPHET, June 26, 2020.

In terms of communicating the outcomes of NPHET meetings, after each meeting a letter from the Chair was sent to the Minister for Health outlining the recommendations of the group. As can be seen from the governance structure presented in Figure 3, it was the responsibility of the Minister for Health to relay NPHET's recommendations to the Special Cabinet Committee on the Government

Response to Covid-19, a committee established on March 3rd 2020 and chaired by the Taoiseach, the head of government. The recommendations were intended to assist government officials in making decisions related to their handling of the public health emergency. A letter from the Chair is also sent to the Chief Executive Officer (CEO) of the HSE following each meeting (NPHET; June 26, 2020: 4). The NPHET has a dedicated page[13] on the publicly available Government of Ireland website where the minutes of most meetings are published and archived—albeit with some irregularity in terms of when they became available—together with regular formal dispatches from the NPHET Chair to the Minister for Health in the form of letters, as well as documents published by the group outlining its recommendations and proposed guidelines in various areas. Lastly, the group's webpage also published documents providing information on the group's terms of reference, membership, and governance[14].

A special subgroup of the main NPHET group, the Expert Advisory Group (EAG) was formed at the same time as the main NPHET group to provide independent, expert advice on the coronavirus based on the evolving international and national evidence base. The EAG is described in the NPHET governance document as a "multidisciplinary group with representatives from the Department of Health, Health Service Executive, Health Research Board, Science Foundation Ireland and leading experts from academia" (NPHET; June 26, 2020: 8). Apart from a patient representative and two members with nursing qualifications, the 27 member EAG is composed of medical and clinical professionals with expertise including but not limited to infectious diseases, microbiology, virology, public health medicine, histopathology, respiratory medicine, paediatric medicine, emergency and intensive care medicine, and occupational medicine. The group also includes representatives from the HSE departments for acute hospitals and primary care (NPHET; June 26, 2020: 8) (See Appendix B, Table 8 for further details). In effect, the EAG is presented as a nucleus of expertise on the coronavirus pathogen and developments in its clinical treatment, within the broader NPHET expert advisory group.

In addition to the special EAG subgroup, 10 additional subgroups covering specific technical or topical areas were also established over the course of March 2020 to feed into the core NPHET group (See Figure 3). The chair of each subgroup was drawn from the membership of the main or core NPHET group, in theory, facilitating reporting from the subgroups to the main group. With the exception of the Irish Epidemiological Modelling Group (IEMAG), all subgroups were stood down at the end of August 2020 as Ireland emerged from the first wave of the pandemic, following the government's decision to subsume the responsibilities of the subgroups into the work of relevant

[13] NPHET webpage: https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/
[14] Ibid.

governmental agencies/departments. It was determined at the time that the subgroups in question had fulfilled their mandates (Cullen, 2020; NPHET; August 27, 2020).

It is worth noting the gender balance of NPHET and its subgroups, given the value and importance of women's representation and participation in political decision-making (Shreeves & Prpic, 2021; van Daalen et al., 2020; Wenham, 2020). While men and women are fairly evenly represented in the membership of the core NPHET group and its subgroups, the position of chair for the main group is held by a man, as is the chair for the EAG. Across the other 10 subgroups, there is an even five-five split in terms of male and female chairpersons. Yet arguably the most influential subgroup—the Irish Epidemiological Modelling Advisory Group (IEMAG)—was chaired by a man. It is also interesting to note that three of the five subgroups chaired by women—the Vulnerable People Subgroup, the Pandemic Ethics Advisory Group, and the Behavioural Change Group—relate to disciplines within the 'soft' social sciences, which traditionally attract greater numbers of female professionals as opposed to the 'hard' sciences which continue to be dominated by men, particularly at more senior levels (NPHET; June 26, 2020; Shreeves & Prpic, 2021).

The subgroup most relevant to the situation of older adults is the Vulnerable People Subgroup (see Figure 3). The subgroup was chaired by Dr. Kathleen MacLellan, Assistant Secretary of the Social Care Division in the Department of Health and had 30 members in total (See Appendix B, Table 9 for further details). Members of the subgroup were drawn from multiple key governmental agencies (NPHET; June 26, 2020). In addition, the voluntary sector was represented by Sean Moynihan, CEO of the non-profit organisation ALONE, which provides services to support older people living at home, and by Dr. Joanne McCarthy, Director of Policy, Advocacy and Engagement at the Disability Federation of Ireland. Lastly, Brigid Doherty, a public/patient representative was also a member of the subgroup (NPHET; June 26, 2020). It is not clear from the publicly available documents how the members from the voluntary sector, and pointedly, the public/patient representative, were selected for membership, and why the number of these kinds of representatives were so limited, particularly given that the 'vulnerable' populations falling under the remit of this group are as numerous and diverse as they are (See Appendix B, Table 9, for complete list).

The Vulnerable People Subgroup was formed on March 3, 2020, to address the needs of various groups of people deemed 'vulnerable' in the context of the coronavirus. According to the subgroup's terms of reference, the term vulnerable people, "is being used to include older people, people with a disability, mental health service users, those with an underlying illness or condition, children in care and those accessing social inclusion services (not an exhaustive list)" (NPHET; June 26, 2020: 15). The mandate of the Vulnerable People Subgroup, as stated in the governance structure document published by NPHET, is: "To provide oversight and assurance with regard to the specific

preparedness, measures and actions that need to be taken to protect vulnerable groups and individuals in society" (NPHET; June 26, 2020: 15).

In late January and February, 2020, in the weeks before Ireland reported its first cases of coronavirus, the first meetings of NPHET were in the main focussed on following information and epidemiological data as it became available on outbreaks of coronavirus first in China, then in other countries in Asia, and then in Europe and the rest of the world; on communicating said information to relevant government agencies and service providers, and on preparing the healthcare sector, primarily the acute/hospital sector but also community health organisations and GPs.[15] The procurement of Personal Protective Equipment (PPE) for the acute/hospital sector was also discussed, as was securing laboratory capacity for testing, and the communication of information about coronavirus to healthcare workers and to the public[16]. Notably absent from these early meetings is any mention of high-risk groups. Also absent is any mention of potentially high-risk settings, including nursing homes[17]. At the time, the European Centers for Disease Control (ECDC) were advising European countries that the virus could still be contained and that the likelihood of it spreading to the region was minimal. The meeting notes from NPHET's second meeting on January 30, 2020, include the statement: "It was noted that the ECDC's risk assessment for the EU/EEA is now 'moderate' but that, subject to appropriate control measures being in place, the risk of onward transmission is rated as 'low'" (NPHET; January 30, 2020: 1).

On the 29th of February 2020, almost exactly one month after NPHET was established and began preparing the country for what would increasingly be seen as an inevitability, the first case of a person testing positive for coronavirus was reported in Ireland. That same day, then Minister for Health Simon Harris made a statement to the press in which he announced that a first case had been confirmed (Department of Health; February 29, 2020). In his brief remarks, Harris set a reassuring tone, assuring the public that the government had been preparing for just such a scenario since January, and that everyone should follow the advice of the government's National Public Health Emergency Team (Department of Health; February 29, 2020). For the time being, the *advice* was just that—advice—as opposed to legislated measures.

On March 6th, NPHET's Vulnerable People Subgroup held its first meeting. In the meeting notes from that first meeting, the subgroup's terms of reference are recorded as twofold: "a) Identification of vulnerable people, b) Identify State Agencies responsible for service provision" (NPHET

[15] See NPHET Meeting Notes for January and February available online: https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#documents-from-meetings-in-january
[16] Ibid.
[17] Ibid.

Vulnerable People Subgroup; March 6, 2020: 2). Under the terms of reference, the minutes cite that the following was discussed by the members in attendance:

> "There was a discussion on the categories of vulnerable people that would need to be protected in the event of a Covid-19 outbreak and the range of State Agencies responsible for service delivery to these cohorts. A draft table of Vulnerable People/Responsible Department/Agency was circulated at the meeting for consideration in this regard" (NPHET Vulnerable People Subgroup; March 6, 2020: 2).

One of the actions agreed to in advance of its next meeting, taking place the following week on March 10th, was to submit any amendments to the draft list of vulnerable people and responsible agencies (NPHET Vulnerable People Subgroup; March 6, 2020). On March 10th, a report composed by the members of the Vulnerable People Subgroup and published online, presented the group's work to date to identify vulnerable groups and responsible agencies (NPHET Vulnerable People Subgroup; March 10, 2020). The final list is presented in Table 3 below.

Table 3. Vulnerable people and State Agencies responsible for service provision, as identified by NPHET Vulnerable People Subgroup

Category	**Responsible Department**	**Responsible Agency/other**
Elderly: residential, respite, day services, people living at home, homecare	Health	HSE, private providers
Disability: residential, respite, day services, people living at home, homecare	Health	HSE, private providers
Mental health: residential, day services, people living at home	Health	HSE, private providers
Underlying illness: chronic diseases, immunosuppressed, rare diseases, cancer	Health	HSE, private providers
Palliative care: hospices, homecare	Health	HSE, private providers
Prisoners	Justice	Irish Prisons Service
Homeless population	Housing	LGMA, Homeless Executive
Asylum Seekers	Justice	NGOs
People in Direct Provision	Justice	
People with addiction problems	Health/Justice	HSE
Irish Travellers & Roma	Health/Justice	HSE
Children in Foster Care	DCYA	TUSLA

Source: Table reproduced from NPHET's Vulnerable People Subgroup Report (March 10, 2020: 2).

While the list in Table 3 is surely intended as a rough outline of vulnerable groups and the division of responsibilities across the various governmental and private and voluntary sectors, it is nonetheless remarkable for its seeming arbitrariness. No details are provided regarding the approach and the criteria used to define said 'vulnerable groups'. While presumably some of the listed 'groups' were designated based on individual health-related risk factors, other groups would seem to have been included due to members' housing and living conditions, family situations, and so on. Certain groups whose living and working conditions place them at high-risk, such as migrant workers, were not included on the list, however. The latter oversight became all too evident when multiple meat processing plants across the country, employing disproportionately high numbers of migrant workers, experienced numerous outbreaks of coronavirus during the first wave of the pandemic (Houses of the Oireachtas Special Committee; May 19, 2020). Lastly, the silo approach to designating vulnerable members of the population and responsible services flies in the face of rhetoric around a 'cross-sectoral' and 'integrated' approach to the government's coronavirus response, as stated in the NPHET governance structure document (NPHET; June 26, 2020). It also suggests a lack of understanding or appreciation of the heterogeneity of these 'vulnerable groups' and of the intersecting and often inextricable nature of such categorisations as age, disability, health, addiction, underlying illness, right on down the list.

Crucially, what this timeline likewise suggests, is that a week after the first case was reported in Ireland, and more than one month after the NPHET's core group had been established, the government had yet to officially identify members of the population at high-risk from the virus and had yet to identify those agencies responsible for providing services to specific high-risk groups. It is clear, then, that the necessary preparations had not been laid, nor a strategy or approach developed, to address the needs of these 'vulnerable' people.

In addition to the identification of vulnerable groups and the government and private sector agencies with responsibility for coordinating respective services, the March 10 Report details the subgroup's proposal for ensuring that vulnerable persons living in the community are supported and cared for (NPHET Vulnerable People Subgroup; March 10, 2020). In essence, the proposal is for the Department of Rural and Community Development, with the involvement of the HSE, to engage with established Public Participation Networks—collectives of community and voluntary organisations based across the country in each local authority—to ensure that,

> "vulnerable people living in the community can continue to have their needs met in the event that their usual sources of support become unavailable. Basic needs such as doing the weekly shopping, ensuring the house is warm and clean and keeping in regular contact by phone are among the tasks that local volunteers could carry out to enable vulnerable people to continue

> to live their daily lives safely in the community" (NPHET Vulnerable People Subgroup; March 10, 2020: 3).

This reliance on community-based, largely charity-based organisations to deliver services is in keeping with Ireland's historical embrace of the Catholic social teaching of subsidiarity, in which delegation of responsibility is decentralised to the greatest extent possible to the local level (Fahey, 1998). Two stakeholders from the voluntary sector are also mentioned as being central to this initiative, Volunteer Ireland and ALONE, both of which are cited as having large networks of volunteers from which to draw for this community effort. ALONE, it should be noted, is the sole representative from the voluntary sector included in the membership of the Vulnerable People Subgroup. In the same March 10 report, ALONE is described as "the organisation that supports older people" (NPHET Vulnerable People Subgroup; March 10, 2020: 3). A newly established helpline that older people living in the community can call for support during the pandemic, "ALONE National Support Line – Older People", and ALONE's collaboration with the HSE and the DOH on a "response to support older people who have concerns, may be at risk or who have contracted COVID-19" is also recorded in the report (NPHET Vulnerable People Subgroup; March 10, 2020: 3). Why ALONE has been singled out as *the* organisation supporting older persons in Ireland, and the exclusion of other voluntary sector organisations working in this area, is unclear. The mobilisation of volunteers to provide a continuation of basic support to older people in cases where their "usual sources of support become unavailable" (NPHET Vulnerable People Subgroup; March 10, 2020: 3) is an implicit acknowledgement of the shortage of formal, public sector long-term care provision and of the state's ongoing reliance on informal care by family members, a care workforce that the social distancing and 'cocooning' regulations and recommendations would jeopardise.

Also noteworthy in the March 10 report is information provided to the subgroup by the Health Information and Quality Authority (HIQA) on available capacity in nursing homes at the time (NPHET Vulnerable People Subgroup; March 10, 2020). The report states that 7,000 nursing home beds were unoccupied as of January 1st, 2020. Of the 7,000 beds, HIQA informed the group that 555 were HSE (public) beds, while the remaining 6,450 available beds were in private nursing homes. The report goes on to say, "the remaining private nursing homes will be predominantly single rooms or a maximum of triple rooms…*This provides potential for accommodation for appropriate discharges from the acute hospital setting where required* [emphasis added] or may support isolation of patients who would otherwise be in shared rooms (NPHET Vulnerable People Subgroup; March 10, 2020: 4). The discharge of older patients in March 2020, from acute settings to nursing homes to free up hospital capacity in anticipation of a surge in cases, would become a highly contentious issue in the Special Committee's post-mortem of the government's response to the first wave of the pandemic (Houses of the Oireachtas Special Committee; May 26, 2020; June 18, 2020). Approximately 800 older people in hospital at the time were transferred to nursing home beds in March 2020, *without* having been tested for coronavirus unless they were symptomatic (Houses of

the Oireachtas Special Committee; May 26, 2020; June 18, 2020). Representatives from the Department of Health and the HSE would state that this was done in adherence to guidelines published by the HSE on March 10th, 2020[18], in which the testing of asymptomatic patients was not yet advised (Houses of the Oireachtas Special Committee; June 18, 2020). Although follow-up data on these persons was never collected, concerns were raised by several deputies and witnesses in Special Committee hearings that a lack of appropriate risk assessment was partially responsible for the explosion of cases in nursing homes in March and April 2020. The latter will be addressed in detail in *Act II* of this chapter.

On the same day that the Vulnerable People Subgroup of NPHET convened its first meeting, March 6th, 2020, Nursing Homes Ireland (NHI), the national body representing the private and voluntary nursing home sector, published a press release on its website advising restrictions on visitors at its member nursing homes (NHI; March 6, 2020). Of a total of 557 registered nursing homes in Ireland, 443 (77 percent) are private or voluntary (Houses of the Oireachtas Special Committee; July 31, 2020). Private/voluntary nursing homes account for 79 percent of registered nursing home beds across the state. The average capacity of a nursing home in Ireland is 55 beds and approximately 38,000 staff are employed across these settings (Houses of the Oireachtas Special Committee; July 31, 2020).

The March 6 press release states that, "Older people and people in nursing homes with pre-existing medical conditions are particularly vulnerable if they contract the virus. The virus presents an unprecedented situation for our nursing homes and the care provided within them. Nursing homes are imposing the visitor restrictions in the best interests of residents and staff" (NHI; March 6, 2020). At the end of the statement, NHI concludes with the assurance that it is in communication with the DOH, NPHET, HSE, and all other relevant health authorities (NHI; March 6, 2020).

Fast forward to the notes from the NPHET meeting the following week on March 10th, and the group explicitly contravenes NHI's recommendation to restrict visitors. The meeting notes state, "NPHET recommends that unilateral/widespread restriction of visiting to nursing homes, hospitals and healthcare facilities is not required at this time" (NPHET; March 10, 2020: 6). On this advice, the HSE did not move to restrict nursing homes to visitors at the time (NPHET; March 10, 2020). In the same March 10 meeting of NPHET, the group proposes that restrictions on mass gatherings, and school/educational institution closures may form part of the response and will remain under review,

[18] The March 10, 2020, version of the HSE's guidelines mentioned in the Special Committee's hearing on June 18, 2020, is not available online. Version 1.1 of the document is available online and is dated September 21, 2020. In this version of the guidelines, the testing of all patients being transferred from acute settings to nursing home setting is required 72 hours before transfer, regardless of whether the person is symptomatic or not. Retrieved from: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Guidelines%20on%20admissions%20transfers%20to%20and%20discharges%20from%20RCF.pdf

yet similar proposals for safety precautions and restrictions in congregated settings, including nursing homes, are not made. Just two days later, in its March 12th meeting, NPHET does an about-face and advises the government to enact restrictions in long-term care facilities (NPHET; March 12, 2020). This recommendation is taken up by the Department of Health and HSE only several days later, at which point it restricts visitation in all residential care facilities, public and private/voluntary (NPHET; May 26, 2020). In later meetings of the Parliamentary Special Committee on Covid-19 Response, this is a critical decision that Tadgh Daly, the CEO of NHI, and certain Deputies (members of parliament)—from opposition parties but also from the governing coalition Fianna Fáil and Fine Gael parties—will partly fault for the subsequent outbreaks and deaths in nursing homes (Houses of the Oireachtas Special Committee; May 26, 2020; May 19, 2020). This point will likewise be discussed in greater detail in Act II of this chapter.

Against the backdrop of these early efforts to mobilise the institutional infrastructure to respond to the rapidly escalating crisis in February and early March 2020, then-Taoiseach Leo Varadkar addressed the public directly for the first time on the evening of March 12th to announce new public health measures (See Appendix D, Document 1, for full text). Broadcast on Ireland's public TV station, RTÉ, in the middle of a state visit to the United States, Varadkar, himself a medical doctor by training, assured the Irish public that the government had taken swift and strong action and was implementing measures according to the recommendations of NPHET. He aligned his government's actions with the advice of key international expert bodies, the ECDC and the World Health Organisation (WHO), further cementing the message that Ireland is committed to a science- and evidence-based strategy to mitigate the spread of the virus. Throughout the speech, the Taoiseach uses war and battle metaphors, pitting the "great nation" of Ireland against the virus which is "all over the world" and which "will continue to spread" (Department of the Taoiseach; March 12, 2020). He uses elevated, poetic language to appeal to the public for solidarity and sacrifice to protect the most vulnerable members of society. He states, "We know that older people and those with chronic diseases are at real risk. We have a duty as a society to protect ourselves and above all to protect others—our parents and grandparents, our family and friends, co-workers and neighbours" (Department of the Taoiseach; March 12, 2020). He acknowledges the reality that "more people will get sick and unfortunately, we must face the tragic reality that some people will die" (Department of the Taoiseach; March 12, 2020). It is a sombre speech but a confident one as well.

While the measures Varadkar announced in his speech included the advice that everyone reduce their social contacts as much as possible, the guidance—it would never be a legally enforceable measure—that older adults over the age of 70 'cocoon' at home was not yet part of the brief (Department of Health; March 27, 2020). The directive for older people and people with chronic health conditions to 'cocoon'—the term used in Ireland to denote self-isolating in one's home—would be announced two weeks later on the 27th of March in another nationally televised speech by the Taoiseach

(Department of the Taoiseach; March 27, 2020) (See Appendix D, Document 2, for full text). In that speech, the Taoiseach announces: "Shielding, or cocooning, *will be introduced* [emphasis added] for all those over 70 years of age and specified categories of people who are extremely vulnerable to COVID-19. Detailed guidance will be available" (Department of the Taoiseach; March 27, 2020). There is not a great deal of ambiguity in the language the Taoiseach employs. He does not qualify his proclamation in the moment, though he does allow for certain exemptions and for individual choice elsewhere in the same speech (Department of the Taoiseach; March 27, 2020). For everyone watching, however, the message was clear: this is what is going to happen, and this is what is expected of you.

To provide the government with the legal basis to enforce public health measures to mitigate the spread of coronavirus, a bill was proposed in parliament on March 16th, 2020 and was passed into law on March 20th. 'The Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020' amends Ireland's Health Act (1947), Customs Act (2015), and Social Welfare Acts (2005) (Houses of the Oireachtas; March 20, 2020). The first lines of the Act spell out the justification for a derogation of legislation—a partial suppression of a law—protecting the human and civil rights of people resident in Ireland in peacetime.

> "An Act, to make exceptional provision, in the public interest and having regard to the manifest and grave risk to human life and public health posed by the spread of the disease known as Covid-19 and in order to mitigate, where practicable, the effect of the spread of the disease known as Covid-19" (Houses of the Oireachtas; March 20, 2020).

The Act grants extraordinary executive authority to the Minister of Health to exercise emergency powers. These include the power to isolate persons infected with coronavirus, or suspected of being infected with coronavirus in designated facilities if they cannot safely isolate at home and to detain them bodily if they do not comply; to restrict international and domestic travel; and to require people to remain at home if they are suspected of having contracted the virus or of having been exposed to it. Enforcement of these powers is delegated to *An Garda Síochána*, Ireland's national police force (Houses of the Oireachtas; March 20, 2020).

The blanket guidance that people over the age of 70 must cocoon, announced at the end of March (Department of Health; March 27, 2020), does not fall under the legal powers outlined in the Health Act 2020. Indeed, the fine print of the guidance on cocooning available on various government agencies' websites includes the caveat that individuals "have the right to exercise your own judgement as to the extent to which you consider the cocooning guidance appropriate for you" (Department of Health; March 27, 2020). Yet the government's messaging foregrounded the public health aim of 'protecting' older, 'vulnerable' people above all other considerations. This is evident in the Taoiseach's March 12 and March 27 speeches, in NPHET's designation of all older people as

'vulnerable', and in the Department of Health and HSE guidelines equating people over the age of 70 with those "extremely medically vulnerable from Covid-19". In a report by members of the COVID-19 Law and Human Rights Observatory at Trinity College Dublin published months later in February 2021, the government's messaging around cocooning would be criticised for the "blurring of law and guidance such that it is close to impossible for conscientious citizens to identify the extent of their legal obligations" (Casey et al., 2021: 103). And on a more visceral level, the government's messaging served, whether intentionally or not, to encourage compliance with guidelines by instilling fear. Fear for loved ones and for one's own self.

The legislative basis for these measures, and notably the lack of adequate provision in the amendment for parliamentary oversight of the derogation, is addressed in detail several months later in a hearing of the Special Committee on September 9th, 2020 (Houses of the Oireachtas Special Committee; September 9, 2020). The suspension of certain rights and the guidance that all adults over the age of 70 should essentially isolate themselves for months on end does not seem to have been questioned at the time, at least not in official documents that are publicly available. The NPHET Pandemic Ethics Advisory Subgroup (see Figure 3) published an 'Ethical Framework for Decision-making in a Pandemic' on March 27th, 2020, in which they outline the key ethical principles that policymakers and frontline healthcare providers should consider (NPHET Pandemic Ethics Subgroup; March 27, 2020). Over the course of their mandate, the subgroup would also publish guidelines on the following topics: ethical considerations for PPE use by healthcare workers in a pandemic; ethical considerations relating to critical care in the context of the coronavirus; ethical considerations relating to long-term residential care facilities; and procedural values for decision-making in a pandemic[19]. What was not discussed, or rather what has not been published if indeed it was discussed, is an overarching ethical framework for the government's initial response to or strategy for the pandemic, and the balancing of individual human rights against emergency measures to protect the public. From the beginning, the government's approach and messaging reflected NPHET's composition of experts who were principally drawn from biomedical, clinical, and epidemiological professions and backgrounds. It is important to recognise that not all countries followed the same approach in responding to the pandemic (Mathieu et al., 2020; Greener, 2021; Daly et al., 2022). By some accounts, Ireland implemented one of the strictest and most sustained lockdowns in Europe during the first year and a half of the pandemic (Köppe & Cazaciuc, 2021). This is not intended as a normative judgment about which approach was the 'correct' one, but rather to emphasise that while it was presented as the only viable course of action in the official discourses, it was in fact one of many.

[19] The publications of the NPHET Pandemic Ethics Advisory Group are available online at: https://www.gov.ie/en/collection/504017-nphet-covid-19-subgroup-pandemic-ethics-advisory-group-peag/#minutes-from-meetings-in-march

By the week ending April 5th, the number of outbreaks reported in nursing homes rose significantly, with approximately one in every five reported cases nationwide occurring in long-term residential care settings[20] (NPHET Vulnerable People Subgroup; March 31, 2020) (See Appendix A, Figure 4, for weekly trends in coronavirus clusters by setting). It is clear from the press releases and meeting minutes published during that week and in subsequent weeks that the issue had become a central concern for NPHET and for government officials. In a press release published on March 31st, NPHET announced that it was engaging with DOH to agree on additional measures for residential care institutions and for nursing homes (NPHET; March 31, 2020). NPHET Chairman Tony Holohan is quoted saying, "The measures that we have recommended today should significantly enhance the preparedness and response to cases and outbreaks in nursing homes and other residential settings" (NPHET; March 31, 2020).

It is worth noting that the previously detailed back-and-forth between the NHI director Tadhg Daly, NPHET, and the DOH occurring in early- to mid-March had revolved primarily around visitor restrictions in nursing homes, while other measures to prevent and respond to cases in these settings had not been addressed or seemingly considered (NPHET; March 10, 2020; NHI; March 6, 2020). In the same March 31st press release, Holohan goes on to state: "As we have said from the beginning our efforts must be focused on protecting the most vulnerable to COVID-19 and these recommendations announced today seek to achieve this" (NPHET; March 31, 2020). The recommendations Holohan cites were prepared by members of the Vulnerable People Subgroup and include a set of 15 national 'priority public health actions' for state agencies, as well as a sizeable list of actions at the facility level for service providers to implement (NPHET Vulnerable People Subgroup; March 31, 2020). The first recommended action for facilities/service providers is to "Develop a COVID-19 preparedness plan" (NPHET Vulnerable People Subgroup; March 31, 2020: 4). Another key action listed is preparing a 'surge plan' to replace staff who fall ill. That these and other fundamental, basic recommendations were published—not to speak of implemented—at the very end of March when nursing homes and other residential care facilities were already being overwhelmed by outbreaks, and more than two months after NPHET was formed, is astonishing for its belatedness. In addition, the consideration given to residents, to the rights, wishes, and non-medical/clinical needs of the individual men and women who live in these long-term care facilities is virtually non-existent. In the 'Residents' section of recommendations for facilities/service providers, the first and second of 10 bulleted actions are: "Alcohol sanitizer provided in every resident's room"; "Cocooning (Restrict residents to room - no visiting except for compassionate circumstances)", where determining 'compassionate circumstances' is left to the discretion of the individual care providers (NPHET Vulnerable People Subgroup; March 31, 2020: 5). This latter action is particularly striking in its use of paternalistic and coercive language. The last action on the

[20] Long-term Residential Care (LTRC) includes facilities for older people, people with disabilities and mental health care facilities (NPHET Vulnerable People Subgroup; March 31, 2020).

list, and the only one to directly recognise and address residents' psychosocial wellbeing is: "Put in place communications plan with families" (NPHET Vulnerable People Subgroup; March 31, 2020: 5).

While some individual nursing homes may have adapted and extended this list of actions—perhaps even after consultations with residents and family members—to include ones that took residents' preferences and needs into account, the point here is that the official, government recommendations, developed by *the* relevant 'experts', neglected to consider, much less incorporate the autonomy and other fundamental human rights of older persons living in nursing homes, both in content and in the language used. Based directly on these recommendations from the Vulnerable People Subgroup, Minister for Health Simon Harris announces enhanced measures for nursing homes a few days later on April 4th (Department of Health; April 4, 2020). Judging Harris' choice of words and the sentiments he expresses in his statement, it seems evident that his intention is not only to announce new measures, but also to assuage growing public concern and outrage over the rising cases and fatalities taking place in nursing homes:

> "The nursing home sector cares for one of the most precious, and vulnerable groups in our society. We must do everything we can to support them to help break the transmission of the virus. To this end we are extending supports to this sector so that they can continue their role in the overall public health response to COVID-19. Our goal, in these challenging times, is to protect our older people, wherever they are living" (Department of Health; April 4, 2020).

Following on the Vulnerable People Subgroup's recommended actions, HIQA published its 'Regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak' on April 21st (HIQA; April 21, 2020). The framework aims to support residential care facilities to prepare for an outbreak and to develop contingency plans. In addition to sections on capacity, governance, staffing, healthcare, infection control, and so on, the assessment framework outlined in the document also includes sections on residents' rights, communication, and visits (HIQA; April 21, 2020). Unfortunately, the regulations included in it are at times in direct conflict with other regulations listed in other sections, and there is no guidance for service providers on how to balance these sometimes-contradictory points. The guidelines are vague, and the self-assessment nature of the framework and the fact that its submission to HIQA is not required (it needs only be available for on-site inspections, which were suspended altogether for a period of several weeks due to infection control concerns during the first wave of the pandemic), indicates a lamentable lack of government oversight of a critical process.

For much of April 2020 then, NPHET's press releases are intensely focused on the nursing home crisis (NPHET; April 10, April 16, April 17, April 20, April 29, 2020). Its statement from the 17th announces a blanket testing campaign for residential care staff and residents, to take place over a

period of 10 days, again citing the government's prioritisation of the 'most vulnerable' (NPHET; April 17, 2020). And on the 16th, Holohan is quoted expressing concern about the situation in nursing homes:

> "The data clearly shows that there are two very different experiences of COVID-19 in Ireland today. In the population at large, the virus is contained and effectively suppressed. However, the experience of the disease in long-term residential care settings continues to be a source of concern. In order to protect the vulnerable the first task was to suppress the virus in the population at large. We are increasingly confident that we are achieving this. All of our efforts now need to be on extinguishing COVID-19 in our community residential settings, including nursing homes" (NPHET; April 16, 2020).

The logic behind Holohan's statement is not entirely convincing. If the government's priority from the beginning was to protect the 'vulnerable', why were nursing homes—and other residential care facilities—neglected in those crucial first months? In its statement to the press a few days later on April 20th, Holohan and two other health officials and NPHET members describe their specific department's actions and role in addressing the crisis[21]. This seems to be an attempt to be transparent with the public and to assure them that everything that can be done is being done. HSE National Clinical Advisor and Group Lead for Older Persons Siobhan Kennelly's statement is noteworthy:

> "There has been an ongoing process of engagement and support with the nursing home sector since the start of February. We know from international and domestic experience that this disease disproportionately targets vulnerable groups such as older people and those with underlying health conditions. But we also know that the Irish experience in relation to deaths in nursing homes is not an outlier in relation to the European experience" (NPHET; April 20, 2020).

While it is certainly true that other European countries experienced significant outbreaks in nursing homes as well, this blatant attempt by a government official to evade responsibility is striking. In addition, the testimony of Tadhg Daly of NHI before the Parliamentary Special Committee on Covid-19 Response will call into question the degree to which the HSE and Department of health actually engaged with the private and voluntary nursing home sector in the early stages of the pandemic. This issue will be addressed in detail in *Act II* below. On April 29th, the Department of Health published disaggregated mortality data for different residential care facilities for the first time, likely in a bid to respond to increasing media coverage of the high numbers of deaths in nursing homes with greater transparency (Department of Health; April 29, 2020). In its statement to the press released the same day, Assistant Secretary of the Department of Health and Chair of NPHET's Vulnerable People

[21] Kathleen MacLellan (Assistant Secretary Department of Health, and Chair of NPHET Vulnerable People Subgroup); Siobhan Kennelly (HSE National Clinical Advisor, and Group Lead for Older Persons).

Subgroup, Kathleen MacLellan, addresses the fatalities in nursing homes, stating, "As we continue to collect and report mortality data coming from this sector we will have a greater understanding of the behaviour of the disease in this setting and it will help us to inform public health actions and clinical care." (NPHET; April 29, 2020).

While a great deal of attention was clearly being paid and considerable human and financial resources were being mobilised in these weeks to address the growing crisis in nursing homes, the level of preparedness that would have been needed to effectively protect "one of the most precious" population groups was not achieved in those early months. The government found itself on the back foot and its response was reactionary and traditionalist in its approach. It reached for the traditional biomedical toolkit, rather than truly embracing a multi-disciplinary, multi-perspective, and cross-sectoral strategy. The government's response focussed on meeting what it viewed as the most urgent need: to prevent or halt the spread of the virus, even if it meant disregarding the rights of older persons living in the community and in residential facilities.

4.3 Act II: Coming under criticism and 'learnings' [May 2020 – September 2020]

In the aftermath of the worst of the outbreaks of coronavirus in long-term residential care facilities in March, April, and early May 2020, and the high fatality rate among older people resident in nursing homes, the government came under increasing pressure to explain its response to the pandemic up that point, and the official discourses would be dominated by this issue into late spring, summer, and early fall of 2020. On May 6th, the Special Committee on Covid-19 Response, the parliamentary committee convened by the principal chamber of Ireland's parliament, the Dáil Éireann (*Irish Assembly* in Irish), to consider and hear evidence from relevant officials and from other stakeholders on the State's response to the coronavirus pandemic, embarked on its mandate (Dáil Éireann; May 6, 2020). From the beginning of May to the conclusion of its work in early October, the Special Committee held debates on a wide range of topics related to the government's response, numbering 29 in total. Of these, four debates were explicitly convened to address the situation of older persons living in nursing homes, and a further nine debates considered issues with relevance for older persons living both in nursing homes and in the community (see Appendix C, Table 10 for a complete list).

The 16 members of the Special Committee were drawn from each of the political parties holding seats in the Dáil Éireann. The ruling party, Fine Gael, together with the two other parties with the greatest number of seats, Fianna Fáil and Sinn Féin, were allowed to appoint four members or deputies each, while the remaining smaller parties appointed just one member each (Dáil Éireann; May 6, 2020) (See Appendix C, Tables 11 & 12 for detailed membership). Following Irish parliamentary elections and the formation of a new coalition government in the spring of 2020, a few members were replaced with new deputies, but this did not affect the proportionality of the

Committee in terms of party representation (Houses of the Oireachtas Special Committee; October 6, 2020). As mentioned previously, the two largest parties, Fine Gael and Fianna Fáil are both centre-right parties. Sinn Féin, meanwhile, and most of the smaller parties in parliament and thus on the Special Committee are further to the left on the ideological and political spectrum. Of the 16 deputies on the Committee, six were women and the remaining ten, men. In terms of achieving a gender balance, the Special Committee does slightly better than the Dáil Éireann overall (Connor, 2020).

On May 19th, the Special Committee had its first opportunity to hear testimony by key officials representing the DOH, the HSE, and NPHET, who appeared before the Committee to brief its members on the current situation (See Appendix C, Table 10 for a complete list of witnesses) (Houses of the Oireachtas Special Committee; May 19, 2020). Officials from the DOH testified during the first session of the hearing, while representatives from the HSE appeared in the second session after a short recess. Over the course of the two sessions, officials from the DOH and the HSE consistently avoid taking responsibility for the clear governance failures with respect to the nursing home sector incurred under their stewardship. Instead, they regularly reach for the word 'learnings', and refer to the 'unprecedented' and ever-evolving nature of the pandemic. They imply that any missteps, while lamentable, were inevitable given the novelty of the virus and the crisis they were facing. Special Committee deputies from opposition parties, meanwhile, are determined to find someone or some department accountable, but the evasiveness of the witnesses, and the fact that the representatives from the DOH and HSE are not present in the same sessions, makes it difficult to get definitive answers regarding the responsible party or parties. It does not help matters that the Minister for Health—the country's most senior health official—is not in attendance. The exchanges below are representative of the tone permeating the exchanges between deputies from the opposition parties and the witnesses. In the first session with officials from the DOH, Teachta Dála (TD) Louise O'Reilly (Sinn Féin) addresses the (lack of) cooperation between the different health agencies:

> "I will not go over the reported tensions between the Department and the HSE. All those have been well ventilated in the public domain. I refer to reports following publication of the letter that there would be twice-weekly phone calls between the CMO [Tony Holohan of DOH, and Chair of NPHET], the head of the HSE and the Secretary General. Are those phone calls happening? Are the witnesses finding them useful? Are they minuted and if so, can they be published so we can all be up-to-date on it? (Houses of the Oireachtas Special Committee; May 19, 2020: 11).

Jim Breslin (Secretary General, DOH) responds to O'Reilly by stating that key officials from both agencies have agreed to participate in weekly teleconferences, and that in fact of late they are in contact daily, almost hourly (Houses of the Oireachtas Special Committee; May 19, 2020: 11). In the second session with officials from the HSE, O'Reilly bores down on the outcomes of a meeting between Paul Reid, CEO of the HSE, and Tadhg Daly of NHI:

> "People in my constituency and elsewhere have expressed to me the view that it was at the very start, when hospitals were cleared and people were transferred into nursing homes, that the virus was brought into those nursing homes. What specific actions were taken arising out of Mr. Reid's meeting with representatives of Nursing Homes Ireland on 19 February? Was a plan - not advice and guidance, but a plan - put in place with regard to the human, financial and other resources that would be needed following the meeting?" (Houses of the Oireachtas Special Committee; May 19, 2020: 55)

Reid responds by stating that as this was his very first meeting with Daly in his tenure as HSE CEO, it was meant to be an 'informal welcome' and that the pandemic and its impact on the nursing home sector was not actually discussed in-depth (Houses of the Oireachtas Special Committee; May 19, 2020: 55). O'Reilly is incredulous:

> "Come on. Less than two weeks after that meeting, Nursing Homes Ireland imposed visiting restrictions in nursing homes. Did the HSE consider doing the same for public nursing homes? It was clearly thinking ahead. A couple of weeks later it was able to impose the restrictions. Mr. Reid is saying he had an informal meeting with its representatives in the middle of the preparations for the pandemic, but it was not mentioned, or it was not the focus of the discussion" (Houses of the Oireachtas Special Committee; May 19, 2020: 56).

Several issues are covered over the course of the testimony. Of greatest relevance are the delays and inconsistencies of the testing system in nursing homes; the decision to discharge and transfer older patients from hospitals to nursing homes to free up beds in the acute sector; the impact of the pandemic on an already struggling health and social care system; and confusion around the decision-making chain between NPHET and the HSE's national crisis management team. Ultimately, it is the government's lack of preparedness and the lack of a clear strategy and governance structure to oversee its response to the pandemic in the nursing home sector that is most evident. Older people resident in the nursing homes under discussion are themselves rarely mentioned, and in the various tense exchanges between the assembled deputies and witnesses, they are the 'vulnerable' that each side claims to want to protect and advocate on behalf of. Older people living in the community, people who at the time were by and large complying with the government's directive to 'cocoon' themselves, and who, together with their family members were coping with the suspension of vital day care, respite care, and homecare services due to the pandemic—and the strain on the health and social care workforce—are not mentioned, not yet. Issues concerning older people living in the community become central in the official discourses only later on. Notably, they are addressed in the lengthy report published by the Nursing Home Expert Panel in late August, 2020, a panel convened by the DOH to assess implemented and planned measures for the sector (COVID-19 Nursing Home Expert Panel; August 19, 2020). The authors of the report will determine that the historic focus of successive governments on funding institutional or residential long-term care, and the lack of

oversight over and regulation of the private/voluntary nursing home sector lay at the root of the crisis experienced by nursing homes in the first months of the pandemic. The authors will argue for a 'community first' approach to health and social care going forward, citing the pandemic and the lessons learned from it as an opportunity for reform (COVID-19 Nursing Homes Expert Panel; August 19, 2020).

The Special Committee held its first debate on so-called 'congregated settings' on May 26th (Houses of the Oireachtas Special Committee; May 26, 2020). In the first session dedicated to nursing homes, the Special Committee heard testimony from two representatives of the non-governmental/voluntary sector, Tadhg Daly of NHI and Mervyn Taylor, Executive Director of Sage Advocacy, an advocacy organisation for the rights of older adults. In the second session, the witnesses were drawn from HIQA and the HSE (See Appendix C, Table 10 for complete list of witnesses). Again, the key issue raised was the perceived abandonment by the HSE and DOH of the private/voluntary nursing home sector, represented by NHI. Specifically, their delayed action vis-à-vis nursing home visitation policy, availability of testing for staff and residents, and the procurement/provision of adequate PPE. With respect to visitation policy, HSE officials testified that they were acting on the expert advice of NPHET, and that at the time, what later would become known about asymptomatic transmission was not known, and that therefore blanket restrictions on visits was not warranted at that point. For his part, Daly of NHI stated that NHI was following the emerging international evidence and recommendations by the ECDC in its decision to announce the restriction on visitors in its member nursing homes weeks before it became government policy. Every witness in turn seems to be acting on the recommendation of various collectives of experts and competing expertise, resulting in confusion and, what's more, an absence of accountability on the part of government officials (Houses of the Oireachtas Special Committee; May 26, 2020).

In the same session, Daly also questions why NHI was not represented on the NPHET or on any of its subgroups (Houses of the Oireachtas Special Committee; May 26, 2020). The HSE representative responds by saying that the sector as a whole (public/statutory, and private and voluntary nursing homes) was represented by HIQA as the regulatory body and by the HSE, and that both agencies were in regular communication with Daly and the NHI. Daly testified that numerous attempts on his part to communicate his concerns about the impact of the pandemic on nursing homes in early March were more or less ignored by the HSE and DOH. The issue of the lines of communication between NHI and the relevant health agencies are examined in greater detail in the Special Committee's second, resumed debate on congregated sessions on June 18th, in which additional, more specialised albeit less senior, representatives from DOH and HSE were called to testify (Houses of the Oireachtas Special Committee; June 18, 2020) (See Appendix C, Table 10 for complete list of witnesses).

The political in-fighting, finger-pointing, and general combativeness on display in several of the Special Committee debates distract at times from very real concerns about the government's failure to adequately prepare and support the individuals living and working in the country's more than 500 nursing homes in the early months of the pandemic. In the June 18 resumed debate on congregated settings, Deputies Duncan Smith (Irish Labour Party) and Ossian Smyth (Green Party) raise the issue of older people's human rights and quality of life in light of the ongoing restrictions on visitation and the forced physical separation from family members. Citing a submission to the Special Committee, Smith questions Paul Reid (CEO, HSE):

> "I acknowledge a submission to the committee from former Senator Colette Kelleher, Dr. Maeve O'Rourke and their colleagues on a human rights-based framework not only for learning from what has happened but also planning for a resurgence or second or third waves. With due regard to that submission and Mr. Reid's opening statement, where he indicated that significant areas of development are needed, how will people who are currently living in the institutionalised care settings such as nursing homes be considered and heard with respect to developing improvements in this area?" (Houses of the Oireachtas Special Committee; June 18, 2020: 16).

After a vague and unhelpful response by Reid, Dr. Kathleen MacLellan, Assistant Secretary of the Social Care Division at the DOH stepped in to answer the deputy's question as follows:

> "The voice of the resident is something we take very seriously. We have already agreed with HIQA, the HSE and the Department that the national care experience survey, which the Deputy knows is conducted annually across acute hospitals, and which has been extended to maternity hospitals this year, will be extended to long-term residential care settings. This will provide a real structured approach to hear the voice of residents within those settings and to have that information used as it is currently used across our acute hospitals to provide quality improvement.
>
> NPHET has published an ethical guidance framework for long-term residential care settings, including nursing homes, which takes into account a human rights approach. The approach has proportionate measures for protecting residents as well as trying to support those residents so they can have as high a quality of life as possible. It is something we will keep a focus on in as much as we can while being very conscious that these are people's homes and where they live, so we must try to open them as much as we can to people's families. We have seen significant innovation across nursing homes to continue contact with families, including the use of FaceTime and other types of technology. We really want to get back, as much as possible, to the type of visiting and supports described by the Deputy" (Houses of the Oireachtas Special Committee; June 18, 2020: 17).

MacLellan's response—and the steps taken by various government actors that she describes—is commendable. Yet it must be noted that the ethical framework MacLellan refers to was published by NPHET on June 4th, some weeks after the worst of the outbreaks in nursing homes had already occurred (NPHET; June 4, 2020). Similarly, if the voices of older people residing in nursing homes was considered important to the DOH and the other agencies operating under its purview, why was the National Care Experience Programme survey being extended to long-term care settings only then? As detailed earlier in *Chapter 2: Literature Review*, the extent to which older people's experiences and voices would be captured by the National Nursing Homes Experience survey, published in 2022, was laughable (HIQA, 2022). Mervyn Taylor of Sage Advocacy, and on occasion Tadhg Daly of NHI are among the few witnesses called to testify who remind the assembled deputies and witnesses of the actual people whose lives are being affected by the decisions taken in response to the pandemic (Houses of the Oireachtas Special Committee; May 26, 2020; Houses of the Oireachtas Special Committee; June 18, 2020). In his opening statement to the Special Committee on May 26, Taylor says:

> "I will first give some sense of what it has been like from the perspectives of residents, relatives and staff. 'You have no idea how awful it is – it's horrific.' These were the words of a member of staff in a nursing home that experienced a serious outbreak and many deaths. The impact of an outbreak has been frightening for many residents, and for those with dementia, the arrival of people in full PPE was terrifying. Serious shortages of staff meant that there was little, if any, time to provide support to residents in facilities where many died. For families with relatives who were extremely ill or dying, the inability to visit or even to talk to their loved one by phone was a source of considerable distress and frustration" (Houses of the Oireachtas Special Committee; May 26, 2020: 7).

Four key reports investigating the outbreaks of coronavirus and deaths in nursing homes are published between May and July 2020 by NPHET (NPHET; May 26, 2020), by HIQA (HIQA; July 21, 2020), the Special Committee (Houses of the Oireachtas Special Committee; July 31, 2020), and by the DOH-commissioned independent Expert Panel (COVID-19 Nursing Homes Expert Panel; August 19, 2020). Three of the Special Committee debates held in September 2020 directly address the findings from these four reports (Houses of the Oireachtas Special Committee; September 10; September 16; September 30, 2020). Emerging from these and from the earlier Special Committee debates is the narrative that the pandemic has exposed and exacerbated substantial structural weaknesses in the long-term care sector. The Expert Panel's report goes to considerable lengths to put the coronavirus crisis in social care for older people into historical context, detailing the political and institutional causes that created the pre-existing crisis of care. Of all the four reports published, it in particular emphasises the importance of learning from what has happened and using it as an opportunity to reform the care sector towards a system of continuous, integrated care with a strong community care focus (COVID-19 Nursing Homes Expert Panel; August 19, 2020).

4.4 Act III: Navigating a second wave and the bid to 'save' Christmas [September 2020 – November 2020]

A certain momentum was achieved as a result of the various probes into the situation in nursing homes detailed above—rhetorically speaking, at least—in terms of using lessons learned during the first wave of the pandemic as an 'opportunity' to reform the long-term care sector, and more immediately, to make institutional changes to the government's pandemic response. On September 15th, 2020, just as Dublin was moving from Level 2 to Level 3 restrictions to combat a sharp rise in cases following a summer reprieve (Department of the Taoiseach; September 18, 2020), the government published its short- to mid-term strategy, 'Resilience and Recovery 2020-2021: Plan for Living with COVID-19' (Department of the Taoiseach; September 15, 2020). One of the measures included in the Plan is the establishment of the Covid-19 Oversight Group, formed to review and to filter recommendations from NPHET before reaching the Taoiseach and his cabinet. Ostensibly, the intention behind the creation of the group was to formalise the pandemic-related decision-making structure and to make it more inclusive and 'trans-governmental' by bringing representatives of other agencies onboard (Department of the Taoiseach; September 15, 2020). Another possible reason for establishing the group could have been to reduce opportunities for direct tension between NPHET and policymakers, using the Oversight Group as a buffer between the executive branch and NPHET's recommendations, which were becoming less and less popular with an increasingly lockdown-weary public. Older people are mentioned in the plan primarily in the context of continued prevention and control measures in residential facilities, and briefly in the introduction as among those most vulnerable and affected by the pandemic (Department of the Taoiseach; September 15, 2020). In the Plan's chapter on 'Community Wellbeing', older persons are briefly referenced in the context of community initiatives to promote living with chronic illnesses and positive ageing.

Following the dissolution of the Special Committee on Covid-19 Response's at the end of September, a Joint [Parliamentary] Committee on Health was convened to continue oversight of government policies related to health more broadly (Houses of the Oireachtas Joint Committee on Health; October 1, 2020). One of the first hearings it held in mid-October called on government officials to provide an update on the implementation of Ireland's *Sláintecare* [Healthcare] programme, the country's ten-year strategy to reform its health and social care systems (Committee on the Future of Healthcare, 2017). Also notable is the HSE's 'Winter Planning within the COVID-19 Pandemic', which prioritises protection of vulnerable groups, including older persons, and advocates for a 'community first' approach, aligning its objectives closely with those of Sláintecare (HSE, September 24, 2020). The announcement of the coalition government's Budget 2021 on October 13th too is noteworthy. The budget allocates 'unprecedented' funds towards the care sector, including 5 million additional home care hours, a welcome additional bundle of funding for expanding community-based services to be sure, but nowhere near what independent analysts would argue is needed to address the ongoing care crisis (Department of Finance; October 13, 2020; Walsh & Lyons,

2021). In early November, the Minister for Health testified before the Joint Committee on Health on the implications of Budget 2021 for the ongoing coronavirus crisis and the health and social care systems and reaffirmed the government's commitment to expanding home-/community-based services and, crucially, to laying the groundwork for a statutory entitlement to home care (Houses of the Oireachtas Joint Committee on Health; November 4, 2020). An entitlement to home care in Ireland—as exists for nursing home care through the Fair Deal Scheme since 2009—has been almost 30 years in the making (O'Shea & Hughes, 1994; Mercer Report, 2002).

The Vulnerable People Subgroup of NPHET was disbanded in early July 2020 after it was determined that it had fulfilled its terms of reference (NPHET; August 27, 2020), just as Ireland was preparing to emerge from its first national lockdown. In its stead, NPHET stated that, "it is intended that a cross-Government mechanism will be established to coordinate supports for those that are vulnerable. Under this mechanism, the implementation of agreed actions to support vulnerable groups will remain with the Department/Agency with the relevant policy responsibility. Final arrangements to be put in place in the coming weeks" (NPHET; August 27, 2020). During a parliamentary debate a few months thereafter on November 3rd, a deputy from one of the opposition parties questioned Minister for Health Stephen Donnelly on the status of this new mechanism (Dáil Éireann; November 3, 2020). Donnelly provided a written response to the deputy's query, and it is worth reproducing at some length:

> "For your further information, Government has recognised that vulnerable groups have been disproportionately affected by COVID-19 and there continues to be a need for a cross-Government mechanism to coordinate sustained support for those who are vulnerable, and disproportionately impacted by the pandemic. In this regard, the Department of the Taoiseach has established a new cross-Government mechanism for higher risk groups including those with a disability. Each Government Department with lead policy responsibility is represented on this oversight group. The Department of Health is represented on this group by the Social Care Division (policy remit for Older People and people living with a disability) and the Assistant Secretary with responsibility for Mental Health and Social Inclusion" (Dáil Éireann; November 3, 2020: Question 1139).

Unlike the activities of the Vulnerable People Subgroup, which, for the most part, were made publicly available online following each meeting, the minutes of this oversight group have not been made available, raising concerns about the transparency of this oversight mechanism.

The second wave of the pandemic hit Ireland between September and November 2020. Thankfully, it did not lead to the same scale of outbreaks in nursing homes as the first wave had. This was no doubt the result in part of nursing homes having greater access to PPE, more rigorous testing regime for both staff and residents, and additional staff training on and adherence to strict infection protocols.

More generally, the government's relatively quick reintroduction of restrictions in September, first in Dublin County and soon afterwards across the country—resulting in Ireland's second Level 5 lockdown—succeeded in suppressing the spread of the virus to a great extent. By November 27th, the day Taoiseach Micheál Martin addressed the public in a speech announcing the easing of restrictions from Level 5 to Level 3, he could proclaim that Ireland had the "second lowest infection rate in the European Union" (Department of the Taoiseach; November 27, 2020). Urging caution and calling for individuals to behave responsibly, the Taoiseach announced that while Level 3 restrictions would not usually allow for multiple households to gather, or for hospitality to re-open, an exception would be made for a three-week period from December 18th to January 6th as a concession to the Christmas holiday period (Department of the Taoiseach; November 27, 2020). Martin declared, "the Government and I are satisfied that this combination of new arrangements strikes a safe balance between maintaining the pressure on the disease and creating space for families, friends and loved ones to be together this Christmas" (Department of the Taoiseach; November 27, 2020). It is difficult to express at the relative remove of the present day, after the first and second dose vaccine and multiple booster rollouts, and at a time when all but a few restrictions have been lifted in Ireland, what a drastic shift the Taoiseach's announcement heralded at the time.

To support families in having a 'safe' Christmas while still meeting loved ones, the government created a 'Safe Christmas' webpage (Department of Health; November 27, 2020). The page provided the following 'tips' for "visiting vulnerable family, friends, and neighbours: wear a mask when mixing with vulnerable people and those with underlying conditions; if indoors, make sure where possible that the space is well ventilated; limit the amount of time you spend together; make sure these people are comfortable with you visiting before you land at their doorstep" (Department of Health; November 27, 2020). The guidance is decidedly superficial and the tone verges on the jocular. The guidance on maintaining ventilation in indoor spaces is also somewhat unrealistic given that the average temperature recorded by counties in Ireland in December 2020 was between four and eight degrees Celsius (Met Éireann, 2020). There is no guidance provided regarding the need to self-isolate before or after traveling to visit family members who may be high-risk, or regarding testing. Concessions to the Christmas holidays and family gatherings were also made in nursing homes. A guidance document on visits to long-term care facilities, including nursing homes, grants significant discretion to the care providers in terms of permitting residents to receive visitors or not (HSE; January 11, 2021). A version of the document published on November 24th, just days before the Taoiseach's announcement that restrictions would ease, states that visiting is restricted to 'critical and compassionate grounds' (HSE; January 11, 2021). The difficulty is in defining what constitutes 'compassionate grounds', as the authors of the guidelines themselves concede (HSE; January 11, 2021: 7). In addition, explicit allowances for a more liberal interpretation of compassionate grounds over the Christmas period are included:

> "At all framework levels every practical effort should be made to accommodate an additional visit to residents who wish to receive visitors in the LTRCF on compassionate grounds during the period [*sic*] a major cultural or religious festivals or celebrations of particular significance to the resident. For example a visit should where possible be facilitated during the Christmas/New Year period for those residents for whom this is an important period" (HSE; January 11, 2021: 11).

In a November 26, 2020 letter to Minister of Health Stephen Donnelly, the day before the Taoiseach's speech, CMO and Chair of NPHET Tony Holohan outlined the group's recommendations for the upcoming Christmas period (NPHET; November 26, 2020). While acknowledging the country's significant progress in stemming the spread of the virus, Holohan warns that the epidemiological situation was fragile:

> "[…] there is persistent and delayed incidence in healthcare workers and notification of healthcare setting outbreaks, and the number of confirmed cases in hospital, critical care, and Covid-19 deaths are not decreasing which gives rise to significant concern. In addition, the incidence in older persons, a population group who are most vulnerable to this disease, remains high" (NPHET; November 26, 2020: 5).

Crucially, in that same letter, Holohan recommended that *either* restrictions on household visits *or* on indoor dining should be eased, but *not* on *both* (NPHET; November 26, 2020). And just three days after the Taoiseach had hailed Ireland's low numbers and like an indulgent parent announced a loosening of restrictions for the holidays, the country's public health officials were continuing to sound the alarm, citing rising cases and hospitalisations (NPHET; November 30, 2020). At a briefing by NPHET on November 30, the day before restrictions were to be eased, Deputy CMO and member of NPHET Dr. Ronan Glynn warned the public, "just because you can do things tomorrow doesn't mean you should" (Thomas, 2020). In its attempt to forge a middle road between NPHET's cautious, conservative approach and pressure from the public and from the hospitality sector in particular, the Taoiseach and his cabinet rejected a core element of NPHET's recommendations, namely the warning against relaxing restrictions on indoor dining and household visits simultaneously. While claiming to have created a 'safe' space for families to celebrate Christmas together, the government did not do enough to enforce the restrictions that remained in place, to make available adequate testing, nor did it effectively communicate adequate guidelines to the public on reducing the risks of spreading the virus to potentially vulnerable family members and friends. After almost two months of strict lockdown, the floodgates were effectively opened, all in the name of giving people the opportunity to have 'a meaningful Christmas'.

4.5 Act IV: 'Only the vaccine can save us now' [December 2020 – March 2021]

Within a few weeks of the December 1st move to a modified Level 3, a surge in new cases and deaths would force government to reverse its position and reintroduce Level 5 restrictions for an initial period of 6 weeks, which would ultimately be extended (Department of the Taoiseach; December 30, 2020). The Taoiseach's December 30th speech came just eight days after he first addressed the public to announce the sudden need for additional restrictions on December 22nd (Department of the Taoiseach; December 22, 2020). While in his December 22nd address Martin already announced a return to Level 5 from Christmas Eve until January 12th, 2021, some allowances for the holiday were still included, notably "visits to private homes/gardens will be allowed from one other household up to and including 31st December" (Department of the Taoiseach; December 22, 2020), among others. On the 30th, however, following a week in which the epidemiological picture continued to decline severely (NPHET; December 30, 2020), Martin was back at the podium to announce an immediate return to "full scale" Level 5 restrictions (Department of the Taoiseach; December 30, 2020). Behind the scenes, meetings of NPHET on the 10th, 17th, 22nd and 30th of December serve as records of the country's rapidly deteriorating epidemiological profile across all data points (NPHET; December 10, 17, 23, 30, 2020). Once again, however, NPHET was reporting serious cause for concern as early as December 17th, and in its December 23rd meeting notes stated explicitly that the group was agreed that the measures that had been announced the previous day by the Taoiseach were insufficient (NPHET; December 17, 22, 2020). In a letter sent to Stephen Donnelly, Minister for Health and a member of the Taoiseach's cabinet, on December 21st, one day before the cabinet would meet and the Taoiseach's address, and two days before the next scheduled meeting of NPHET, Holohan provided his own considered opinion that Level 5 restrictions should be introduced immediately (NPHET; December 21, 2020).

The backtracking and side-tracking by government in the one-month period between November 30th and December 30th, 2020, is enough to induce whiplash. In his two December speeches, delivered on December 22nd and 30th, respectively, the Taoiseach details the additional restrictions implicated by the increasingly tighter regulations. However, neither set of newly announced restrictions adhered to the five levels outlined in the government's 'Resilience and Recovery 2020-2021: Plan for Living with Covid-19' (Department of the Taoiseach; September 15, 2020), resulting in a difficult-to-absorb list of special allowances and exceptions, many of which started and ceased on various dates (Department of the Taoiseach; December 22, 30, 2020) (see Appendix D, Documents 3 & 4).

In his speech on the 22nd of December, the Taoiseach says that the decision to lift restrictions in anticipation of Christmas was in large part a concession to people's need for a reprieve after months of lockdown: "It was important for people's mental health and well being that there was some respite from the restrictions that had been in place. It is also important that people have the chance to celebrate the Christmas period with their loved ones" (Department of the Taoiseach; December 22,

2020) (See Appendix D, Document 3). In his December 30 speech, Martin points to the arrival of the new 'British' variant of the virus as the cause of the sudden spike in cases (Department of the Taoiseach; December 30, 2020). While the new variant certainly contributed, in these speeches the Taoiseach espouses a simplified narrative of cause and effect, one which ignores the role played by a haphazard easing of restrictions in combination with a lack of effective messaging ahead of the Christmas season. The speeches also downplay the pressure the government was under from the hospitality and retail sectors in particular, but from other sectors of the economy as well, to lift restrictions to allow business owners to capitalise on the holiday period. Again, 'the virus' is endowed with agency, while the human actors implicated in the situation, specifically those with actual decision-making power, are portrayed as having limited agency and therefore cannot be held accountable.

Over the course of January and to a lesser extent February, new reported cases surged to levels not seen in prior waves and nursing homes experienced another round of outbreaks (HPSC; March 22, 2021b). People over the age of 65 continued to be disproportionately represented among fatalities (HPSC; March 22, 2021a). A new version of the HSE's 'Guidance on visits to Long Term Residential Care Facilities' document, published on January 11th, included a special notice on the first page addressing the surge in cases in preceding weeks and highlighting key elements of the document. Visits were still restricted except on 'critical and compassionate grounds', but the notice reminds the reader that "service providers will need to limit such critical and compassionate visiting to times when visiting can be effectively supported by available staff" (HSE; January 11, 2021: 3). Coming on top of chronic staffing shortages, the surge in cases in December 2020 and through to February 2021 resulted in approximately 1,800 nursing home staff being absent from work (Houses of the Oireachtas Joint Committee on Health; February 2, 2021). The message seems to be that service providers should now be interpreting the definition of 'critical and compassionate grounds' more conservatively.

Tasked with delivering the bleak news of a return to more severe restrictions, not once but twice spanning the Christmas week, on both occasions the Taoiseach reaches for words of hope and consolation to temper the sombre news. He commends the Irish public for its resilience and its collective commitment to protecting each other by adhering to restrictions during the lengthy lockdown periods (Department of the Taoiseach; December 22, 30, 2020). But the real source of optimism he invokes is the imminent approval and arrival of a vaccine—the same beacon of hope alluded to ten months prior by his predecessor Leo Varadkar in his very first address to the public about Covid-19 (Department of the Taoiseach; March 12, December 22, 2020) (See Appendix D, Documents 1 & 3). Here is Martin on December 22nd:

> "And as despondent as any of us might feel with the return of restrictions, it is important to remember that the hope is real. There is a light at the end of this tunnel. Vaccines are on the

> way. Last night, I received confirmation that we will shortly receive delivery of almost 10,000 vaccines against this disease. The roll out of these will commence next week to our most vulnerable, and we will safely and swiftly build from there" (Department of the Taoiseach; December 22, 2020).

And again on December 30th:

> "We will rebuild the economy, we will repair the damage to our society. We will come to terms with this crisis and make sense of the trauma we have all been through in due course. We will do all these things, and we will start them this coming year, because the vaccine now exists" (Department of the Taoiseach; December 30, 2020).

The Taoiseach heralds the vaccine as saviour, pitting one non-human actant, the villainous virus, against another: the vanquishing vaccine. To be fair to Martin, he credits "the most extraordinary effort by the most talented scientific minds on earth" (Department of the Taoiseach; December 30, 2020) with developing the vaccine. But this too reinforces the primacy and prestige of the biomedical professions in the state and in the official, public response to the pandemic. It recalls the many instances in which frontline healthcare workers were offered thanks and heralded for saving lives—and rightfully so—while many thousands of formal and informal carers providing long-term care in precarious conditions went unmentioned or were subsumed under the designations of 'support bubbles' and 'family visits'.

There is a strong argument to be made that talk of the imminent arrival of an effective vaccine, which reached a fever pitch in November and December 2020 in the news and on social media, in combination with Ireland's relatively low case number in the Fall of 2020, led to a false sense of security among government officials and thus to the haphazard loosening of restrictions ahead of the Christmas period. In two speeches delivered on the 24th and on the 27th of November by Taoiseach Martin, the advent of the vaccine is invoked at some length (Department of the Taoiseach; November 24, 27, 2020). In both speeches, Martin cautions that it will still be some time before the vaccine is approved and rolled out, and beseeches the public to hold on, to hold the line, effectively, until that time comes. Despite these caveats, there is a great sense of relief and triumph in his tone. In the speech given on November 24th, Martin says, "In the last few weeks there has been great news about promising vaccines. An effective and widely used vaccine is the final route to recovering from the pandemic and I want to say again that this government will do everything to make sure that the Irish people have rapid, fair and comprehensive access to the vaccines" (Department of the Taoiseach; November 24, 2020). And on the 27th of November, looking ahead to Christmas and the New Year, Martin assures, "After Christmas comes the New Year. The days will start to lengthen again and we can face into 2021 with renewed hope. We have all watched with great anticipation the news of the

development of a series of vaccines showing very promising results" (Department of the Taoiseach; November 27, 2020).

Two weeks later, on the 14th of December, the office of Ronan Glynn, Deputy Chief Medical Officer at the time, issued a press release entitled "COVID-19 Vaccine on the Horizon: Statement from Dr. Ronan Glynn, Deputy Chief Medical Officer, Department of Health" (Department of Health; December 14, 2020). As Martin had done in his November speeches, Glynn cautions that while the vaccine offers reason to hope, the public should continue to observe social distancing measures in the coming weeks and months (Department of Health; December 14, 2020). Yet his statement contributes to a narrative of hope offered by scientific innovation and discovery building at the time: "2020 has been an incredibly difficult year for everyone. But this has also been a year of very significant medical and scientific achievement in which a new illness has been characterised, its genome sequenced, and diagnostics and treatments have been developed. And now, subject to authorisation by the European Medicines Agency, Ireland is on the cusp of deploying at least two COVID-19 vaccines as part of a national vaccination programme" (Department of Health; December 14, 2020). Interestingly, while the Department of the Taoiseach and the Department of Health both hailed the imminent arrival of the vaccine, the published minutes of meetings and press releases by NPHET during this same period of time do not once mention the vaccine as a significant gamechanger. It would seem that while government officials felt the need to respond to increased public excitement about the vaccine, and indeed used its advent to assuage a lockdown-weary population in its messaging, it did not have an impact on the actual epidemiological picture in Ireland at the time, nor, it follows, on the recommendations of NPHET to the Minister for Health or the Taoiseach and his cabinet.

As Martin outlines in his December speeches, 'vulnerable' people were prioritised in the vaccination programme, starting with adults 65 years of age and older living in long-term care facilities (together with staff), including nursing homes, followed by cohorts variably designated according to age-, health condition-, and occupation-based risk level (NIAC; February 19, 2021: 9). Older people over the age of 65 resident in the community—divided into five-year age brackets, prioritised by seniority—were third in line after frontline healthcare workers (NIAC; February 19, 2021: 9)[22]. While there seemed to be consensus regarding the National Immunisation Advisory Committee's (NIAC) suggested prioritisation schedule, the first weeks of implementing the programme proved bumpy. In a February 2nd meeting of the Joint Committee on Health updating members of the Committee on the situation in nursing homes, Tadhg Daly of NHI testified that a "critical window of opportunity" had been missed between December 26th, when the first vaccines arrived in Ireland, and

[22] On March 31st, 2021, NIAC published amended recommendations for Ireland's vaccination programme. It changed its prioritisation methodology from a risk- and exposure-based approach to an age-based approach (NIAC; March 31, 2021). Available at: https://www.rcpi.ie/news/releases/national-immunisation-advisory-committee-niac-issues-updated-recommendations-on-prioritisation-groups-for-covid-19-vaccination-2/

January 7th, when the first vaccine was administered in one of NHI's 400 member nursing homes (private/voluntary) (Houses of the Oireachtas Joint Committee on Health; February 2, 2021: 3). In the same session, an exasperated Deputy Shortall (Social Democrats) asks the health officials testifying before the Committee for updated data on the progress of the rollout in nursing homes. Yvonne O'Neil, National Director of Community Operations at the HSE responds that 97 percent of nursing homes had received a first dose of the vaccine, but concedes that 117 nursing homes will have to be revisited due to the fact that some residents and staff were not able to get the vaccine on first visit for a variety of reasons, including illness and absence (Houses of the Oireachtas Joint Committee on Health; February 2, 2021: 17).

In his testimony before the Joint Committee on Health a month later, Minister for Health Stephen Donnelly faced criticism for the rollout in residential facilities and among the 85 and older population living in the community, and for the lack of transparency in terms of providing members of the Committee—and the public—with regularly updated vaccination figures (Houses of the Oireachtas Joint Committee on Health; March 2, 2021: 12). In his testimony, Donnelly's responses are evasive, and he regularly defers to decisions taken by the 'vaccination taskforce'. He does state that, according to the latest information he has from the HSE, "a large majority of those aged 85 and older will have received their first vaccination by the end of this week" (Houses of the Oireachtas Joint Committee on Health; March 2, 2021: 11). This does not include those older adults who are housebound, though Donnelly assures the Committee members that a plan is being formulated to vaccinate such individuals with the assistance of GPs making house calls, and the National Ambulance Service (Houses of the Oireachtas Joint Committee on Health; March 2, 2021). While issues with the supply of the vaccines—a legitimate problem in Ireland as in most other EU countries—go some way to explaining the relatively slow rollout of the vaccine programme, the supply chain problem cannot be blamed for the multiple delivery hiccups experienced in residential and community settings in the early stages of the vaccination programme.

A point repeatedly raised and emphasised by several members of the Joint Committee, and indeed by several of the witnesses testifying in a series of sessions over the course of February and March 2021, is that while the vaccine is a crucial development in the fight against the virus, policymakers and service providers cannot afford to lose sight of the myriad, long-standing vulnerabilities of the care system which the pandemic has exposed. Joint Committee meetings on the nursing home situation, on the issue of recruitment and retention of the healthcare workforce, and on long-awaited adult safeguarding legislation all serve to highlight serious issues facing the sector, and the frustration of several deputies and Committee members at the lack of change or movement on these issues is unmistakable when reading the transcriptions of these debates (Houses of the Oireachtas Joint Committee on Health; February 2; February 9; February 16; March 2; March 9, 2021).

While the majority of the country waited to be vaccinated, the government did not seem willing to take any more chances in the aftermath of the Christmas period debacle. The Level 5 lockdown which came into effect on January 1st, 2021 was still in place four months later at the end of April, with gradual easing of restrictions beginning only from May onwards. The third wave of the pandemic in Ireland saw a dramatic increase in the number of cases not seen in the first two waves, peaking in January 2021 in terms of number of cases, with a delay in peak number of deaths into late February 2021 (Kelly et al., 2022; Lima, 2021). In one three-week period, more than 160,000 new cases were recorded (Lima, 2021). Over 40 percent of all deaths since the pandemic began, and over 50 percent of all coronavirus cases were concentrated in the 45 days from January 1st, 2021 to February 15th 2021 (See Appendix A, Figure 5) (Lima, 2021). While other European countries also experienced a surge around the holiday period, Ireland had the distinction of going from being one of the countries in the EU with the lowest infection rates to one of the highest in an astonishingly short period of time. While private households had by far the greatest number of outbreaks as a setting, cases in this setting were severely underreported making it difficult to have accurate data. After private households, long-term care facilities, including nursing homes and other residential care facilities, together with workplaces, were the leading settings for outbreaks in waves two and three (Kelly et al., 2022). There is strong consensus among analysts, including the members of NPHET, that the abrupt relaxing of restrictions—without proper and adequate communication of key guidelines—ahead of the Christmas holidays, the subsequent extremely high rates of community transmission across age groups, notably younger persons, led to the sharp rise in cases and deaths in the weeks and months following (Kelly et al., 2022; Lima, 2021; NPHET; December 22, 2020).

Addressing the public again on February 23rd, 2021 to announce the publication of the revised "Living with Covid-19" plan (Department of Health; February 23, 2021), the Taoiseach outlined a conservative, phased approach to reopening society (Department of the Taoiseach; February 23, 2021). He stated:

> "[…] the situation that we and indeed all of Europe find ourselves in today is very different to where we were just a few short months ago. The difference, of course, is the emergence of the so-called UK or B-117 variant. It is equivalent to a new virus almost, and it is a major problem" (Department of the Taoiseach; February 23, 2021).

"The difference, of course…". The Taoiseach again lays the blame for Ireland's third wave on the new variant and its higher rate of transmissibility. While undoubtedly part of the picture, it is not the whole picture and there is once again no accountability to be discerned.

4.6 Conclusion

This chapter has charted the major narrative arcs of the Irish government's response to the pandemic between January 2020 and March 2021, specifically as it relates to older people and their care. It has introduced the reader to the key events, actors and actants involved in the 'situation' under analysis in this project. At the risk of exhausting the metaphor, the descriptive narrative laid out in the four acts sets the stage for the analysis of emergent concepts in the two chapters that follow: *Chapter 5: Silences and absences* and *Chapter 6: Continuities and discontinuities*.

Chapter 5. Silences and Absences: A Focus on Actors/Actants

5.1 Introduction

In reading through and analysing the documents outlined in the previous Chapter's four acts, two robust conceptual strands or categories begin to emerge from the abundance of textual data. The first turns on a prominent and pervasive vulnerability discourse emerging around older persons in the context of the coronavirus pandemic in Ireland. The unpacking of this conceptual category is the subject of this chapter and is titled: "Silences and absences: a focus on actors/actants".

The second conceptual arc revolves around constructions of the coronavirus *cum* pandemic as a disruptive force, an opportunity for reform, and is called: "Continuities and discontinuities; a focus on institutional and temporal elements." This prominent narrative of virus/pandemic as disruptor or catalyst references its potential to change the course of future Irish social policy, and more fundamentally, to bring about a re-examination of the values and norms undergirding the state's public institutions. This second conceptual category is discussed in the next chapter, *Chapter 6: Continuities & Discontinuities.*

The aim of this chapter is to analyse the processes by which various actors in the official discourses construct older people as 'vulnerable'. It quickly becomes apparent in reading through and coding the data that a variety of strategies are being employed in these texts to construct an edifice of vulnerability. Some of these strategies are easily observable and identifiable, for example the explicit designation of all older persons above 70 years of age as a 'vulnerable group' by members of the NPHET and government officials. Other strategies require closer consideration and analysis, such as the government's selection of certain types of experts and expertise, and not others, to guide the response to the pandemic, which was in keeping with the narrow conception of 'public health' used as the reference point for the government actors' approaches to responding to the pandemic, particularly in the early months when little was known about the 'behaviour' of the virus and how it would impact Irish society. The chapter proceeds by first giving an overview of the various phases or stages in the evolution of the vulnerability discourse, and then by discussing each phase or stage in turn. The analysis proceeded according to Grounded Theory methodology, as detailed in *Chapter 3: Methodology*.

5.2 Older persons as a 'vulnerable' group: an evolving construction

In the government's very first public statements and at the texts documenting its first monitoring and planning efforts, it is striking that older persons, and indeed any other group later referred to as a

'vulnerable' group, are not mentioned, are not yet designated as such. Take for example the minutes of NPHET's second ever meeting on the 30th of January 2020 (NPHET; Jan 30, 2020). At the time of the meeting, the first known case of coronavirus on the island was three weeks away from being announced to the public in a statement released by NPHET on February 29th, 2020 (Department of Health; February 29, 2020). Contingency planning was already underway, however, and the need to consider the impact of social distancing measures was already being addressed. One short line under the AOB ('any other business') heading of the meeting minutes reads: "The potential implications of measures such as self-isolation will have on individuals in terms of work was discussed" (NPHET; January 30, 2020: 3). So, while a range of restrictions were already being considered at the time of the meeting, the official discourses were trained on the population as a whole, not on particular 'vulnerable' groups. For a short period of time, everyone was being considered vulnerable. And pointedly, the effects of restrictions on *adults of working age*, and not on any other designated groups, are discussed. The potential effects of social isolation on other groups are not mentioned.

The construction of older persons as 'vulnerable' appears decisively in the official discourses only after the first cases are reported in Ireland at the end of February and in early March 2020. From then on, various actors consistently use specific vocabulary to distinguish between 'older people' and the rest of the population, constructing older adults as a monolithic group apart, an 'other'. A press release issued by the non-governmental association NHI announces a restriction on non-essential visits in its member (all private and voluntary) residential care facilities (NHI; March 6, 2020), and this is followed, on the 13th of March by the HSE endorsing the same restrictions across all residential care facilities in the country, public and private/voluntary (NPHET; May 26, 2020). The subgroup of NPHET dedicated to reviewing scientific evidence and making recommendations relevant to high-risk population groups – named the Vulnerable People Subgroup – met for the first time the same day, cementing the explicit association of vulnerability with the 'elderly', and with other identity categories, in the official discourses (see Table 3). During those heady days of early to mid-March 2020, then-Taoiseach Leo Varadkar addressed the Irish public for the first time on the subject of the coronavirus, invoking Irish society's collective responsibility to protect its most vulnerable, referring specifically to older persons and people with chronic conditions (Department of the Taoiseach; March 12, 2020).

In terms of the evolution of the concept of 'vulnerability', then, the designation is initially deployed as a justification for the announcement of self-isolation measures or 'cocooning' for persons 70 years of age and older living in the community (Department of Health; March 27, 2020), for the locking down of nursing homes and the isolation of its residents and staff, to the extent possible (NPHET; May 26, 2020), and as an inducement for individual members of the public to act 'responsibly' and in solidarity with the country's older residents. The tone is advisory in nature and relatively abstract.

As the pandemic wears on, however, a shift occurs in the way in which 'vulnerability' as a characteristic of older persons is used in the official discourses. Evidence from Ireland accumulates showing that older people are getting sicker and dying at higher rates than other age groups, and that certain government measures – specifically to do with infection control in residential care facilities for older adults, among other 'congregated settings'– have failed to prevent outbreaks and deaths (HPSC; June 30, 2020; COVID-19 Nursing Homes Expert Panel; August 19, 2020). As government officials come under increasing criticism from members of the political opposition, from civil society actors, and from the media, older people living in nursing homes become heavily politicised, with each side seeking to outdo the other by expressing their concerns and their desire to protect this vulnerable group. The vulnerability discourse takes on a more sharply de-humanising character, where references to older people as 'residents' and 'patients' and to the 'nursing home' itself renders individuals as mere functions of the care settings they occupy and the services they are provided with.

Another shift occurs in the autumn and winter of 2020 and early 2021. Ireland briefly relaxes restrictions at the end of November 2020, ushering in a particularly devastating third wave of the pandemic starting in mid-December 2020 and extending over the Christmas holiday and into January and February 2021. In the official texts appearing during this period, the vulnerability discourse is counterbalanced by officials' acknowledgement of the importance of family and family togetherness during the holiday season, for older people but also for the wider population more broadly. Older people come to be portrayed as vulnerable not just in the face of the virus, but also in the face of isolation. They are thus doubly vulnerable. For the remainder of the data collection period—through March 2021, when the vaccination programme begins, prioritised first and foremost according to age, the discourse toggles back and forth between this double vulnerability designation. There is a strong sense throughout that the supposed vulnerability of this 'group' (older people as a 'group' is itself a construction of note) is used in various ways by different actors to justify what is politically expedient from their respective points of view. The following sections provide a closer look at each phase in this evolving construction of older people as vulnerable individuals and as members of a vulnerable group.

5.3 Defining older people as a vulnerable 'other'

On the 10th of March, 2020, the Vulnerable People Subgroup published a report in which the following categorisation of who was to be considered 'vulnerable' in the context of the pandemic is delineated: "The term vulnerable people is being used to include older people, people with a disability, mental health service users, those with an underlying illness or condition, children in care and those accessing social inclusion services (not an exhaustive list)" (NPHET Vulnerable People Subgroup; March 10, 2020: 2). In the Subgroup's terms of reference, the authors relate that the

assembled group deliberated on the matter of who should be considered 'vulnerable', and should be provided services accordingly: "There was a discussion on the categories of vulnerable people that would need to be protected in the event of a Covid-19 outbreak and the range of State Agencies responsible for service delivery to these cohorts" (NPHET Vulnerable People Subgroup; March 10, 2020: 2). It is interesting to note that the categorisation of being 'vulnerable' or 'vulnerability' is tied in the context of this document to the provision of services by different departments or agencies of the government, allocated based on the category of vulnerability. For example, the 'elderly' are assigned to the Department of Health and the HSE, while 'asylum seekers' and 'people in direct provision' are to be provided services by the Department of Justice, and the 'homeless population' by the Department of Housing. The implication here is that for the purposes of the government's response, people's identities and vulnerabilities are one-dimensional rather than multi-dimensional, intersectional.

The Vulnerable People Subgroup, consisting of representatives from various governmental departments and agencies working in areas and on issues relevant to the designated vulnerable groups, one civil society organisation (ALONE), and one 'patient representative' (See Appendix B, Table 9 for further details), was in a position to heavily influence the government's national response to the pandemic, specifically the allocation of public resources, as well as private/voluntary resources (notably in the form of voluntary organisations and their volunteers through Ireland's Community Call initiative). In inhabiting this decision-making—or shall we say recommendation-making—role, and in categorising all older people as a vulnerable group seen only through the lens of their level of health risk, the members of the Subgroup are the active actors in the situation, the actors positioned to 'provide for' the individuals designated 'vulnerable' and dependent. The 'vulnerable' older person, meanwhile, is thus constructed as a passive dependent, a needy recipient of health care and support services. Older people are being constructed as helpless, with limited autonomy and agency, and thus in need of protection.

In a NPHET press release published in April 2020, the group deploys the following explanation to justify the categorisation of older people as vulnerable: "Each COVID-19 death reported is a tragedy. This is an incurable illness and while 80% of the population will experience a mild form of the disease, our older and more vulnerable people are at a much greater risk due to the behaviour of this disease within this group" (NPHET; April 17, 2020). Chronological age, irrespective of health or wellbeing status of the individual, or indeed any group characteristics associated with worse health outcomes, for example lower socioeconomic status, housing status, and so on, is used to justify the designation of vulnerability. International scientific evidence and expertise is consistently invoked to support the generalisation that every individual over a certain age is vulnerable. Also noteworthy in the above quotation is the characterisation of the illness as 'incurable', implying that it is a terminal illness, a death sentence, for those 'vulnerable' individuals who catch it. If the 'vulnerable' are

portrayed as passive victims of the virus, then the virus itself is anthropomorphised, endowed with active 'behaviour' and agency. It must also be said that the overall, combined effect of these discursive constructions—that all older people are at risk, are dependent and helpless, that the virus is actively targeting certain populations groups, and that the illness it causes is incurable, terminal—has the distinct effect of instilling fear. Whether that is also the intention is harder to surmise.

Dr. Siobhan Kennelly, HSE National Clinical Advisor and Group Lead for Older Persons, is quoted in a NPHET statement released a few days later in April 2020, saying: "We know from international and domestic experience that this disease disproportionately targets vulnerable groups such as older people and those with underlying health conditions" (NPHET; April 20, 2020). Again, the virus is a powerful, knowing agent here, acting with intention in 'targeting' certain 'vulnerable' groups. NPHET's national experts are empowered by having the weight of the international scientific community on their side. It should be noted that the scientific consensus is far from clear on whether 'old age' is an independent risk factor for severe illness or death from the coronavirus. It has proven difficult to disentangle age from other risk factors in study settings, and for obvious reasons, no precise age threshold has been identified beyond which age becomes a risk factor. The consensus seems to be that pre-existing chronic conditions, the presence of comorbidities, and frailty *associated* with advancing age are the more significant risk factors rather than (older) age alone (Romero Starke et al., 2020, 2021; Ho et al., 2020; Zhang et al., 2022).

A desire to protect the 'vulnerable' has been a stated government priority since the beginning of the pandemic. In his first public address on March 12, 2020, then-Taoiseach Leo Varadkar likewise explained the designation of certain individuals as vulnerable by citing the scientific consensus that chronological age itself was a risk factor for contracting a severe case of the illness caused by the coronavirus. He stated, "We know that older people and those with chronic diseases are at real risk. We have a duty as a society to protect ourselves and above all to protect others - our parents and grandparents, our family and friends, co-workers and neighbours" (Department of the Taoiseach; March 12, 2020).

While scientific evidence—notably from international, reputable institutions and scholars—is cited in these explanations, it is not entirely clear that clinical data existed, particularly in the first months of the pandemic, to justify an across-the-board designation of advanced chronological age as a significant risk factor. Had there in fact been studies carried out that distinguished between chronological and biological age, or that isolated chronological age from other risk factors such as chronic medical conditions, or frailty? In May 2020, an editorial appeared in the *Financial Times* newspaper, written by Camila Cavendish, former Director of Policy in the UK under Prime Minister David Cameron with expertise in health policy (Cavendish, 2020). Cavendish argued that researchers investigating the risk factors for contracting the coronavirus had not paid sufficient attention to the

intra-group differences within older age cohorts to date, leading to ageist generalisations and over-simplifications in the evidence base (Cavendish, 2020). In her view, researchers appeared to have little interest in designing more precise investigations.

> "Frustratingly, researchers show little interest in trying to find out. They routinely lump all pensioners together, as does society. Much of the language around shielding and isolation portrays older people as helpless victims. Yet only two months ago many were pillars of their communities, picking up grandchildren from school, running pubs, and manning phone lines for the same mental health services that they may soon need in the quiet desperation of enforced isolation" (Cavendish, 2020).

Cavendish articulates the point well. The way older members of the population are perceived has changed with the introduction of the virus and the ensuing pandemic. More to the point, the perception has actively been changed, been constructed, by those with the strongest discursive voices, the experts. Perhaps it is not fair to fault researchers for their omissions in this regard, particularly early on when information about the virus was scarce, the learning curve was steep, and the scientific community was under pressure from policymakers to provide guidance on how to respond. Nonetheless, the measures taken in Ireland related to vulnerable groups were based on this early evidence and have had far-reaching consequences for older persons of all ages and mental and physical health conditions, through to the time of this writing. Specifically, the recommendation – which though not legally enforceable nonetheless was interpreted as a directive – for all persons over the age of 70 to 'cocoon', or to self-isolate at home during multiple waves of the pandemic. According to analyses by the Irish Council for Civil Liberties and the Irish Human Rights, and by the Equality Commission in collaboration with the Trinity College Dublin COVID-19 Law and Human Rights Observatory, this was not entirely unintentional (Ansbro et al., 2021; Casey et al., 2021). What is particularly problematic is not the content or the substance of the recommendation itself, but rather the authority and lack of ambiguity with which the 'advice' was communicated to the public, emanating as it did from a group of highly regarded and redoubtable experts and decision-makers, with the collective weight of 'international scientific evidence' on their side.

The choice of a cocoon to symbolise older persons isolating at home amplifies the perception of older people as vulnerable and in need of protection. On the one hand, it calls to mind a nest, a safe, nurturing place providing shelter from dangers without. Presumably, whoever first suggested use of the term had this image in mind. On the other hand, it conjures up larvae still in development and vulnerable, unable to survive outside the cocoon's protective walls. In Western culture, cocoons are commonly associated with the life cycle of the butterfly or the moth. These insects spend their vulnerable, undeveloped pupa stages immobilised in a silky cocoon before emerging transformed. Using a cocoon to represent older people's homes, and particularly the 'cocooned' to represent older adults, is infantilising and fundamentally ageist, even if this was not the intended meaning. As the

pandemic stretched on and the isolating effects of cocooning on people's mental and physical wellbeing became increasingly evident, the term took on more than a little tinge of irony. For many, the safety of staying at home, in their 'cocoons', gave way to anxiety, depression, and loneliness (Ward et al., 2020, 2021; Gilbert, 2021). Their homes had turned into prisons around them.

On March 27, 2020, the Department of Health published its "Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from Covid-19" (Department of Health; March 27, 2020). While the title of the document suggests that people over 70 years, and those 'extremely medically vulnerable' are two distinct groups, the first section of the document makes it clear that people over the age of 70 are considered first in a long line of groups, all coming under the umbrella of 'extremely medically vulnerable groups':

> "**What we mean by extremely medically vulnerable**
> Those most at risk from COVID-19 are people who:
>
> - Are over 70 years of age - even if you're fit and well
> - Have Down Syndrome
> - Have cancer […]
> - Are on dialysis or have end stage kidney disease and an eGFR less than 15
> - Have a condition affecting the brains or nerves that has significantly affected your ability to breathe, meaning you require non-invasive ventilation (such as motor neurone disease or spinal muscular atrophy)
> - Have unstable or severe cystic fibrosis, including people waiting for a transplant
> - Have severe respiratory conditions including Alpha-1 antitrypsin deficiency, severe asthma, pulmonary fibrosis, lung fibrosis, interstitial lung disease and severe COPD
> - Have uncontrolled diabetes
> - Have had an organ transplant or are waiting for a transplant
> - Have had a bone marrow or stem cell transplant in the last 12 months, or are waiting for a transplant
> - Have a rare condition that means you have a very high risk of getting infections (such as APECED or errors in the interferon pathway)
> - Have sickle cell disease
> - Have been treated with drugs such as Rituximab, Cyclophosphamide, Alemtuzumab, Cladribine or Ocrelizumab in the last 6 months
> - Have certain inherited metabolic disorders (such as Maple Syrup Urine Disease)
> - Have obesity with a body mass index (BMI) greater than 40"
>
> (Department of Health; March 27, 2020).

What does it tell us when a person who is ‘fit and well’ but is over the arbitrary threshold of 70 years of age is considered by the health authorities and experts to be in the same category of extreme vulnerability as someone who has end stage kidney disease, or someone who has uncontrolled diabetes? At its most benign, it suggests a decision to err on the side of caution, a conservative interpretation of the evidence to hand on the part of NPHET and its Vulnerable People Subgroup. This approach may have come from a well-intentioned desire and sense of duty to protect older persons, but it is nonetheless patronising and paternalistic in the extreme and demonstrates a one-dimensional, blinkered way of thinking about older persons and the ageing process, and about vulnerability and autonomy. More insidiously, it reflects what Cavendish characterised above as a lack of awareness stemming from a systemic and entrenched lack of interest on the part of researchers and policymakers—among people, pointedly, in positions of authority and power—to recognise the tremendous diversity within older age groups and of the ageing experience across a wide range of well-established determinants of health (Dahlgren & Whitehead, 2021). The result in either case is that older people are made out, *en masse*, to be extremely vulnerable and at great risk, and thus to be kept apart from and treated differently from the rest of the population, from those of ‘us’ who are, presumably, young and healthy.

In the next section of the same document, the authors address older members of the public directly, informing individuals of their right to make up their own mind about whether or not and to what degree to follow the guidance to cocoon:

> "**What you need to know**
> Cocooning is advised for your personal protection and you will make your own judgement about the extent to which cocooning guidance applies to you. If you are unsure whether or not you fall into one of the categories of extremely medically vulnerable people listed above, you should discuss your concerns with your GP or hospital clinician.
>
> It is recognised that you have the right to exercise your own judgement as to the extent to which you consider the cocooning guidance appropriate for you. However, older people (aged 70 years and over) and those with pre-existing chronic conditions have been found to be more susceptible to COVID-19 infection and are most likely to experience severe consequences from infection so it is still recommended that you remain cocooned for your safety. Should you wish to visit someone, receive visitors in your home, visit shops, and engage in other outdoor activities, you should continue to strictly adhere to the public health and social distancing guidance” (Department of Health; March 27, 2020).

The title of the section—'What you need to know'—is itself notable. Who decides what people 'need to know' and what they do not? The idea that ‘knowledge is power’ has been around since at least the writings of Plato, and in this context, NPHET’s experts are in the position to determine both what

information is considered relevant, and who among the non-expert, lay population, should have access to specific pieces of information or knowledge. Considering this asymmetry in access to knowledge and in access to power or authority, the assertion that older people have the "right to exercise your own judgement as to the extent to which you consider the cocooning guidance appropriate for you" (Department of Health; March 27, 2020), seems like an afterthought, a tick-box exercise to satisfy human rights and civil liberties watchdogs. Miranda Fricker's theory of epistemic injustice (2007) is useful here. According to Fricker, an epistemic injustice occurs when someone is "wronged specifically in their capacity as a knower" (2007: 1). She distinguishes between two types of epistemic injustice: *testimonial* and *hermeneutical*. More relevant to the "Guidance on Cocooning" (Department of Health; March 27, 2020), is hermeneutical injustice, which in this case can be said to marginalise older persons as knowers because it, "renders the collective hermeneutical resource structurally prejudiced, for it will tend to issue interpretations of that group's social experiences that are biased because insufficiently influenced by the subject group, and therefore unduly influenced by more hermeneutically powerful groups" (Fricker 2007: 155). Essentially, Fricker is arguing that those 'knowers' in positions of power determine the social realities and structures under which those without or with less power, live (Hartsock, 1998; Fricker, 2007). I will return to Fricker's theory at greater length in *Chapter 7: Conclusions*.

The actors/speakers cited above effectively construct older people as a distinct, homogenous group, divided from the rest of the population by their vulnerability and their general helplessness in the face of a malevolent virus.

5.4 Nursing homes as embodied spaces: constructing vulnerable older persons as functions of their care setting

As has been mentioned in previous sections, older persons were constructed relatively early on in official texts as a vulnerable group in need of protection from the virus. People over the age of 70 were strongly advised to cocoon, and the Department of Rural and Community Development was charged with spearheading the 'Community Call' initiative to mobilise an already active voluntary sector to provide supports to vulnerable members of the community, including self-isolating older people (Department of Rural & Community Development; March 20, 2020). Despite this early designation of older persons as particularly vulnerable, the discourses produced by NPHET and by the governmental agencies with responsibilities in the areas of health—specifically the Department of Health and its implementation arm, the HSE—were, certainly initially, closely attuned to the acute care sector, to the neglect of residential care and community care settings. Reading NPHET's meeting minutes from March 10th, 2020, the flurry of activity veritably jumps off the page, 'cooperation' and 'collaboration' across the various member departments, agencies, groups, committees, and subgroups is the order of the day; 'deliberative papers' are being shared and

discussed on pressing issues. From what can be gleaned from the minutes, the topic given the most time during the meeting (and *space* in the text of the meeting minutes) is the issue of increasing capacity, foremost in acute care settings (i.e., increasing the number of hospital beds available to treat the anticipated onslaught of people being admitted with coronavirus), and increasing PCR testing capacity (NPHET; March 10, 2020). Markedly, nursing homes, and congregated settings more generally, are not mentioned in the section of the minutes discussing Ireland's National Plan and 'vulnerable people':

> "8. National Plan
>
> …
>
> b) Vulnerable people and community capacity
>
> The Chair of the Vulnerable People Subgroup provided a deliberative paper for discussion and gave an overview of the work to date. **The importance of sufficient capacity within the acute hospital system and in the community was noted**. The HSE has provided a paper in this regard for the action plan and are working closely with the DOH" [emphasis added] (NPHET; March 10, 2020: 4).

Upon first reading this excerpt from the minutes, the mention of vulnerable people in the context of sufficient capacity in the acute hospital sector and in the community, and by contrast the omission of nursing homes/the residential care sector leaves one wondering if nursing homes are being considered part of 'the community' here. How else could such a glaring omission be explained given what was already known about the elevated risk for older individuals, and about how the virus was spread?

The paper cited in the above excerpt was drafted by the HSE on March 7th, 2020, but is not publicly available. A more detailed reference to its contents is made in a working paper published online on March 10th by the NPHET Subgroup on Acute Hospital Preparedness, which, among other action points—related to reduction of elective procedures, and increasing general acute and ICU beds—states that the following action is being taken to increase acute sector capacity:

> "*Additional capacity*
>
> …
>
> The HSE in its submission of Saturday 7 March has set out the following actions in regard to acute hospital capacity:
>
> - Moving delayed discharge patients to the community. **379 of the just over 600 delayed discharges (as of Saturday 7 March) require nursing home beds. Figures provided by HIQA indicate that there are adequate vacant beds in private nursing homes.** [emphasis added] A further 113 are awaiting home care and 113 awaiting complex care. Investment in transitional care beds, home supports,

> complex case supports, CIT, GP ooh [out of hours] services, in-home respite services will be required" (NPHET Acute Hospital Preparedness Subgroup; March 10, 2020: 1).

Older people here are 'discharge patients', 'delayed discharges' requiring 'nursing home beds', and future occupants of 'adequate vacant beds'. Returning for a moment to the March 10th meeting minutes of the core NPHET group, the only mention of people living in nursing homes is as an 'item for discussion' related to visitor restrictions. At this point, NPHET is still advising that unilateral restrictions are not necessary:

> "The restrictions on visitors to nursing homes was discussed. It was agreed that the current practice of restricting visitors to nursing homes was not required and this would be kept under review. However, there is an opportunity to reiterate infection prevention and control advice to the public and visitors to healthcare facilities. Additionally, the importance of ongoing communication with stakeholders in this regard was emphasised. **Action: NPHET recommends that unilateral/widespread restriction of visiting to nursing homes, hospitals and healthcare facilities is not required at this time**" [Emphasis in the original] (NPHET; March 10, 2020: 6).

Keep in mind that a few days prior on March 6th, NHI had announced restrictions in their member nursing homes (private/voluntary), except in 'essential' cases. What is interesting is that in this same March 10, 2020 meeting of NPHET, the evidence on asymptomatic transmission and its implications for testing protocols and capacity was discussed (NPHET; March 10, 2020). The NPHET's Expert Advisory Group advised the Department of Health, who was then to inform the HSE, that such testing was advised. And yet the connection was not made—or rather was not made quickly enough—about the risk of transmission posed by people who were close contacts but were asymptomatic, and family members, friends, and other visitors to nursing homes and other congregated settings. Why, when the discourse concerning other areas such as the acute care sector was so focused and stringent, were nursing homes and the people living and working in them disregarded almost entirely? The March 10, 2020, meeting minutes of NPHET state that while nursing homes should not be closed to visitors, "there is an opportunity to reiterate infection and control advice to the public and visitors to healthcare facilities" (NPHET; March 10, 2020: 6). "Reiterating infection and control advice" sounds like a rather laissez-faire approach to supporting a sector, which less than a month later will be referred to by the acting Minister for Health as caring for "one of the most precious, and vulnerable groups" (Department of Health; April 4, 2020). Just a few days later, the Department of Health, following new recommendations by NPHET, reverses course and announces the ban on visitors in all nursing homes.

It is all too easy, in reading and sorting through the pertinent texts, and in recreating the timeline of events, to want to engage in a critical analysis of the policy decisions and actions taken by the government in the early months of 2020. It is worth a reminder at this juncture that this is not the aim of the present study. Instead, the aim here is to analyse the discursive strategies employed by the actors involved (and those not involved) in making these decisions to construct older persons in certain and specific ways [in this chapter, as inherently vulnerable]. Going a step further, the aim of this analysis is to reflect on what these constructions of older people in the discourses reveal about society's attitudes and assumptions about older individuals and about ageing. It strikes me that a tension is discernible up to this point in the official discourses, between what is professed by actors in positions of authority to be true about the value and importance of older persons in Irish society—namely, that they are cherished, precious, worthy and indeed in need of protection because of the vulnerability that age brings (a construction which has been built upon during the coronavirus pandemic but which verily predates it)—and the presumably more inadvertent, unintentional rendering of older persons as a group separate and apart from the rest of the 'working age', productive population; if not legally required then strongly advised into 'cocooning' self-isolation in a strange evocation of developmental regression; and forgotten by the public healthcare system except as inanimate bodies to be vacated from acute sector beds and transferred to vacant beds in 'adequate' private facilities.

On April 4, 2020, following the worrying increase in the number of coronavirus cases and deaths among people living and working in residential care facilities in the state (NPHET; March 31, 2020), then-Minister for Health Simon Harris announced a series of 'enhanced' measures recommended by NPHET to support the sector (Department of Health; April 4, 2020). By way of introducing the measures, he states:

> "**The nursing home sector cares for one of the most precious, and vulnerable groups in our society**. We must do everything we can to support them to help break the transmission of the virus. To this end we are extending supports to this sector so that they can continue their role in the overall public health response to COVID-19. **Our goal, in these challenging times, is to protect our older people, wherever they are living.** We must also support staff working in nursing homes, and ensure their safety and health as we continue to deal with this pandemic. **It is vital we leave nobody behind as we navigate our way out of this pandemic**" [Emphasis author's own] (Department of Health; April 4, 2020).

It is worth noting how Harris characterises older people. They are one of the "most precious, and vulnerable groups", and are subjects to be cared *for*. This is in keeping with earlier examples of paternalistic condescension and infantilising language used in the official discourses. Despite the Minister's expressions of concern, in many ways older people living in residential facilities and staff

had already been left behind by this point, lending his statement a degree of tragic irony. This 'leaving behind' of older persons in residential care settings appears to have been the result of a series of unfortunate decisions taken by the government on the advice of NPHET in the early period of the pandemic. These included the focus on the acute sector to the exclusion and explicit detriment of other care settings (i.e. discharging patients from hospital to nursing homes without up-to-date testing protocols), and poor communication across the agencies represented on NPHET and its multiple subgroups.

Undergirding the government's and NPHET's approach is a long-standing tension in Ireland about whether care for older adults should be a public duty or whether it should remain firmly in the private/voluntary, notably the charity, sphere. Among other consequences of this historical tension is the chronic lack of oversight of private and voluntary nursing homes, which constitute a majority of such facilities in the state—not to speak of private home-/community-based care services (HIQA; April 9, 2020). These dynamics which will both be addressed in greater detail in the next chapter, *Chapter 6: Continuities and discontinuities*, which focuses on institutional processes. The Minister's statement marks a turning point, in which 'nursing homes' become the focus of official discourses—particularly those emerging from the special parliamentary committee hearings on the pandemic response, a committee formed in the wake of the first wave of the pandemic in Ireland—discourses in which older people are increasingly referred to in terms of their status as 'residents' and 'patients' and 'bodies' in receipt of care.

Three weeks later, on April 29, 2020, Dr. Siobhán Ní Bhriain, HSE National Lead for Integrated Care, is quoted saying the following in a NPHET statement published on April 29, 2020: "We have put significant effort into developing clinical guidance for the residential care sector. This has driven the operational response and has been supported by education for all staff in this sector. This work is crucial in making sure our most vulnerable people get the best possible care in what is a very challenging time" (NPHET; April 29, 2020).

If the Minister in his statement above was setting out or promising a course of action to 'protect' vulnerable older people (Department of Health; April 4, 2020), then Dr. Ní Bhriain's statement (quoted as part of a longer press release by NPHET) a few weeks later seeks to demonstrate the 'significant efforts' and 'crucial work' NPHET and the government has undertaken in the interim on behalf of "one of the most precious, and vulnerable groups in society" (Department of Health; April 4, 2020). Dr. Ní Bhriain's statement was released at a time when the government was coming under significant public and media scrutiny and criticism as a result of the high numbers of deaths reported in nursing homes across the country relative to other settings and segments of the population (McGrath, 2020; Carswell & Power, 2020). The coronavirus outbreaks and subsequent deaths reported in nursing homes during the first wave of the pandemic had the government scrambling to

explain how the situation had been allowed to happen, and in this context, Ní Bhriain's comments seem to be an attempt to prove that the government was doing everything it could to live up to its promise to shield 'vulnerable' older persons resident in nursing homes in 'challenging times' and thereby to avoid accountability for possible missteps. The reference made to 'precious', 'vulnerable' older persons by both the Minister and Ní Bhriain—in her role representing the HSE—also smacks of virtue signalling, positioning government actors and their actions as morally righteous and good.

Government officials' consistent rhetorical and very practical reliance on 'scientific expertise' in its handling of older, 'vulnerable' residents of nursing homes is also significant. The 'expert' recommendations relayed by NPHET to the Minister for Health, and up the chain of decision-making command to the Cabinet and the Taoiseach, and the subsequent actions taken, are thus justified by the morally virtuous stated aim of protecting the vulnerable, and furthermore are unimpeachable because they are based in the latest available scientific evidence. Invoking experts to explain their approach in an April 10 press release, NPHET cites international scientific expertise: "The ECDC has highlighted infection control measures to protect vulnerable populations in nursing homes, which Ireland is following" (NPHET; April 10, 2020). And again, referring to international expertise, in this case the World Health Organisation, to explain or justify the categorisation of older persons as vulnerable, a text published by the Vulnerable People Subgroup of NPHET on March 31, 2020, intended as a guidance document for Long-term Residential Care Facilities (LTRCF) states: "People living in LTRC are vulnerable populations and have been identified by the World Health Organisation to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes" (NPHET Vulnerable People Subgroup; March 31, 2020). In the same document: "Residents by their nature of age or other underlying conditions are at high risk of contracting Covid-19" (NPHET Vulnerable People Subgroup; March 31, 2020). The invocation of older persons' vulnerability, and of the hegemonic medical scientific community—which functions both as originator and preserver of the vulnerability discourse, and which likewise offers solutions to act on behalf of those it designates as vulnerable, lends itself to a kind of discursive double buffer for government actors against being held accountable.

In HIQA's "Regulatory assessment framework of the preparedness of designated centres for older people for a Covid-19 outbreak," published on April 21st, 2020 (HIQA; April 21, 2020), the tension between biomedical/clinical and human rights/ethics-informed approaches is very clearly on display. The purpose of the document is ostensibly to allow managers of residential care facilities to self-assess the facilities' processes and protocols against a standardised framework in preparation for inspection by the national regulatory body (HIQA) – an exemplar of care taylorisation at work (Knijn, 2001). The document delineates 26 regulations, with each regulation the subject of a table within which a series of measures framed as questions are posed as yes/no questions, to be ticked off accordingly (HIQA; April 21, 2020). Alongside regulations named, for example, 'infection control',

‘persons in charge’, ‘staffing’, ‘managing behaviour that is challenging’, and ‘risk management’, are regulations termed ‘residents’ rights’, ‘communication’, and ‘visits.’ It is evident that the regulator is attempting to strike a balance—and to induce care providers to strike a balance—between controlling the spread of the virus at all costs and the psychosocial wellbeing of the persons living in the ‘designated centres.’ Yet one is left with the overall impression that the ‘managing’ of both infection/the virus and of the residents is the priority, and that the two aims are at odds with one another, particularly when one considers the chronic shortage of care professionals working in nursing homes, a phenomenon which predated the pandemic and which was severely exacerbated by it as scores of care workers fell ill themselves and were absent from work (Houses of the Oireachtas Special Committee; October 6, 2020). The repeated reference to nursing homes as ‘designated centres’ and to older individuals as ‘residents’ and as ‘vulnerable’ in this document has a distinct dehumanising effect. The focus here is on the ‘preparedness’ of nursing homes and on the prioritisation of preventing infections *in* nursing homes, with individual residents discussed almost as an afterthought. The nursing home itself, the institution, and the physical edifice, is being embodied, while the human beings living in them are simultaneously being disembodied.

If the texts discussed above mark the beginning of a shift in a discursive focus on the nursing home sector and the people living and working within its bounds, the establishment of a special parliamentary committee to examine the state’s response to the pandemic, and the forum it provided for debate about what had transpired in nursing homes, among other issues, cements this focus. As discussed in relation to HIQA’s ‘regulatory assessment framework’ document, the tension between the government’s ‘public health’ response—focused as it has been on a narrow, biomedical interpretation of public health, with infection control as its primary goal—and calls mainly by various actors from political opposition parties for consideration of the effects of social isolation on older persons living in nursing homes, continues and is explicitly discussed. In the first hearing of the Special Committee on Covid-19 Response to address the situation in nursing homes, TD Matt Shanahan of the Independent Party poses the following question to Tadhg Daly of NHI, who has been called as a witness:

> “On the isolation of residents at present, we know that four out of five residents who have come into contact with Covid have survived. We assume the science is not exact, but we know people have antibodies for a period. Is it possible that we could look at antibody testing to try to identify those nursing home patients and allow them to have access to their family and relatives, rather than continuing to be locked down?” (Houses of the Oireachtas Special Committee; May 26, 2020: 26-27).

The imagery TD Shanahan evokes is a strong one. Older people are being constructed as ‘patients’ and as ‘residents’ who are locked in, locked down, effectively locked away, and denied their (supposedly) only window to the outside world, their “family members and relatives”. But who or

what is denying them their freedom? Is it the virus, that non-human actant that is nonetheless endowed with immense power and agency in this discourse, or is the 'we' that Shanahan implicates himself as part of, namely those in the state who are in positions of authority and who thus have the power to decide whether to 'allow' nursing home 'patients' to see their families? In both scenarios, older adults are themselves rendered powerless, stripped of their agency. Shanahan is seemingly well-intentioned, after all, he wants to make it possible for people living in nursing homes to be reunited with their families. Yet his choice of words and his formulation demonstrates that the association of older persons with vulnerability and lack of agency goes much deeper than the circumstances brought about by the virus and the pandemic. It is ingrained in our collective conscience and in our institutions. Shanahan's formulation of allowing older persons to 'have access' to their family members is also telling, calling to mind access to a service rather than a basic human interaction. In this construction, older persons should have 'access' to their family members not necessarily because it is their right as human beings, but because a certain group of individuals possessing power, Shanahan's 'we', has determined that this is the morally correct course of action.

The Special Committee hearings are littered with this characterisation of older persons. The various witnesses who testify and the member TDs of the committee often disagree with one another about the government's policies, usually along ideological or, rather, party lines, yet with very few exceptions, the vulnerability discourse, which sees older individuals in nursing homes in particular as powerless and without agency, remains intact. A notable exception is in the testimony of Mervyn Taylor of Sage Advocacy. The way in which members of this group are overwhelmingly represented in these texts is in keeping with how they are constructed in most official sources: as bodies indistinguishable from one another, most often associated with nursing homes, rather than as visible and active members of the community. Rarely are they spoken of as people with experiences and interests outside the confines of their care setting or as individuals with identities apart from rather static and puppet-like 'family roles'. Particularly in the documents included in the first two Acts when the focus on the crisis in nursing homes was greatest and the government's 'advice' to all older adults to 'cocoon' was most prominent, 'older people' and other variations on the term effectively disappear from vast sections of official texts as 'the nursing home' is used as a synecdoche to refer to the people living and working within its walls. Older people are consistently referred to as a monolithic group, with little reference to the vast demographic, physiological and socio-economic diversity among adults over the age of 65. This pattern emerges despite evidence of differences and indeed inequalities in terms of who is at higher risk for contracting and dying from the virus. These rhetorical patterns contribute to a narrative in which older people are dehumanised, stripped of their agency and consistently 'othered' by actors in positions of power and decision-making influence.

5.5 The significance of absent voices, absent actors

In the May 26, 2020, hearing of the Special Committee on Covid-19 Response, which was devoted to the situation in nursing homes, the issue of representation, of giving voice to "vulnerable people in a vulnerable sector" (Houses of the Oireachtas Special Committee; May 26, 2020: 8) in the words of Mervyn Taylor, receives a great deal of attention. Testifying in the first session of the hearing are Mervyn Taylor, then Executive Director of Sage Advocacy, and Tadhg Daly, CEO of NHI. In their respective opening statements to the committee, both men are critical of the government's handling of the pandemic in nursing homes and of what they perceive as the marginalisation of the people/groups they respectively represent. An important difference is that while Daly has an operational interest inasmuch as he represents the private/voluntary nursing home sector, Mr. Taylor represents the interests of the older individuals and their families themselves. As far as I can discern, he is the only witness to be called to testify in the course of the Special Committee's short lifespan to represent older persons themselves and not any professional association or care provider. In his opening statement to the Special Committee on May 26, Taylor says:

> "I will first give some sense of what it has been like from the perspectives of residents, relatives and staff. "You have no idea how awful it is – it's horrific." These were the words of a member of staff in a nursing home that experienced a serious outbreak and many deaths. The impact of an outbreak has been frightening for many residents, and for those with dementia, the arrival of people in full PPE was terrifying. Serious shortages of staff meant that there was little, if any, time to provide support to residents in facilities where many died. For families with relatives who were extremely ill or dying, the inability to visit or even to talk to their loved one by phone was a source of considerable distress and frustration" (Houses of the Oireachtas Special Committee; May 26, 2020: 7).

Responding to a follow-up question by a member of the committee about whether he was satisfied that older persons' voices were belatedly being adequately heard, he responds:

> "Regarding a voice, I look forward to legislation that will legitimise the role of independent advocates. I remember private nursing homes throwing our staff out and not allowing them to contact residents. That is a rare occasion, but it has happened. When we talk about a voice, we need to talk about a right for independent advocacy and recognising that practice in law" (Houses of the Oireachtas Special Committee; May 26, 2020: 39).

And responding to TD Shanahan's query on safeguarding legislation, Taylor brings in the language of human rights:

> "Legislation has been anticipated for safeguarding adults and the Law Reform Commission has a consultation going on regarding how such a framework might best occur. We believe that is a mechanism for framing legal recognition of independent advocacy. There is also a

> need for legislation on protection of liberty of people in congregated care settings because that is a serious issue. People have been transferred from acute hospitals to nursing homes on temporary transition funding. The question is: will they have a choice of staying there or getting the package they need to support them to go home? Legislation can come either way" (Houses of the Oireachtas Special Committee; May 26, 2020: 27)

It is notable here that Taylor is the only witness to refer to older persons as 'people' and as 'adults'. The effect is striking. He refers to the importance of enabling people to have a choice in where they receive care. We do not hear much about 'choice' in the discourse otherwise. Also, Mervyn Taylor is one of the only people throughout the entire series of Special Committee debates to shine a light on the experiences of people with dementia living in nursing homes: "The impact of an outbreak has been frightening for many residents, and for those with dementia, the arrival of people in full PPE was terrifying" (Houses of the Oireachtas Special Committee; May 26, 2020: 7). Even though, according to certain estimates, the proportion of nursing home residents with dementia is as high as 70 percent (O'Shea et al., 2017; Pierse et al., 2019; Hennelly & Cahill, 2020), it is barely discussed in any of the official documents related to older persons resident in nursing homes and in their own homes. This includes guidance documents intended for nursing home care providers (see for example, NPHET; March 31, 2020; HSE; January 11, 2021), as well as the independently commissioned Final Report of the COVID-19 Nursing Home Expert Panel (August 19, 2020).

In the May 26 debate of the Special Committee, then TD Stephen Donnelly[23] makes much of the lack of representation of the nursing home sector during the early months of pandemic decision-making. It is worth reproducing an excerpt of his comments at some length:

> "It seems clear given the scale of clusters, outbreaks and fatalities in nursing homes that opportunities were missed to support the nursing homes and prevent contagion into them. Various vectors into the nursing homes have been discussed today, including staff being discharged from hospitals, for example. I believe one of the reasons is that nursing homes and older people have had no voice in the room where the decisions are being taken, which is the National Public Health Emergency Team. I have put this to the Minister for Health repeatedly in the Dáil and he has repeatedly told me that nursing homes do have a voice and HIQA is their voice. The Minister's formal position is that HIQA is the voice of nursing homes on NPHET. We have a limited number of minutes from NPHET meetings but on 30 January, the second meeting, HIQA was present and nursing homes were not discussed. On 4 February, the third meeting, HIQA was present and nursing homes were not discussed. At the fourth meeting on 11 February, HIQA was present and nursing homes were not

[23] Just one month later, Stephen Donnelly would be appointed Minister for Health by the new coalition government which came into power on June 27, 2020. Source: https://www.oireachtas.ie/en/members/member/Stephen-Donnelly.D.2011-03-09/

> discussed. At the fifth meeting on 18 February, HIQA was present and nursing homes were not discussed. On the eighth meeting on 25 February, HIQA was present and nursing homes were not discussed. At the ninth meeting on 3 March, HIQA was present and nursing homes were not discussed. At the 12th meeting, on 10 March, HIQA was present and nursing homes were discussed. The action that was agreed was that the unilateral restriction of visiting to nursing homes was not required at that time" (Houses of the Oireachtas Special Committee; May 26, 2020: 66).

TD Donnelly mentions the absence of the voice of older people early on in his rhetorical flourish, but it is then subsumed under the aegis of the 'nursing home'. He misses or chooses to ignore the point that Taylor raised concerning the need for safeguarding legislation to recognise older persons' rights and to formalise independent advocacy for older persons who may not be able to advocate for themselves.

The construction of older people as vulnerable and in need of protection by certain actors in the official discourses is reinforced by the almost complete absence of older persons as speakers/actors, as well as the near exclusion of organisations advocating on their behalf and on behalf of their families. While older individuals were the subject of countless meetings and deliberations and debates in parliament, family carers and home care professionals were rarely mentioned at all, even though during the pandemic, to an even greater extent than before, unpaid informal carers and low-paid home care professionals were propping up the country's long-term care system. In stark contrast, the voices of medical and clinical experts, and to a large extent the voices of men, are dominant in all aspects of pandemic-related, high-level decision-making. It is almost as though the older population had disappeared into their homes-cum-cocoons and into their nursing homes and were made invisible, despite being the topic of constant discussion by other actors at various intervals during the pandemic.

In the proceedings of the Special Committee, for the most part, older people are consistently referred to as 'the elderly', as 'vulnerable', 'in need of protection', as 'patients', 'residents'. On several occasions they are reduced to physical bodies; bodies being discharged, transferred, isolated, tested, and so on. Mervyn Taylor of Sage Advocacy, and on occasion Tadhg Daly of NHI break through this clinical 'othering', simply by reminding the assembled deputies and witnesses of the actual people whose lives are being affected by the decisions taken in response to the pandemic (Houses of the Oireachtas Special Committee; May 26, 2020).

This points to the persistence of a biomedical approach to ageing and care in Ireland, despite long-standing awareness and repeated efforts to deinstitutionalise and move towards a more integrated, social, and human rights-based model, and underlines the persistence of a significant gender imbalance in the halls of power. Paradoxically, the construction of older people as vulnerable also

contradicts the 'active ageing' framework that had become the lodestar for ageing policy in Ireland as elsewhere in Europe in the decade prior to the pandemic, and which stated as part of its 'vision statement' that it would, "promote and respect older people's engagement in economic, social, cultural, community and family life, and foster better solidarity between generations" (Department of Health, 2013: 3). It is interesting to note that 'active' and 'positive' ageing theories have been criticised for essentialising older people in the *other* direction, and thus for marginalising people who do have care and support needs, and as a way to obviate the need for public sector care financing and services in the face of demographic ageing (Katz & Calasanti, 2015; Timonen, 2016; Pfaller & Schweda, 2019).

5.6 Valuing older persons for their role as dependent family members

Another interesting aspect of the vulnerability discourse is the construction of older persons as occupying a largely passive position within society, of being defined solely through their relationality with family members. In this construction, 'othered' older people are valued for their connection to the 'rest of us' rather than having their intrinsic value as individuals and as co-producers of relations with others acknowledged and considered. This construction sees older people being valued as 'loved ones', as 'precious' and 'vulnerable', as venerated members of family units in need of protection, of care; as dependents on family members, on their communities, on wider society, and on the state. In every one of the hearings of the Special Committee and subsequently the Joint Committee on Health addressing the situation of older persons, the disproportionately high number of deaths of older persons living in nursing homes is frequently referred to as a 'tragedy', and without fail TDs and witnesses extend their sympathies to family members who have 'lost loved ones' (see for example Houses of the Oireachtas Joint Committee on Health; February 2, 2021; Houses of the Oireachtas Special Committee; May 19, 26, 2020). This serves once again to exclude older people from the discourse. They are not the ones being addressed, being sympathised with, rather it is their family members who are the target audience. Older people are merely being talked *about*.

A rare departure from this discourse comes when Taoiseach Martin gives his address on November 27th, announcing the partial lifting of restriction ahead of the Christmas holiday (Department of the Taoiseach; November 27, 2020). He pleads with the public to do their part to keep the 'vulnerable' members of society safe: "Our older people, who we deeply cherish and who contribute so much to our society and our nation, are particularly vulnerable to this disease. They are relying on the rest of us to be responsible" (Department of the Taoiseach; November 27, 2020). Yet even as he recognises their contributions, the Taoiseach's formulation begs the question, who is his speech addressing? It seems clear that he is not addressing older people themselves, as they are not included in his 'we', nor in the 'rest of us'. The speech is addressed to everyone who is *not* older, *not* vulnerable, to those

members of the population who have the power to act, to protect; to those, in other words, who have agency and a voice.

Constructing older people in this way not only fails to recognise that not everyone over the age of seventy is vulnerable, it also fails to acknowledge that many older people are active members of their households, their families, and their communities—engaging in significant affective labour (i.e. caring responsibilities), paid employment, and volunteering activities, as well as providing substantial financial transfers, and importantly, emotional support to others (Ward et al., 2021). Furthermore, in valuing older persons primarily for their roles as 'precious' albeit passive family members, the importance of intimate relationships, friendship, and social connectiveness for older individuals, outside the domain of the family, is likewise neglected. While the issue of family visitation in nursing homes becomes a central point of discussion throughout the pandemic in the official discourses, and understandably so, there is little mention of the impact of social distancing measures *within* nursing homes, where spouses, partners, and friends, were, in many cases at various times, forced to isolate from one another (Gilbert, 2021).

Such discourses that fail to recognise the myriad and significant contributions of older individuals follows on from ageist discourse that long predates the pandemic, a discourse in which older people are viewed in terms of their position vis-à-vis the labour market, the sum of their economic (un)productivity. This kind of structural ageism is deeply entrenched in Ireland's and in much of the West's neoliberal economic and political systems (Tronto 1993, 2013; Fine & Tronto, 2020. In fact, if one considers which groups are defined as 'vulnerable' by the NPHET Vulnerable People Subgroup, the majority refer to groups of individuals who, for one reason or another, find themselves on the periphery of or outside the labour market altogether, e.g. asylum seekers, people experiencing homelessness, people in prisons, members of the Irish Traveller and Roma communities, children in care, people with disabilities, and of course, 'the elderly' (March 10, 2020: 2). The role of socioeconomic status, and of social and financial capital, as determinants of 'vulnerability' in the face of the coronavirus does not feature prominently—if at all—in the official discourses.

5.7 The powerful agency of 'the virus'

While older persons are constructed as passive actors in this vulnerability discourse, the virus, by contrast, is consistently endowed with great powers by official actors, possessed of significant agency and capacity to cause devastation, but also a source of innovation and opportunity– it is credited with both causing illness and death and the breakdown of certain social and institutional relations and interactions, while concurrently driving the creation of new ones. Western societies have by and large adopted a biomedical understanding of and approach to health and illness, to the extent that it is easy to forget that "what counts as sickness, disease, injury, pathology, including the International

Classification of Diseases (ICD) system, is fundamentally a matter of historically situated social ideas and values" (Hahn & Schoch-Spana, 2021: 1). Plainly put, while the virus as biological entity and the disease it causes are objectively 'real', their clinical classification/definition and the characterisations of the virus's 'behaviour' are themselves social constructions, demanding a particular course or courses of action in response.

The debates circulating in the early days of the pandemic around the naming of the virus are illustrative of this point. In 2015, the World Health Organization published guidelines for the 'naming of new human infectious diseases', with the stated aim to "to minimize unnecessary negative impact of disease names on trade, travel, tourism or animal welfare, and avoid causing offence to any cultural, social, national, regional, professional or ethnic groups" (WHO, 2015: 1). While its technical, scientific designation became 'severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)', non-scientific appellations and abbreviations abounded, with certain politicians and members of the public using colloquialisms that are explicitly and intentional political, xenophobic, such as the Chinese virus or the 'China virus', in the words of Donald Trump and others of his ideological ilk, or the 'Indian variant', which was later officially changed to the 'Delta variant' following the WHO's recommendation (WHO, 2021). Naming the virus gives it an identity as an actant—a non-human actor—which other actors and actants can react to and against.

Early in the official discourses in Ireland, the corona*virus* was pitted against the Irish people and Irish society (and people and societies worldwide) using the language of war. It is characterised as a foreign, alien invader, a destroyer of social norms and traditions; again, an actant endowed with intentionality. In the minutes of the earliest NPHET meetings, it is stated that representatives of the HSE provided "an outline as to the nature of coronaviruses and the emergence and epidemiology of the novel coronavirus (2019-nCoV) in Wuhan, China" (NPHET; January 27, 2020), reminiscent of a mythical villain's or a superhero's antagonist's origin story. On January 30th, the minutes of the meeting include the statement: "The importance of a unified national approach to the management and containment of 2019-nCoV was noted" (NPHET; January 30, 2020: 1). The first step towards 'managing' and 'containing' the virus, essentially marshalling the powers of the state to control it, is to officially designate the virus as a 'notifiable disease' under the law. One of the action points in the meeting's minutes outlines the bureaucratic, administrative importance of naming and officially recognising the virus in order to trigger governmental measures:

> "**7. HPSC Proposal to Designate 2019-nCoV as a Notifiable Disease**
> Prior to the meeting, HPSC circulated a document for consideration regarding the addition of 2019-nCoV to the list of notifiable diseases under the Infectious Diseases Regulations 1981 and subsequent amendments. The DOH agreed to progress amending the legislation as proposed. This amendment is subject to the usual legislative processes.

> It was noted that the current legislation already has the provision for the novel agents to be managed as notifiable diseases and that this would work until the amendment was in place.
>
> **Action: Progress amendment of the Statutory Instrument of the Infectious Diseases Regulations 1981 and subsequent amendments to include 2019-nCoV**" [Emphasis in the original] (NPHET; January 30, 2020: 3).

Taoiseach Varadkar's March 2020 speeches, as mentioned previously, set the stage for an epic battle between the Irish people—led gallantly by the officers of the state and by the experts it assembled—and the sinister virus (Department of the Taoiseach, March 12, 27, 2020) (see Appendix D, Documents 1 & 2). In his statement to the press on April 17th, 2020, as reports of outbreaks in nursing homes were proliferating, CMO and NPHET Chair Tony Holohan comments, "…we endorsed a proposal to increase testing of staff and residents across all long-term residential care settings including nursing homes. The *behaviour of the virus* [emphasis added] among vulnerable groups who live in these care settings continues to be a concern and this remains a priority for NPHET" (NPHET; April 17, 2020). So that it can be managed, the virus must be given human characteristics, transformed from an abstract, non-material idea into a material, embodied presence. And managed it is, by legislative and administrative means, as well as by the 'metrics' of public health and epidemiology. Data on the 'spread' of the virus, on its movements and the disease it causes became ubiquitous. Among just some of the official sources providing daily updates on coronavirus data were: Ireland's COVID-19 Data Hub, a dedicated public-facing webpage maintained by the government to bring regularly updated data on coronavirus data together in one place[24], the more detailed and technical information available on the HSPC's website[25], and the Covid-19 Tracker mobile application[26], deployed in July 2020, in addition of course to the daily updates on the 'spread' and impact of the virus provided by NPHET/Department of Health on the Government of Ireland website[27].

If the early period of the pandemic is characterised by a discourse of attempting to control the 'ever-evolving' virus so that it might be vanquished, of managing it, of monitoring and tracking it, of containing it, and of passing measures to protect the vulnerable from its effects, a noticeable shift occurs in the way in which government representatives speak about the virus as soon as the government is exposed to closer scrutiny of its response by other actors. They alternate between blaming the virus when their particular department or agency's response is questioned or criticised, and heralding their achievements in 'fighting' it, in the face of it. During the May 17, 2020 meeting

[24] Ireland's COVID-19 Data Hub: https://covid19ireland-geohive.hub.arcgis.com
[25] HSPC's Covid-19 Information website: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/
[26] Covid-19 Tracker app: https://covidtracker.ie
[27] NPHET/Department of Health Covid-19 website: https://www.gov.ie/en/news/7e0924-latest-updates-on-covid-19-coronavirus/

of the Special Committee, Jim Breslin, then-Secretary General of the Department of Health[28], begins his testimony by declaring, "None of us has seen anything like this before – the scale of the challenge is unprecedented but so, too, has been the response" (Houses of the Oireachtas Special Committee; May 19, 2020: 5), and continues on to say, "Because the virus is so new, there is much that we still do not know. A proven blueprint was not available at the outset on how this public health crisis would be managed" (Houses of the Oireachtas Special Committee; May 19, 2020: 6). CMO and NPHET Chair Holohan reinforces Breslin's sentiment moments later stating, "While we had high levels of preparedness arising from our experience with pandemic influenza and other public health challenges, it was quickly clear to us that this virus was very different" (Houses of the Oireachtas Special Committee; May 19, 2020: 7). Despite leveraging all the resources at their disposal, the virus is wily and not fully knowable to its human actor counterparts, even to the international and national 'experts' so often invoked in communications to the public (Department of the Taoiseach; March 12, 27, 2020; NPHET; March 31, 2020; NPHET; April 10, 2020). The inscrutable nature of the virus is even more pointedly invoked in the May 26, 2020, and June 18, 2020 meetings of the Special Committee, during which the government's response in congregated settings, including nursing homes, and in particular the previously highlighted issue of discharging older persons from acute settings to nursing homes *without* blanket testing, is examined. In a tense exchange between TD John McGuinness (Fianna Fáil) and Dr. Siobhán Kennelly (National Clinical Advisory Group Lead Older Persons, HSE), McGuinness attempts to pin Kennelly into conceding that the HSE had made a mistake.

> "**Deputy John McGuinness:** Does Dr. Kennelly dispute the statements made by both witnesses this morning[29] or does she accept some of the criticism and charges made in those statements?
>
> **Dr. Siobhán Kennelly:** I refute it. As a matter of public record, I can show the Deputy evidence of the correspondence that myself and officials in the HSE issued through the system, in line with the public health advice and with colleagues from Infection Prevention and Control. It is very important to understand that we are in a very fast-moving situation when we are trying to address these issues. […] Everything we did and all the guidance we issued - including the very comprehensive guidance that was issued again on 17 March regarding how patients would be cared for in nursing homes, regardless of whether they were in public or private facilities - was on the basis of the information we had and our

[28] 'Secretary General' is the title given to the Head of a Civil Service Department; as opposed to 'Minister', which is a political appointment.
[29] Tadhg Daly, Chief Executive Officer, Nursing Homes Ireland, and Mervyn Taylor, Executive Director, Sage Advocacy, testified in the morning session of the same meeting held on May 26, 2020.

> understanding of the pandemic" (Houses of the Oireachtas Special Committee; May 26, 2020: 50).

The virus is not directly mentioned in this exchange, but it is the implicit cause of the 'fast-moving situation' Kennelly refers to as it continues to defy understanding or 'knowing'. Some months later, on September 30, 2020 (incidentally, the committee's last meeting before ending its mandate), Minister for Health Donnelly, among other representatives of the Department of Health and the HSE, appeared before the Special Committee to take questions regarding his department's recently released Resiliency and Recovery 2020-2021, the government's short- to mid-term plan for 'living with Covid'. In his opening statement, Donnelly crafts a narrative in which his department and the whole of government have succeeding in controlling, in 'fighting' the coronavirus:

> "Since we last met the committee, a great deal has been done in Ireland's fight against Covid-19. […] Chapter 1 of Ireland's efforts in response to Covid-19 involved closing down much of the country to flatten the curve. This roadmap is how we navigate chapter 2, keeping the country open by suppressing the virus. The strategy is to suppress the virus. It is public health-led and involves acting quickly and locally in targeting how the virus spreads in order to protect lives, health services, schools, colleges and jobs" (Houses of the Oireachtas Special Committee; September 30, 2020: 5).

In the same hearing, Dr. Ronan Glynn, acting Chief Medical Officer at the time, is even more explicit in demarcating an 'us' versus 'it' divide between the Irish state and the people of Ireland on the one side, and the pernicious virus on the other. In response to a query from TD Bernard Durkan (Fine Gael) regarding the perceived failure of the government's messaging strategy in maintaining public adherence to social distancing measures, he says rather dramatically, "[…] first of all we need to get back to a position where we, as a nation, understand that we have one enemy, that is, the virus" (Houses of the Oireachtas Special Committee; September 30, 2020: 12). The othering of the virus as enemy agent is politically expedient; it is invoked by Donnelly and Glynn, among others, to trumpet the government and the state's successes, and to align the institutions of state with the nation's people. In the same hearing during which these 'battle lines' were being drawn by the country's most senior health officials, the government's Resilience and Recovery 2020-2021, also known as the 'Living with Covid Plan' was in focus. The virus-enemy is living among us like a guerrilla fighter, invisible to the naked eye, infiltrating our bodies, our homes, our schools and places of work and leisure, and our relations and interactions with each other.

Government actors' discursive framing of the pandemic as a biblical battle between good—the Irish people and the state—and evil—the virus, becomes even more pronounced in the run up to the 2020 Christmas holiday. Towards the end of Ireland's second, shorter, lockdown in October-November

2020, Taoiseach Martin addresses the public, beginning by acknowledging the Christ-like sacrifice of the Irish People:

> "Almost six weeks ago, I stood here and talked with you about what urgent action we needed to take together to drive down high and rising Covid infection rates. […] And so, in the days after, together we moved into another massive national effort to isolate and push back the disease.
>
> It hasn't been easy. Many individuals and businesses have made huge sacrifices. And many more are totally fed up with Covid-19 and everything that has come with it over the past nine months. […] But as we go through the daily experience of the fight against Covid, it can be easy to forget the magnitude of what it is we are fighting against." (Department of the Taoiseach, November 27, 2020).

Martin then goes on to quote the Catholic Pope Francis in his recognition of the healthcare community's dedication and sacrifice:

> "To quote Pope Francis in his recent reflection on the pandemic, 'They are the saints next door… They are the antibodies to the virus of indifference.' And so, what now? There has been much speculation in media over recent days and weeks about what a meaningful Christmas will look like. […] This cannot and will not be the kind of Christmas we are used to, but it will be a very special time when we will all be able to enjoy some respite from the hardships of 2020 and in particular the last six weeks" (Department of the Taoiseach, November 27, 2020).

After laying out the new, more relaxed suite of restrictions planned for the month of December and into the new year, Martin ends his speech by saying:

> "The Government and I are satisfied that this combination of new arrangements strikes a safe balance between maintaining the pressure on the disease and creating space for families, friends and loved ones to be together this Christmas" (Department of the Taoiseach, November 27, 2020).

As becomes apparent in a matter of two short weeks, this 'balance' is not achieved, and Martin is twice forced to return to address the nation and inform people that more severe restrictions are needed (Department of the Taoiseach; December 22, 30, 2020). Discursively then, the government's officials engage in a kind of rhetorical dance vis-à-vis the virus; in one moment, the government is fully in control, taking all the necessary steps, using all its resources to fight the virus. In the next moment, the virus is victorious, through no fault of the government or the Irish people, but rather by virtue of its embodied wily nature. It was the virus that forced the government's hand in implementing the measures that it did. It was the virus keeping older people cocooning at home, isolated, and it was

the virus prohibiting families from visiting their older relatives in nursing homes. The way in which the virus is described and characterised in the discourses dictated the government's response. As several scholars from the fields of medical anthropology and sociology have pointed out, the response from the world's governments is straight out of Michel Foucault's lectures on what he termed 'biopolitics', or the mechanisms by which [sovereign] powers, state powers, control populations by exerting control over the "species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary" (Foucault, 1978: 139).

The absence of older people's voices in the official discourses, their exclusion from having a seat at the decision-making table, and their being 'disappeared' into their 'cocoons' and into nursing homes effectively stripped this segment of the population of their agency. In an op-ed published in the newspaper *The Irish Times* in June 2021, the writer and journalist Fintan O'Toole reflected on lessons to be learned from the pandemic and the country's road ahead:

> "The disastrous death toll in residential settings – not just for older people but for people with disabilities and in direct provision – demonstrated the wisdom of keeping vulnerable people close to their own communities. But it also pointed to a larger lesson: nobody should be rendered invisible. To disappear as a citizen is a kind of metaphoric death. Now we know that it can also be the literal kind too" (O'Toole, 2021).

5.8 Conclusion

This chapter has charted the evolution of the construction of older persons as a vulnerable group, as dependent, and as lacking agency and voice. As the above sections make clear, the vulnerability and lack of agency of older people is in stark contrast with the powerful agency of official actors—even if they sometimes disagree—and their appointed experts, and significantly, of the virus itself. From the early days of the pandemic, when no meaningful distinction is made between different population groups in official texts, to a marked shift which saw all community-dwelling older people shunted into their cocoons, to an all-consuming preoccupation with securing-by-locking-down the 'precious' residents of nursing homes, the chapter tracks how the constructions and the narrative changes as the political priorities of the official actors shifts.

Chapter 6. Continuities and Discontinuities: A Focus on Institutional and Temporal Aspects

> "It is by studying the anomalous that we learn most about the true character of the normal."
>
> — Jonathan White, *Emergency Europe*, 2015

6.1 Introduction

Where the previous chapter, *Chapter 5: Silences and absences*, homed in on the social constructions of older persons, elaborating in particular the vulnerability discourse that so strongly emerged from the official discourses, this chapter turns the analytic lens to consider a second prominent emergent concept: continuities and discontinuities in the institutional and temporal elements that reveal themselves in the discourses. Institutional elements refer to the institutions of state and government, and temporal elements refer to the positioning in relation to the past, present, and future. This conceptual arc addresses the way the coronavirus and the ensuing pandemic are treated on the one hand as a disruptive force, one which is undoubtedly perceived to be negative in nature overall, but which also acts as an "opportunity", as (potential) catalyst for much-needed and long sought-after policy reform. On the other hand, upon closer analysis, the discourses lay bare the virus *cum* pandemic to be a force of and for continuity, continuity of social norms and values informing the political and policy landscape. Secondly, the chapter dives into the complex ways in which temporality and time are constructed in relation to how official actors perceive older persons and their care and support needs, and how they talk about what they think can and should be done, and when, at the institutional level to address these needs. Speaking strictly in terms of analysing the official discourses (and *not* in terms of analysing the government policies/measures themselves), this chapter examines a finding that has already been alluded to in the previous chapter. Namely, that the coronavirus and the circumstances it has brought about in Ireland and elsewhere—a pandemic, a crisis, an emergency—come to serve various political ends for the institutional actors implicated in the discourses.

6.2 The 'tragedy' of the coronavirus for older persons creating an 'opportunity' for reform

As mentioned in the last chapter, the disproportionately high numbers of outbreaks in nursing homes and the high mortality rate resulting from these outbreaks among the older population was invariably spoken about in the discourses as 'tragic'. In analysing the texts included in this study, it quickly became clear that the 'tragedy' of older persons dying in such high numbers relative to other members of the population was being used as a launching off point for either defending government measures and action—on the part of members of the governing parties and members of the administration, or

conversely, for attempting to hold government actors—usually particular agencies or groups rather than individual officials—to account for missteps and for failing to prevent said tragic deaths. This political wrangling resulted in the emergence of a narrative in which the first wave of the pandemic and the circumstances leading to outbreaks in nursing homes, and subsequently to deaths among older persons residing in them, were transmuted into 'lessons learned' and 'learnings' from the past, to be carried into current and future policymaking. From all sides of the political spectrum, these 'learnings' have been seized on as an 'opportunity' to, 'once and for all', address the host of systemic problems plaguing Ireland's long-term care sector (see *Chapter 1: Introduction* for overview of care policy context). What follows is an examination of how the outbreaks in nursing homes, and the deaths of 'vulnerable' older persons have been used by actors in the discourses as both a potential catalyst for institutional reform, and as a rhetorical and discursive strategy on the part of certain actors in powerful, decision-making positions, to avoid taking responsibility for decisions taken, and instead to emphasise the need to concentrate on what can and should be accomplished going forward. The invocation of 'tragic deaths' becomes a discursive strategy to 'look to the future', putting to rest the tragic, not-too-distant past. It is used as a means to shake up the political, institutional status quo that existed before the arrival, discursively speaking, of the virus and the pandemic. Fundamentally, then, constructions of older people's vulnerability in the face of the virus are employed as the means to political and ideological ends; older people as a designated vulnerable group are placed at the centre of an ideological battle over how to address the care and support needs of ageing members of society, a battle that has been waged in Ireland (and in Europe and beyond) for many decades.

A useful place to start in analysing this narrative is with the Special Committee's May 26, 2020, debate, the first of the debates to address the situation in nursing homes (Houses of the Oireachtas Special Committee; May 26, 2020). Tadgh Daly, Director of NHI is one of the witnesses called to testify, as one of the main issues investigated by the Special Committee is the timeliness of government measures and support for the private/voluntary nursing home sector. Given his position, this is a matter Daly was in a unique position to comment on. In an early exchange with the members, or deputies, of the Special Committee, Daly is questioned by Louise O'Reilly (Sinn Féin), a vocal member of the Opposition, about whether, in his opinion, nursing homes were neglected by health officials at the start of the pandemic in early to mid-March 2020. Daly responds by stating:

> "For the period of early March it was very distressing. I was getting calls from members and dealing with staff and with families. As I said in my statement, our first priority should be the residents because they have had a difficult period with no visitors. They have also lost friends and what they see as their family. It was therefore very difficult and we were exasperated by the lack of engagement, as we saw it at that time" (Houses of the Oireachtas Special Committee; May 26, 2020: 11).

Daly is the director of NHI, whose membership is comprised of private/for-profit and voluntary nursing homes. In his response to TD O'Reilly, he aligns himself and his organisation with the people who have been most directly affected by the 'difficult' situation, the 'vulnerable', the victims. While he states that 'our' priority—and presumably by 'our' he means everyone in the private, voluntary, and public sectors involved in care decision making and in the provision of care, as well as everyone assembled as part of the Special Committee hearings—his not-so-subtle criticism of the government's response serves to throw down the gauntlet to the Special Committee members, who are drawn from the governing party at the time (Fine Gael), as well as from each party in the Opposition. TD Fergus O'Dowd (Fine Gael), a member of the Coalition, weighs in a few pages later, responding to Daly's statement above by defending the government's actions and laying the blame for the spread of outbreaks of coronavirus in nursing homes at the foot of the private/voluntary nursing home sector. While lengthy, it is worth reproducing what he says more or less in full:

> "[but I am going to say] ...this louder, and as loud as I can. It is exceptionally clear and it is something that I have said all of my life: the care of older people in nursing homes is not acceptable. The nursing home private sector is not compliant in the main, right across the sector. It comprises very wealthy companies which complain that the taxpayer is not doing enough for them. I wish to state exceptionally clearly that we need a total change in the way we look at the care of older people. We need the home care packages mentioned by Mr. Taylor [then Executive Director of Sage Advocacy], in the smaller units referred to, and to look after people with dementia. We need to stop this game of blaming everybody and to accept the fact that we are not doing enough and have never done enough. Unless things change now, we are going to go down the same road. I respect Mr. Daly, whom I have met a number of times, but I want to make it exceptionally clear that it is not good enough that this system would continue, and the tragedies that have unfolded in many homes because of the deaths of loved ones. We have seen it every day on the television when it comes on about those poor people who have passed away. I knew many of them and I am saddened, and I know that the families are saddened by this. It is a scandal that this happened…We need to move forward together but we must establish the facts. The truth is the truth and the truth will out" (Houses of the Oireachtas Special Committee; May 26, 2020:15).

This statement by Deputy O'Dowd is noteworthy for a number of reasons. Firstly, because just like Daly before him, he begins his statement by placing older persons at the centre and claiming that they have been failed by the inadequacy of the care provided to them by 'wealthy companies'. In other words, older persons are again positioned as the 'poor', 'vulnerable' victims of a system that has failed them, and O'Dowd makes a point of aligning himself—and his party by association—with the vulnerable victims of this professed outrage. He establishes this closeness by speaking of the deaths of people in his constituency, people he 'knew'. Deputy O'Dowd agrees with Daly that what has been allowed to transpire in nursing homes is a tragedy and a scandal. The irony of O'Dowd

calling for an end to ‘blaming everybody’, as he himself is casting blame on the private sector is hard to miss. O’Dowd gamely takes up the blame-game and comes to the defence of his party and the measures it has enacted in the nursing home sector in its role as the governing party during the first wave of the pandemic. In defending the decisions of his party representatives, he turns the tables on Daly and the organisation he represents, locating the inadequacy of care quality squarely within the private nursing home sector, specifically in its historical failure to self-regulate, and in its member organisations placing financial profit over the interests of their clientele. This is a risible argument. It reveals either blatant disingenuousness or an extreme ignorance/naïveté about free-market economics, and the way in which for-profit firms operate in an unregulated or loosely regulated market, where the fundamental aim of private firms is to generate a profit for investors. Private enterprises will not and should not be expected to regulate themselves properly without government intervention and oversight.

O’Dowd also plays an interesting game with time, and his statements encapsulate part of what I am trying to articulate around the concept of ‘temporality’ in the discourses. He admits that Ireland has not historically provided the services and supports necessary to enable people to age in a dignified manner, but he stops short of taking any collective responsibility or admitting the role his own party has played in upholding the woefully inadequate system, and indeed in stymieing attempts at meaningful reform in the years preceding the pandemic. Since Ireland won its independence and became a republic in the early twentieth century, the Fine Gael and Fianna Fáil political parties have dominated the political arena and both parties have overseen the erosion of public provision of [nursing home] care services at various points in the country’s modern history (Coulter & Reynolds, 2020). Instead of accepting some modicum of responsibility, however, O’Dowd lays the blame for past, pre-pandemic failures at the feet of the private sector, while simultaneously entreating those assembled to shift their focus to the road ahead. O’Dowd seems to be employing the pandemic and the havoc it has wrought on the lives of older persons, their families and friends, and on the care staff working in the sector as an opportunity to ‘move on’ and start afresh. In this narrative, the virus and the pandemic serve to blur the past, to create a clear dividing line between a past in which mistakes were admittedly made (by others); a present in which more pressing events are taking place that require everyone’s attention; and a future offering the chance for a change in course in which older people’s value is finally recognised and their right to care is met with the respect and dignity they deserve. This is a convenient narrative from a political standpoint, but it brushes over and obscures a great deal in terms of how the care system developed in the way it did in Ireland, and how it has been allowed to continue to operate as it has despite failing so many people, ‘clients’, families, and care professionals alike.

Deputy O’Dowd’s claims on the ‘truth’ in his comment above are also worth noting: “We need to move forward together but we must establish the facts. The truth is the truth and the truth will out”

(Houses of the Oireachtas Special Committee; May 26, 2020: 15). What 'truth' is he referring to and what can we make of his claim that 'the truth is the truth'? He implies that his version of the truth is the only legitimate one, and more to the point, that there is only one version of the truth. Once again, as discussed at length in the previous chapter, older people's voices are sorely missing from this forum. As mentioned before, O'Dowd attempts to compensate for the absence of older persons and their advocates by claiming to "know" many older people who have died. What does this rhetorical 'bringing himself into proximity with' the people most directly affected, with the "victims", accomplish for O'Dowd? By claiming to "know" many of the people who have suffered during the pandemic and the failures of the [private] nursing home sector, he claims them for himself, for his party, for his agenda. He signals that he is 'one of the people', and that his intentions are altruistic—in contrast with others whose interests are rather less noble. There is a strong claim here being made by O'Dowd on what is morally right and good vis-à-vis meeting the needs of older persons.

TD Róisín Shortall (Social Democrats), speaking during the same meeting of the Special Committee, also remarks on the public/private divide in the provision of social care in Ireland, but perhaps unsurprisingly given her position as a member of the opposition, she portrays this phenomenon as a failure of government policy over many years, rather than as the fault of the private sector itself. TD Shortall refers to a "confluence of policy failures" as regards care for older persons, which have been "exposed" by the pandemic (Houses of the Oireachtas Special Committee; May 26, 2020: 22). She goes on to state:

> "It is important that we bear in mind what those policy failures are. The first is the two-tier health service. The second is in regard to social care being treated as the poor relation of the health service. The third is the fact that nursing homes are regarded as a good investment opportunity, as opposed to a central element of the healthcare service, and that the incentivisation of investment in nursing homes has led to the unrelenting privatisation of the sector. The fourth is the fact that older people themselves are incentivised to access nursing home care because of the lack of statutory entitlement to home care, in spite of the fact that home care is what older people want and is in the best interests of their health needs. The fifth area that has been absolutely exposed is the light-touch regulation of this entire sector" (Houses of the Oireachtas Special Committee; May 26, 2020: 22).

Shortall, similarly to O'Dowd, and despite their significant ideological differences, constructs the fallout from the pandemic as a time for reckoning with past failures, an opportunity to change the way the public sector approaches services for older people. However, while Shortall seems interested in performing a more thorough autopsy of what has, in her estimation, gone wrong in the past, O'Dowd's finger-pointing at the private sector appears one-sided and defensive. Shortall, too, claims to possess intimate knowledge of and to advocate for what it is that older people want and what is in their best interest: "…in spite of the fact that home care is what older people want and is in the best

interests of their health needs" (Houses of the Oireachtas Special Committee; May 26, 2020: 22). While the literature tends to support her claim that a majority of older persons express a preference to age in place, at home, it is not true for everyone, and for some people, group living arrangements and other alternatives to the traditional nursing home model—when appropriately designed and delivered—have been shown to be beneficial to people's health and quality of life (Eisele et al., 2015; Bally & Jung, 2015; Bradshaw et al., 2012; Schulmann et al., 2017). Yet again, older people are being constructed as a homogenous group and their collective experiences and preferences are being claimed by various actors in official roles, in positions of authority. Some pages later in the same debate, TD Mick Barry (Socialist Party) enters the fray and calls out Deputy O'Dowd for his hypocrisy in laying the blame on the private nursing home sector:

> "I lost 20 seconds at the start of my contribution as a result of the carry-over from the previous slot. I will conclude, however, by referring to the passionate speech made by Deputy O'Dowd in which he referred to the private nursing home sector putting profit before health and safety. The Deputy has since left the meeting but I point out to the remaining Government members that the reason for that is that we have gone from having a nursing home sector that was majority publicly owned 35 years ago to one which is overwhelmingly privately owned. The reason for that change was that a policy of privatisation backed up by massive tax breaks was pursued by Governments led by both Fianna Fáil and Fine Gael. There was, therefore, more than a touch of hypocrisy in the bit of outrage we saw earlier" (Houses of the Oireachtas Special Committee; May 26, 2020: 25).

People's preferences with regard to where and how they access care as they get older, and the "truth" about the decisions and actions taken historically by various institutional actors are all being wrangled over in what can only be described as an ideological and political debate between representatives of the different parties. This debate must also be seen in the wider context of Irish politics and in its economic policy and development over the past decades—it has been significantly shaped by the 2008 financial crisis, the unfettered growth that preceded it and the period of austerity that succeeded it—and in rather dramatic shifts in its social and cultural norms (Roche et al., 2017). Older people and their care are at the centre here of an ideological debate revolving around what various actors believe are the values Ireland should embrace in its approach to the welfare of its people. The debate around the need to expand public sector funding and provision for social services pre-dated the pandemic and the 2020 general election turned on, among other things, the electorate's dissatisfaction with existing health and social care policies. So, these Special Committee hearings, while officially tasked with investigating the government's response to the first wave of the coronavirus pandemic and providing the public with transparent proceedings, is playing out against this complex political background, and often devolves into a partisan exercise, with older people—constructed as vulnerable victims of the virus—caught in the middle.

The construction of older people's suffering during the early months of the pandemic, their coronavirus-induced illnesses and their 'tragic' deaths, the professed conviction that their deaths should not be in vain but should rather be turned into a catalyst and an opportunity to reform a long-failing system of care continues to be a key narrative in the official discourses. Most notably, this narrative is seized upon by the independent Nursing Homes Expert Panel, assembled at the request of the Department of Health, in their report investigating the government's pandemic measures in nursing homes (Covid-19 Nursing Homes Expert Panel; August 19, 2020). It is in this report that a focus on 'lessons learned' and taking 'learnings' forward to address the systemic issues in the health and social care sector is truly cemented. While 'lessons' and 'learnings' are certainly vital to prevent future errors, this narrative strategy once again obscures any attempt at accountability for missteps and errors made in the designation and rolling out of pandemic measures. The Executive Summary provides an overview of the authors' Key Findings and Policy Considerations (Covid-19 Nursing Homes Expert Panel; August 19, 2020: 5). The document states:

> "The task of the Panel is forward-looking to protect the at-risk population in nursing homes into the near future, whether or not a surge of COVID-19 occurs or if the infection remains in the community and continues to be a risk to those especially vulnerable to it. The Panel's work has been guided by the principles of in-action and after-action reviews where lessons learned in real time are acted upon. This is not simply to identify those lessons learned but to seek to apply these insights in a tighter timescale in order to improve the outcome of the ongoing response" (Covid-19 Nursing Homes Expert Panel; August 19, 2020: 5).

It is not only that the emphasis on 'lessons learned' distracts from holding responsible parties to account; it is also striking that the act of demonstrating that mistakes made were the result of insufficient knowledge or information about a given situation, serves in this case to absolve the actor, group of actors, and the institutions making the decision(s) in question. As discussed in the previous chapter, the 'ever-evolving' situation of the pandemic is consistently referred to in the official discourses to justify delays and missteps in the government's response. In the text below, the authors reckon with the double necessity of handling the 'ongoing' response— 'emergency' or 'crisis' mode—and thinking longer-term into the future:

> "The Expert Panel makes a substantial package of recommendations having regard to the real-time learnings and, what is felt, is required to ensure ongoing protection and support for nursing homes residents. The recommendations also reflect that systematic reform is needed in the way nursing home care and older persons [sic] care is delivered. Many of these issues have been amplified by the arrival of COVID-19 and focused and sustained attention is required in the context of the ongoing response to COVID-19 and in the longer-term provision of safe, quality care for Ireland's ageing population" (Covid-19 Nursing Homes Expert Panel; August 19, 2020: 6).

The government's short- to mid-term plan for navigating the pandemic, 'Covid-19 Resilience and Recovery 2021: The Path Ahead', was published in February 2021 (Department of Health; February 23, 2021). In reading through and analysing this document, it is once again clear that the narrative being pushed by the Department of Health, and by the Coalition government more broadly, is one in which the government is eager to demonstrate that progress is being made in the fight against the virus in the form of 'lessons learned'. An entire section of the plan is devoted to this account:

> "**PART 1: LEARNING FROM EXPERIENCE**
> **1 PUBLIC HEALTH IMPACT & RISK ASSESSMENT**
> 1.11.1 LEARNINGS TO DATE
> Ireland has now experienced three waves of high transmission of COVID-19.
> There has been an enormous amount of learning over the last year and these learnings must inform our approach over the coming months" (Department of Health; February 23, 2021: 8).

There is no mention of potential errors in government policy, or missteps in judgment or delays in the implementation of measures, just of 'learning from experience', where 'experience' serves to obscure all that transpired during that nebulous period of time, beginning with the first cases of the virus being identified in the country through to the third wave. This pattern of admitting mistakes made and professing to have learned from them and promising to do better in the future is reminiscent of the Catholic practice of confession. Just as with 'sins' in the Catholic religious tradition, however, political 'sins' can be committed over and over again with little genuine intention on the part of the sinner of reforming, as long as a confession is made and absolution is granted. Though the Catholic Church has lost much of its institutional influence and power in the Republic in recent decades, its membership decimated by scandal after scandal, it has nonetheless retained a strong hold on the national psyche and has yet to be exorcised from the country's political and social processes (Brown, 2004).

The virus and pandemic as disruptors are being used in a number of different ways then to suit the purposes of various actors in the discourses. Firstly, as an opportunity not only to address chronic issues with the care system, but to draw attention—public, political—to the fact that those chronic issues are the direct result of bad policies by specific political actors. Not surprisingly, this tends to be the narrative favoured by political actors who are in the Opposition and who are effectively shut out of the government's pandemic decision-making. The other prominent narrative thread—propagated most commonly by actors representing the Coalition government—focuses the discourse squarely on the pandemic as emergency, an ongoing crisis, in the face of which all other longer-term priorities are secondary. According to this narrative, the country's care system has admittedly never been ideal, but what matters now is that important lessons have been learned in the past months of crisis, and that the future will be different. It can be said that these divergent narratives constitute a

straightforward example of political gamesmanship. Both sets of actors promoting their respective narratives are covering their backs, engaging in blame avoidance and setting themselves (and their parties) up for credit claiming in the future, when the 'lessons learned' from the pandemic are, presumably, implemented. What is perhaps more thought-provoking is the way in which the virus and the events ascribed to it are used temporally: to mark progress through moments in time (past, present and future) and to convey significant changes to the political and policy status quo. It serves to highlight past developments in care policy; but it also serves to draw attention away from the past, focussing attention instead on the present care 'emergency'. It also shines a light on the future, in which the lessons from the past and from the present will be—according to the logic of this discourse at least—translated into concrete changes.

6.3 Government 'action' as a veil on decision-making processes

Following on from the previous section, in which 'learnings' and 'lessons learned' from the pandemic were employed as a narrative trope to signal progress and a maturing response to the pandemic on the part of the government, this section looks at how government 'action' is employed in the discourses. As described in the prior chapter (*Chapter 5: Silences and absences*), the relationship between NPHET and members of the government, specifically the Minister of Health, the Taoiseach and members of the Taoiseach's cabinet, underwent an evolution as the pandemic wore on and the first wave gave way to a second, and then a third, and beyond. Initially, there was hardly any daylight between NPHET and the Department of Health, and by extension between NPHET and the Taoiseach and his Cabinet, in that NPHET's recommendations became government policy with minimal modification. As time passed, however, the Coalition came under increasing pressure from other sectors of the economy and other economic, social, and health considerations were pushed to the fore. As a consequence, the all-consuming 'public health response' was tempered somewhat and it could no longer be assumed that the recommendations submitted to the Minister of Health by NPHET would automatically become government policy. The Taoiseach and his Cabinet started to push back. The evolution of this relationship revealed institutional in-fighting among the various departments, agencies, and committees, whereby actors representing the government agencies and bodies involved in the pandemic response shifted blame for missteps onto each other, evading accountability, obscuring transparency, while at the same time claiming to be 'doing' something to counter the negative effects of the pandemic, to be 'taking action'.

Reading then-Taoiseach Leo Varadkar's speech from March 12, 2020, it is notable just how decisive a tone he succeeds in striking, despite admitting that so much about the virus and its impact was unknown at the time. Clearly, his aim was to reassure the public and to emphasise that people with the necessary information and knowledge were in charge, acting fast, and doing everything necessary. He uses poetic, almost elegiac language, invokes the language of war, the battle of good (mankind, resilient Irish society) over evil (the virus); he designates heroes (healthcare workers, other

frontline workers), and designates the individuals and the groups of actors in control, in power (himself and his cabinet, and experts foreign and domestic: NPHET, WHO, ECDC), and designates scientific knowledge and the exchange of same as tools of the powerful. But the element of his decisiveness that is perhaps most conspicuous is his proceeding to outline in no uncertain terms "what will happen":

> "We said we would take the right actions at the right time. We have to move now to have the greatest impact. So, from 6pm today, the following measures are being put in place. They will stay in place until March 29th. Schools, colleges, and childcare facilities will close from tomorrow. Where possible, teaching will be done online or remotely. Cultural institutions will close" (Department of the Taoiseach; March 12, 2020).

The Taoiseach's words convey that the government, the people in power, are fulfilling their duty, their responsibility to the Irish people, that they are responding to the threat posed by the virus by doing things, by 'taking action'. There is a distinct sense of urgency in his statement, commensurate with the 'emergency', or critical situation at hand. This concept of 'taking action' is employed by government officials to demonstrate the legitimacy of their governance to an increasingly weary public. The official discourses are replete with designations of 'priorities' and outlining 'plans of action' and 'next steps'. When observed as a discursive formulation, this collection of statements appears to be a signalling strategy on the part of government actors, wherein 'action' is said to have been taken for the sake of demonstrating that the state is not standing idly by, rather than with the aim of imparting substantive progress on decisions taken. The Department of Rural and Community Development, responsible for organising supports to older persons and other 'vulnerable' people living at home, in the community, stated in its report from March 2020 that it has "… identified three key actions for immediate priority" (Department of Rural and Community Development; March 20, 2020: 3). And that they "…will put the required funding and resources in place immediately and will be working with our partners to implement the measures on the ground as quickly as possible. Work in this regard has already commenced" (3).

The NPHET meeting minutes from March 10, 2020 signal to the reader that the expert group, in setting priorities and developing an action plan, is in control of the situation: "It was agreed that public health capacity for contact tracing and surveillance is an immediate priority and should be addressed as such. This should also be included in the action plan under preparation" (NPHET; March 10, 2020: 2). In the same meeting of NPHET, the action plan is once again invoked, and the decision-making process, involving several governmental agencies and bodies, is delineated:

> "In addition, a National Action Plan on Ireland's response to COVID-19 is currently being prepared and work is ongoing with the HSE in relation to this. This will on be the agenda for the next NPHET meeting. It will then be forwarded to SOG [Senior Officials Group] for

> consideration and onwards to the next meeting of the Cabinet Committee. It was agreed that the NPHET will be reconvened this Thursday evening (12th March 2020) to sign off on this plan in advance of its submission to the SOG" (NPHET; March 10, 2020: 2).

To anyone reading them—and presumably, as all NPHET meeting minutes were published online and made publicly available within a turnaround time of a few days, they were formulated at least to a certain extent with the public in mind—the minutes declare that the following is being done: a plan, an action plan, is being developed; NPHET is collaborating harmoniously with the HSE; an agenda is already being set for a next meeting of NPHET; the SOG (a group established to support the Taoiseach's Cabinet Committee) will be brought into the loop on whatever actions the NPHET and the HSE develop; and that a next meeting of the Cabinet Committee has been set. It gives an impression of a humming, well-oiled government machine, all hands on-deck, acting decisively and quickly to keep in front of the virus. This kind of 'decisive action' in response to the urgency of the situation caused by the virus runs throughout the discourses and is on prominent display at the time when the outbreaks in nursing homes were first becoming apparent during the first wave: "Ireland is seeing a growing number of clusters in nursing homes and recent data from the Health Protection Surveillance Centre indicates that around 1/5 of cases, c20% [*sic*] are in LTRC. This data creates an urgency therefore to target specific focused and enhanced public health measures for LTRC" (NPHET Vulnerable People Subgroup; March 31, 2020: 1). The 'data' on clusters in nursing homes is creating an 'urgency', the government's response to which is 'to target', 'specific', 'focused' and 'enhanced' measures. It smacks of technocratic jargon and of 'consultant speak' rather than genuine, well-thought-through responses to the challenges at hand.

This narrative in which the 'urgency' of the situation necessitated 'quick' and 'decisive' 'action' on the part of the government meant that in some cases, decisions were made and actions were taken rapidly indeed. Legislation initiated by the Coalition government to amend Ireland's Health Act (1947)—granting extraordinary powers to the Minister for Health—was pushed through the Dáil Éireann with little opportunity for parliamentary debate beforehand, garnering criticism from members of parliament and from legal and human rights analysts for both substantive elements of the legislation as well as for the lack of transparency and accountability in decision-making (Irish Centre for Human Rights, 2020; Ansbro et al., 2021; Eustace et al., 2021). At various points in time over the course of the pandemic, decisions were taken by the government practically overnight to enter lockdown, consequently shutting down significant segments of society with little notice or time to prepare. The 2020 Christmas period is a notable example, in which the government moved from a significant lifting of restrictions to a partial reintroduction of restrictions, and then to a complete shutdown, all in a matter of days. While official actors are all 'action', very little information is forthcoming in terms of justifications for the decisions taken. A great deal of public health and epidemiological data was and continues to be made available to the public, e.g. daily updates to data

dashboards[30], but aside from invoking the need to 'protect' the 'vulnerable', and keeping acute beds free, there is no detailed rationale provided. In the absence of transparency and accountability in the decision-making process, the underlying mechanism driving the pattern of 'actions' is the fear—and a kneejerk reaction to that fear— that capacity in the acute sector will be overrun, and a reliance on a narrow selection of 'experts' who took a fundamentally cautious position throughout the pandemic.

In addition to signaling activity and industriousness, the constant references to 'action plans', to 'action points' and 'next steps', and so on, gesture at competency acquired through formality and professionalism (again, that 'consultant speak' referred to above). The construction of cases of coronavirus in older people residing in nursing homes as 'outbreaks', and of the 'urgency' being 'created by the data' adds to the sense that the actors involved in formulating the discourses are doing their best to sound official, formal, scientific, and detached and begs the question: Who is in fact responsible for writing up the summaries of official meetings and to what extent are they accurate and comprehensive representations of the exchanges that took place during the meetings? What was included and what was omitted and who made those decisions? Presumably a senior civil servant, or someone in a leadership position on the NPHET or in the Department of Health had to sign off on content before it was published online. The matter of the authorship of these official texts, especially when individual authors are not listed, raises thought-provoking questions about the way in which institutional anonymity and the cover provided by bureaucratic institutions is employed as a mechanism for controlling the pandemic narrative through the control of information, of knowledge.

6.4 "Not enough time!" The interplay between policymaking in times of crisis and historical inaction on care

Preceding sections have alluded to the importance of temporality in the construction of the pandemic as an emergency and as a crisis that has not yet reached its end (at the time of this writing). Following on from the previous section, in which government 'action' was shown to function as a smokescreen for deliberate, transparent and considered decision-making, this section investigates the way in which the discourses manipulate 'time' itself to suit official actors' purposes/ends. Subsequent paragraphs focus on the emergent finding from the data in which the 'urgent' nature ascribed to the pandemic is used discursively to mark a shift in the normal work of governance and policymaking, to what the political philosopher Jonathan White refers to as "emergency governance" (White, 2015). Whether such a shift, which entailed the introduction of extraordinary measures for members of the executive branch, was justified is not the main point being discussed here. Rather, the intention in the discussion that follows is to look closely at the purposes the designations 'pandemic' and 'crisis' and 'emergency', and so on, serve in the official discourses related to older persons and their care. After

[30] At the time of this writing, *Ireland's COVID-19 Data Hub* continues to publish weekly 'headline' Covid-19 figures, as well as more in-depth reports, on its website: https://covid19ireland-geohive.hub.arcgis.com.

all, such designations are themselves social constructions. What this shift to 'emergency' governance or policymaking did succeed in demonstrating is that the government, when pushed, is capable of intervening, of acting, to make emergency changes to the system of care for older persons. While the emergency situation brought about by the virus is used to justify quick, decisive action on the part of official actors in positions of decision-making authority, it also serves procedurally to minimise the amount of input from other actors—most clearly evident in the hearings of the Special Committee on Covid-19 response—who are not part of the governing coalition's executive branch. Time is always in short supply and the lack of sufficient time, or the 'running out of time' is consistently cited as a justification for rushing through proceedings, with the result that these processes often have a hurried quality to them. Processes intended to deliver greater transparency and clarity as to the government's pandemic decision-making, are thus made subservient to the all-consuming 'crisis' and its curious squeezing and speeding up of time effect. Such processes include the publication online of NPHET's meeting minutes, of government guidelines and various government sanctioned committees' reports, and of the transcripts of the parliamentary Special Committee's proceedings (intrinsically, a process to investigate and bring greater transparency and clarity to government activities; a check on the executive's power).

In nearly all of the Special Committee on Covid-19 Response, and later the Joint Committee on Health debates, there is a striking contrast (and it must be said, a tinge of irony), between the urgency expressed in official documents during the pandemic—procedural urgency, a 'lack of time' in an administrative sense, and the more diffuse yet ever-present existential urgency of policymaking during an 'emergency', 'crisis'—and the several decades of policy stagnation during which successive governments have 'prioritised' yet failed to address chronic, systemic issues plaguing Ireland's health and social care sectors. In the Special Committee's September 30, 2020 meeting, its last meeting before being stood down, the Minister for Health, the acting CMO and Chair of NPHET, together with other members of NPHET all appeared as witnesses in the same session to submit to questions from the Committee. Large sections from the transcript are quoted below as it is impossible to get a sense of the essence of the back and forth between the different actors present without reproducing the text at some length. At the very beginning of the meeting, before the witnesses are called, TD Cullinane (Sinn Féin) gives his two cents as to why the proceedings are problematic from a procedural standpoint, and even more fundamentally, for what he sees as the conflict of interest it represents:

> "It is unfortunate that we have the Minister for Health, the acting CMO and a number of key figures from NPHET in the same session. This is problematic for a number of reasons. We now have to choose to whom we put our questions; and some members only have five minutes, which makes it impossible to put questions to the Minister, the acting CMO and the members of NPHET. We are not doing the committee any service and it is bad form. There is a conflict here in even doing this because the Minister gets advice from NPHET and the

> acting CMO and I do not want members to be in a situation where they put a question to the acting CMO or NPHET and it is then spun, as could happen, that we were somehow trying to play one against the other" (Houses of the Oireachtas Special Committee; September 30, 2020: 2).

TD Richard Boyd Barrett (People Before Profit) and TD Róisín Shortall (Social Democrats), all representing Opposition parties, express similar concern that the Committee's work is being undermined by obstructionism on the part of health officials and members of NPHET. TD Boyd Barrett states,

> "It is precisely because of the threat of Covid-19 to the health and well-being of the citizens that proper scrutiny and discussion of the strategy being pursued is absolutely necessary in order to take the public with us through this difficult situation. […] It is absolutely imperative that we have an open and transparent discussion about the strategy, particularly in the context of rising infections and the hardships people are enduring. Nobody should be afraid of that discussion. […] Such a discussion is not possible now that we have collapsed these two sessions in together. Deputies will have a minimal amount of time to ask questions and will have to make impossible choices between posing a question to the CMO and NPHET or posing it to the Minister for Health" (Houses of the Oireachtas Special Committee; September 30, 2020: 2).

TD Shortall echoes the concerns of her colleagues in the Opposition and, furthermore, demands to know who is to blame for the perceived obstructionism:

> "It is absolutely reasonable of us to expect to have at least one session with NPHET because there are endless outstanding questions about the decisions being taken. As the representatives of the people, we have a right to pose those questions. […] We spoke about this yesterday and agreed we would make ourselves available at any time, day or night, this week to facilitate NPHET for that exchange. Then, out of the blue, yesterday, at 6.15 p.m., we got a notice stating that the two sessions with the Minister and NPHET were to be run in together. I want to know who took that decision, how it was taken and how it was that the media were notified about this by the Department of Health before the committee was notified. My understanding is that it is the job of the committee, not some nameless person in the Department of Health, to arrange its business. […] We cannot have any kind of decent engagement with both the Minister and NPHET over the space of two hours - less than two hours now" (Houses of the Oireachtas Special Committee; September 30, 2020: 3).

Purported time constraints in the proceedings of the Committee are constructed as hindrances to transparency and accountability in pandemic-related decision-making by the government. And the blame for the constraints on government actors' time lies, according to the TDs belonging to the

Coalition parties and to the government witnesses appearing before the Committee, with the virus-pandemic-emergency, rather than through any fault of their own. TD Fergus O'Dowd (Fine Gael) seems less concerned with uncovering the 'guilty' party: "I wish to strike a positive note. Yesterday, it seemed as though the witnesses were not going to come in; today they are here. I welcome them. I propose that we start our meeting. […] We should go ahead and get the business done" (Houses of the Oireachtas Special Committee; September 30, 2020: 3). Again, 'getting business done', taking 'action', keeping busy, is the modus operandi. For his part, Minister for Health Donnelly asks to address the criticism levied at his department and at NPHET:

> "The various frustrations aired by members were new to me so I will set the record straight. […] I am a strong advocate of Parliament and the role of Parliament in holding Government to account and doing all the things these committees need to be doing. I am an advocate and defender of the rights of committees. At no point have I or the Department refused to appear before this committee. […] On the Friday of the week before last, the Department received from the committee an invitation, which might have been sent on the Thursday evening, to me, the acting Chief Medical Officer and various other people to appear before it in three working days. I rang the Chairman immediately and we discussed the matter. I indicated that we were launching the winter plan the following day and, as such, it would be difficult for us to appear on that day, particularly with just three days' notice, but we would immediately make ourselves available again whenever the committee wanted" (Houses of the Oireachtas Special Committee; September 30, 2020: 36).

Donnelly's explanation is reasonable, and likely reflects the very real challenge of getting multiple individuals with busy schedules into the same room (virtually or otherwise) at the same time. But again, this logic obscures a pattern in which actors representing the executive branch and the various departments, agencies, and advisory groups under its authority, prioritise rapid, unilateral decision-making over inclusive democratic processes.

Repeatedly over the course of the September 30th hearing and other meetings of the Special Committee and the Joint Committee on Health, TD's questions to witnesses come up against the very immediate constraints of the time allocated to each deputy and to each committee session. Here again is TD Cullinane, this time posing questions to representatives of the HSE during the February 2nd, 2021 hearing of the Joint Committee on Health in which representatives from the Department of Health and the HSE, together with Nursing Homes Ireland, a gerontology expert, and a clinical nurse with expertise in regulatory compliance are updating members of the committee on the coronavirus situation in nursing homes. After several back-and-forth exchanges between TD Cullinane and the representatives from the HSE, in which Cullinane's questions are not answered to his satisfaction, the Chairman of the committee interjects to tell him that he is out of time:

"**Deputy David Cullinane**: I must come back in because our time is very short. We have ten minutes to ask questions and we really need more distinct answers from the witnesses. We are raising important issues. I want to put a question to Ms O'Neill [representative from HSE]. I appreciate the responses I have been given. I must ask these questions on behalf of all the families and groups I have interacted with over the last number of weeks and months. Has the HSE engaged, or when was the last time it engaged, with the Irish Association of Social Workers, IASW, as one organisation? When was the last time it engaged or met with Care Champions, Sage Advocacy or any of those groups, personally? I ask the same of Dr. MacLellan. When was the last time any of the witnesses has met with those groups?

Ms Yvonne O'Neill [representative from HSE]: Meetings are held with Sage Advocacy a number of times in the year in terms of the service arrangements that the HSE has with the organisation.

Deputy David Cullinane: When was the last time the HSE met any of those groups?

Ms Yvonne O'Neill: I have engaged with the CEO in the lead up to Christmas but we have obviously not had meetings. The service arrangement meeting with Sage Advocacy was also just before Christmas, if I am not mistaken.

Deputy David Cullinane: I wish to refer to the Irish Association of Social Workers and Care Champions so the organisations that are representative of residents and their families. When was the last time that the HSE sat down and engaged with them, and heard their stories and experiences?

Ms Sandra Tuohy [representative from HSE]: The Deputy has commented that families have contacted him. They have also contacted my department directly in terms of not being able to get answers in respect of how their loved ones are doing. We are acutely aware of that. We have raised the matter through our response teams to see how we can improve the correspondence and communication between families and their relatives in nursing homes. To repeat, the challenges that we have—

Deputy David Cullinane: That is not the question I asked.

Chairman: The Deputy has gone way over his time" (Joint Committee on Health; February 2, 2021: 13-14).

Ultimately, The Chairman suggests that the witnesses provide a more detailed written note to the Committee in answer to TD Cullinane's question. Reading this text, one is repeatedly struck by the sense that the opportunity to get to the bottom of vital issues facing older persons and their families—in this case, the perceived lack of engagement on the part of the state's health executive with the very people they provide services to and identify as 'vulnerable' and 'precious'—is being squashed by bureaucratic bludgeon. In another instance, it is the testimony of Mervyn Taylor, then Executive Director of Sage Advocacy, and one of the only representatives of civil society to be invited as a witness before the Special Committee, that is undermined by time pressure, by the insufficiency of

the time allocated to this critical inquiry into the government's response to the pandemic. Deputy Shanahan puts the following Sisyphean task to Mr. Taylor:

> "**Deputy Matt Shanahan**: … Mr. Taylor mentioned advocacy for those in residential care being framed in legislation. In 30 seconds, could he give a quick outline of how he sees that being developed?
> **Mr. Mervyn Taylor**: I will do so very quickly, as I am aware of the time strictures. Legislation has been anticipated for safeguarding adults and the Law Reform Commission has a consultation going on regarding how such a framework might best occur. We believe that is a mechanism for framing legal recognition of independent advocacy. There is also a need for legislation on protection of liberty of people in congregated care settings because that is a serious issue. People have been transferred from acute hospitals to nursing homes on temporary transition funding. The question is: will they have a choice of staying there or getting the package they need to support them to go home? Legislation can come either way" (Houses of the Oireachtas Special Committee; May 26, 2020: 27).

Mr. Taylor's response is admirable for its conciseness and articulateness, but taking a step back, it strikes one as appalling and absurd that a person of Taylor's experience, speaking on a topic of such relevance and importance for the 'vulnerable' people who have been transferred to nursing homes—in many cases likely against their preferences due to a lack of institutional capacity in the health and social care sectors—is not given the time nor the appropriate platform to raise legitimate concerns about the government's response.

TD Shortall, in the February 2nd, 2021 hearing of the Joint Committee on Health during which the rollout of the vaccine was discussed, makes explicit reference to the government's failure to fulfil its past promises, to put the 'lessons learned' from the first wave into practice:

> "**Deputy Róisín Shortall**: As of now, they are not in the prioritised [for the vaccine] as a specific group. I want to move on now to the fact that we find ourselves yet again in a situation where there are extremely high rates of the virus and deaths in the nursing home sector. It is hard to believe we are back in this situation given the experience of last April and May. Yet again, NPHET is expressing serious concern about the very high numbers similar to last April and May and it has referenced a deteriorating epidemiological profile in long-term residential care facilities. Have we not learned lessons from that first wave, which was so tragic? There were three lessons identified at that point from that awful experience. The first was that there was no clinical oversight of private sector nursing homes and that the State was operating an arm's length approach to older people's care. There was a major gap in services and no clinical oversight of private nursing homes. The second lesson that we talk about is the fact it is not an ideal situation for older people to find themselves in

> congregated settings. It is not ideal from a health perspective, certainly in a pandemic, and also not ideal socially. The third area was the chronic under-funding of homecare. Those three lessons were identified by the expert panel and they have been known for a long time by many of the advocacy groups working with older people, particularly Sage. It was also recognised at a political level. Those of us in opposition have recognised these for a long time and it was recognised at Government level last summer that these were lessons that had to be learned, and that we had to find a new model of care for supporting and caring for older people. […] What has been done about those three major areas that had been identified last summer?" (Joint Committee on Health; February 2, 2021: 18).

Amidst debate about who should be prioritised for the vaccine, Shortall brings the conversation back to the government's repeated and multi-layered neglect of the care sector. For government actors, the vaccine was truly a saviour, alleviating to an extent the enormous pressure on the health system caused by the pandemic, and distracting from pesky questions about government oversight and regulation of the sector, adequate funding of integrated services, and the implementation of a new model of care that respects people's human rights.

6.5 Conclusion

There is a seeming contradiction between policymakers' oft-repeated desire to protect older people from the virus and the very real lengths they have gone to during the pandemic to do so, including implementing one of the strictest series of lockdowns in Europe, and the historical neglect by policymakers of the older population's rights to quality, affordable care and their rights to dignity and autonomy in older age. It would be easy to argue that the politicians in decision-making positions now cannot be held accountable for historical neglect, but in fact many of the same individuals are still on the scene, and the same lack of accountability and lack of transparency in decision-making structures and processes endure.

This seeming contradiction unravels, however, when put into context. As alluded to in Chapter 1, there is a tension in Irish society between deep-rooted values of familism and filial piety, where responsibility for caring for older people rests with the family and with the community, and Ireland's idea of itself as a modern, wealthy nation, in which women are emancipated and are no longer bound to domestic and care work. Social norms and values may be changing, but the country's social policies, its system of governance, and the power (or access to power) of certain groups and certain professions are a holdover from twentieth century Ireland. As the findings presenting in this chapter have demonstrated, it has taken a twenty-first century pandemic to shine a light on the inadequacy of the country's care system and its policymaking processes.

Chapter 7. Conclusions

7.1 Introduction

The preceding chapters of this thesis have set out how older people and their care were constructed in the official discourses in Ireland during the first fifteen months of the coronavirus pandemic. By doing so, by laying bare the nature of those discursive constructions, the actors/agents producing them, and the mechanisms through which they are deployed, this research makes an original contribution to our understanding of how power operates in the relationship between older persons and the institutions of state.

As the opening chapter outlined, Ireland's population, and that of all developed countries, is ageing, a demographic shift with momentous consequences for, among other things, the state's allocation of resources and the design and delivery of care services and systems. Literature predating the pandemic provides evidence that long-standing ageist attitudes levied against older people—for example, diminished physical and mental capacity, vulnerability and dependency—have informed and in turn been reinforced by political ideologies and social and economic policies that discriminate against segments of the population on the basis of age. An ample and diversified inventory of literature (in terms of discipline, theoretical approach, method) published before the pandemic also tells us that such attitudes and discriminatory policies are harmful in myriad ways because they challenge older individuals' autonomy and agency in multiple ways, posing a threat to the realisation of their basic human rights.

For a brief interlude, the coronavirus and pandemic propelled 'old people' to the top of the political agenda and into the centre of public and official discourses to an unprecedented degree and intensity. Much of the scholarly research undertaken since the start of the pandemic has focussed on the individual health risks the virus poses to older people, on the physical, mental, and emotional risks posed to older persons by the isolation measures imposed by governments themselves, on the impact of the virus-cum-pandemic on various aspects of the health and social care systems, or on analyses of pandemic governance and policy. Yet few research initiatives have used discourse analysis and exploited the particular fruits of this theoretical/methodological approach for our knowledge base as the research presented in this thesis has done (see Foucault, 1972; Fairclough, 1999; Clarke, 2005).

7.2 Aims and structure of the chapter

The pandemic 'situation' offered a unique opportunity to gather rich discursive data in which people at the highest levels of state power—among others—were talking about, writing about, making

decisions about, and all the while *constructing*, older members of the population in specific ways, with clear consequences for policy, and for older individuals and their families. The findings provide new insights into the building blocks of constructions of older people as vulnerable and dependent members of society. The findings also elucidate the social context within which these constructions operate, the manner of their deployment as powerful tools by powerful actors, and the norms, institutions, and structures they simultaneously uphold and emerge out of. The purpose of this concluding chapter is to bring the research findings into conversation with the research context and with the theoretical and empirical contributions of others, and to present my own *grounded* theory on what constructions of older people tell us about the social order (Jaworksi & Coupland, 1999a).

The three sections immediately following this introduction discuss the original contributions of this research. The first section discusses the constructions of older people and their care and what these signify at an abstract level, in other words, *what* was accomplished in the official discourses related to older persons and their care. The second section burrows deeper into structures and processes to elucidate *how* this was accomplished, identifying the mechanisms that effectuated a vulnerability discourse around older people in the first year or so of the coronavirus pandemic. Finally, highlighting the most substantial of this research's original contributions, the third section theorises *why* it was necessary for older adults to be construed in the ways that they were in the official discourses, which, as I contend, had more to do with institutional vulnerabilities of the state than with the vulnerability of any individual or group. The fourth section reflects on limitations of the present study and possible avenues for future research. The fifth and final section of the chapter is devoted to brief concluding remarks.

7.3 What the discourses 'accomplished' – The building blocks underpinning constructions of older adults as a 'vulnerable group'

7.3.1 Locating vulnerability within the ageing body

The strongest conceptual category to emerge from the data is the construction of older people as a vulnerable group, with specific underpinnings to that vulnerability that draw on longstanding tropes of ageing. As we learned from the literature reviewed, 'vulnerability' is itself a complex term and can have many different meanings. In the official discourses analysed here, older people's vulnerability was consistently represented as *individual* vulnerability to the risks posed to one's *physical* health by the coronavirus. More pointedly, older people's risk of death and the preservation of life at seemingly any cost to *quality* of life was consistently expressed as the primary concern. This distinctly biomedical conception of vulnerability effectively sidelined a biopsychosocial model and understanding of health and ageing. In the process, it betrayed how readily more critical perspectives on health, ageing, and older people are relegated to the sidelines in a crisis to allow a

biomedical model, with its specific and inbuilt power differentials, to (re)gain ascendency. At the same time, the discourses woven by official actors failed to consider the very real vulnerability of some older people—and indeed the resilience of others—generated by the effects of the expert-recommended and government-imposed pandemic measures, particularly the enforced lockdown of residential care home residents and staff, and the self-isolation or 'cocooning' guidelines issued to all persons over the age of 70 living in the community.

Not only is the construction of vulnerability in the discourses focussed squarely on the risk of *physical* harm to older people from the virus, it locates the vulnerability within the bodies of older people themselves, within *all* older bodies. In doing so, firstly, it problematises and pathologises older bodies for not conforming to the norms of physical health and ableness represented by the youthful body. This construction of vulnerability ignores the enormous variation characterising individual health status at every age and stage of the life course, including but certainly not limited to people over the age of 60, 65, or 70, or however 'old age' is defined (another social construction). Identifying vulnerability as it does in the individual physiology of the older person, it also neglects intersecting inequalities in the *social determinants* of individual health over the life course, including social networks and resources, financial resources, access to health and social care, among others. The heterogeneity and diversity of the older population—indeed of all 'populations'—is just one of at least two key critiques of the vulnerability discourse, however. The second is that old age—even and perhaps *especially* very old age—physical frailty, cognitive impairment, and a dependence on others for care and support does not obviate a person's agency and relational autonomy and must not be used to justify the disregard of same.

Perhaps most critically and consequentially for my analysis, the dominant discourse persisted in constructing older people's vulnerability as an individual trait in lieu of acknowledging systemic inequalities, in lieu of recognising that older people are *made* vulnerable by structural conditions, that their vulnerability is situational, and in some ways, pathogenic, or *caused* by the very same policies enacted ostensibly for their protection. Again, I should note that I am not making a normative judgement about the level of risk the virus itself posed to people in a certain age group. What I am trying to underline is the absence among powerful actors in the discourses of any meaningful reflection as to the multiple causes of risk of harm to older persons during the pandemic. Not to speak of any meaningful *action* in that regard. Older people were made doubly vulnerable during the pandemic. Varying degrees of individual vulnerability to the illness caused by the virus was compounded by new and old situational, pathogenic vulnerabilities produced by pre-pandemic and pandemic government policy.

7.3.2 The portrayal of the virus as agent in creating older people's vulnerability

Instead, the risk of harm was consistently portrayed as a biomedical risk emanating from the biological entity of the virus and the virus alone. The virus 'preyed' on ageing, frail, bodies, and again the potential harm was to older people's physical health alone—specifically their loss of life—not to their mental health, cognitive health, or wellbeing in any broader sense. In fact, research suggests that some older people experienced a deterioration in their physical health during the pandemic due to the multifactorial and difficult-to-untangle effects of being locked down, isolated, and of losing access to informal supports and formal health and social care (Bailey et al., 2021). When quality of life was discussed, it was secondary to concerns of life and death, and was portrayed as an unfortunate by-product of the preservation and protection of life at all costs. In a few instances, such as in the testimonies of Mervyn Taylor of Sage Advocacy (Houses of the Oireachtas Special Committee; May 26, 2020; June 18, 2020), an alternative discourse is discernible, one in which the oversimplified binary of life and death is fractured and the life of older persons, of every person, in all its social, relational complexity is briefly reclaimed.

The laser focus of official actors and the experts nominated to NPHET and its various subgroups—perhaps none more than the Irish Epidemiological Modelling Group (IEMAG), the last of the subgroups to be stood down—on mitigating *deaths* caused by the coronavirus was encouraged by and simultaneously reinforced an overwhelming concern with data, with 'numbers' and 'number crunching' and with countable, measurable units. The daily, weekly, collection, analysis, and online publication of epidemiological data was constructed as a planning tool for governments, and as a way for regular people to keep abreast of the latest information. Counting 'deaths' is a terribly simple way to measure a country's success—and implicitly the elected government's success—in 'fighting' the virus. Not only are deaths relatively easy to count, but they also carry a profound weight in the public imagination. Governments and government actors have a strong incentive to minimize the number of deaths in the name of blame avoidance and credit claiming. However, as discussed above, the focus on preventing death came at the cost of broader health considerations. Deaths are a blunt measure to pin the success of policy on and the fact that the government's policy related to older persons centred around this one measure of 'success' meant that longer-term and broader criteria for policymaking success were largely ignored. The focus on counting deaths also allowed for international comparisons of cases, mortalities, which led to countries alternately being ranked as 'the best', 'the worst', with undeniable political and reputational implications for governments at home and abroad. I would argue that it was also a mechanism to 'crisis' signal, to inure people to the terms and conditions of the pandemic situation and to the government's chosen response.

According to a recent OECD report, cancer surgeries fell by 30 percent in the first waves of the pandemic as a result of the disruption in health services in Ireland (OECD, 2023). In addition, the number of hip replacements fell by 19 percent in 2020 compared to the previous year, knee

replacements dropped by 29 percent and cataract operations by 37 percent (OECD, 2023). After the height of the pandemic, there has been considerable consternation about a surge in the mortality rate in the country, leading some observers to speculate that pandemic measures may be at least partially to blame: "Ireland experienced relatively low excess deaths during the height of the pandemic as the country locked down for long periods. Now, we may be reaping the whirlwind of all those missed medical appointments and lack of exercise. We are certainly running above average in the international rankings" (Cullen, 2023).

The virus itself was constructed as a highly active agent, throughout the discourses but especially prior to the arrival of the vaccine. The virus was consistently portrayed as the ultimate catalyst and causative mechanism for the decisions taken by official actors and for the overall direction and urgency of the official response. According to this construction, the virus dictated the government's course of action, conveniently absolving decision-making actors from accountability for errors in judgement, miscalculations, and missteps. If the ageing body was represented as vulnerable to the virus, then the virus was portrayed—again, before the development and deployment of the vaccines—as invulnerable, indestructible, inscrutable, and acting independently of the actions of other actors. Again, imbuing the virus with such power—it is cunning and unpredictable and has the capability to run circles around even the most capable government actors and institutions—makes it a useful blame-avoidance device. Countless times in the discourses, as presented in the findings, government representatives justified perceived errors in pandemic policy on the cunning and changeability of the virus.

In the course of reading hundreds of documents, I did not come across a single instance of a senior public official demonstrating accountability for decisions taken that later came under criticism. Blame was repeatedly shifted to the virus, or to other agencies, who in turn, when called to testify, would blame circumstances beyond their control—circumstances dictated by the virus. Nowhere is this more evident than in the discourses leading up to Christmas 2020 and its aftermath, extending into the first months of 2021. Against the advice of its own NPHET experts, the government suddenly eased restrictions, ushering in the single most disastrous period of deaths experienced in Ireland to date. The government's rationale for lifting restrictions at the time was three-fold: the virus was 'under control', having been suppressed over the course of an almost full year of total or near-total lockdown; the country deserved a 'meaningful Christmas', a joyful event in the midst of the darkness caused by the virus; and the prospect of the vaccine as 'saviour' on the horizon, salvation delivered by science. An added, underlying consideration was undoubtedly the governing coalition's concerns over its own political viability in the eyes of an increasingly disgruntled public in lockdown.

Thus, the virus serves as a double agent—it can be used to justify severe measures and absolve human actors from blame, recalling an almost God-like figure. Collectively, guided by the leadership of

those in government, society could only aspire to mitigate, to suppress, to isolate the virus until the arrival of the vaccine—itself a powerful agent discursively drawn, and brought in to being through scientific knowledge and expertise, once again underlining the supremacy of science and its 'expert' practitioners in the discourses.

7.3.3 The shifting sands of 'vulnerability'

Older people are consistently portrayed as one of the *most* vulnerable groups in society, in need of the *greatest* level of protection. Yet there is an explicit acknowledgement early in the nascent discourses—which later becomes more tacit—that *all* individuals, all bodies, are vulnerable to the potential harms posed by the virus. If we think back to the two main conceptions of vulnerability discussed in the review of the literature (*Chapter 2: Literature review*), on the one hand, Fineman (2008), among others, promotes a universal or ontological model of vulnerability. Universal vulnerability is rooted in the idea that every person, by virtue of being embodied (i.e., having a physical, material body exposes one to a range of harms, including physical injury, exploitation, and harms to interest) and existing in the world, is inherently vulnerable. This conception is born out of Fineman's feminist critique of what she views as the capitalist ideal of the rational (male), autonomous individual who depends only on himself and is invulnerable. Within this version of vulnerability, however, Fineman is quick to recognise that in practice, certain people, given their circumstances, their position, and stage of life, are likely to be more vulnerable than others at various points over the course of their lives and should thus be entitled to protections and supports by the state.

The universal vulnerability model has been critiqued by other scholars for not going far enough, for not being explicit enough about the inherent *relationality* of vulnerability as a concept and its fundamental situated-ness in social relations (see for example, Rogers et al., 2012b; Straehle, 2017). For scholars in this second camp, ontological vulnerability is something of a given, a baseline. It does not, however, adequately address the reality that people are *made* more vulnerable (and less vulnerable) in their interactions with others and with systems of power and oppression. Ontological vulnerability does not take sufficiently into account the central importance that structural conditions and processes play in rendering people belonging to certain identity categories vulnerable, and by association 'weak' and 'dependent', in turn challenging their agency and autonomy. More generously, it allows too much to go unsaid in this regard. The socially situated, *relational* aspect of vulnerability is the key here. Social relations and collective social action simultaneously constitute (*makes-up*) and are constitutive of (*produce*) social life, including living with and being assigned vulnerability (Foucault, 1972; Prior, 1997; Clarke, 2005).

The relevance of these debates within the theoretical literature for understanding the shifting discourses around vulnerability in the official texts is clear. At the start of the pandemic, when the

virus was an unknown quantity, everyone was considered vulnerable. This is evidenced by Varadkar's early speeches (see Appendix D, Documents 1 & 2), the minutes of NPHET's early meetings in which risks to the population were first considered, and the notable omission of and lack of engagement with representatives from the private/voluntary nursing home sector. It was only later, once certain cogs in the institutional gears of state were set in motion that specific groups—older people but also people with pre-existing/chronic conditions, people experiencing homelessness, people living in direct provision, children in care, and others (recall the list of 'vulnerable groups' drafted by the NPHET Vulnerable People Subgroup; March 10, 2020)—were identified as especially vulnerable and assigned a special category. By 'cogs', I am referring to entities positioned to produce dominating discourses for the coronavirus era, first and foremost, the establishment by the Minister for Health of the expert advisory group NPHET, which would operate with *de facto* decision-making power during the first lockdowns, the selection of experts with specific profiles of expertise to serve on that body, and the legislative derogation of civil rights and empowerment of the Minister for Health to enact pandemic measures, without, arguably, adequate or frequent enough parliamentary checks on that power.

Where initially little was known about the virus and all members of the population were perceived to be vulnerable, once the potential risks posed by the virus-as-agent to society—and to the health system—became clearer and were assessed according to a narrow, biomedical interpretation of public health, the state quickly stepped in to manage the perceived risk through the deployment of particular sets of expertise. The organs of state jumped into action, using a range of tools at its disposal to manage the risk, as interpreted by select experts and officials. People were sorted and labelled according to entrenched values and ideological frameworks, a normative stamp of 'vulnerability' was imposed on certain individuals, online data dashboards to monitor the virus and the population were created and updated regularly and often, ostensibly to signal transparency, to enable the public to stay informed alongside the 'experts', and to justify actions taken and measures passed. While the messaging by official actors ignored the role that pre-existing structural conditions and policy decisions had played (prior to the pandemic) and continued to play in creating vulnerabilities among members of the population, the discourses revealed that the vulnerability that government actors were primarily concerned with was the vulnerability of state institutions and care infrastructures, and crucially, their own political survival.

It is notable that older people's vulnerability was constructed differently depending on the type of text. In messages to the public, most prominently in the Taoisigh's speeches (for a selection, see Appendix D), older people are repeatedly constructed as 'treasures', as 'precious' members of society in need of protection. The goal underlying these texts is clearly to induce the public to moderate its behaviour in order to prevent the spread of the virus and prevent deaths among the older population. This inducement is achieved by humanising older people, by leaning on their role as family members

and members of the community, even if in a paternalistic fashion that affords them little agency of their own. By contrast, in the administrative and 'scientific' texts that travelled between officials, those drafted by various expert groups and government agencies, older people are regularly dehumanised, reduced to statistics, to symptomatic or asymptomatic, infected or healthy bodies, patients and residents in various care settings. These different representations of older people and their vulnerability reveal not only that constructions of older people and of older people's vulnerability serve a political purpose, which should be obvious. More critically, they reveal that in the ontologies of biomedicine, epidemiology, of data science—the disciplines from which the experts guiding the government's response mostly hailed—there is no accommodation for human vulnerability *and* autonomy, for vulnerability *and* agency.

7.4 The 'How' and the 'Why' – Mechanisms propping up systems of power

Initially, as the pandemic measures were first being announced and rolled out, I found it difficult to reconcile official actors' expressions of concerns for older people with the dismal state of the health and social care system. It was only when I started thinking more deeply about the roots of this paternalism that I began to understand.

7.4.1 The government's response to the pandemic vis-à-vis older persons - Reverting to type or never having changed?

When the pandemic reached Ireland, the government's instinct was to behave as a 'total institution' might, in Goffman's telling (1961). That is not to say that other countries did not embrace certain features of total institutions in their response to the pandemic as well. Relying on recommendations developed by public health experts at the supranational World Health Organisation level, many countries implemented some form of emergency measures, locking down hard and fast to control the population and manage an unpredictable situation. But Ireland's lockdowns were among the most stringent and sustained of the Western democracies and decision-making was decidedly undemocratic as several non-governmental analysts have pointed out (Ansbro et al., 2021; Casey et al., 2021; Köppe & Cazaciuc, 2021). The pandemic response was led by select biomedical, public health experts and technocrats, with a mandate conferred and overseen by the executive branch of government, in the first order by the Taoiseach and his Special Cabinet Committee. Work by Finnish scholar Rainio-Niemi and colleagues (2022) points to an inverse relationship between the strength of democratic institutions in European welfare states and the stringency of pandemic measures. This does not mean that Ireland's approach to managing the virus was taken consciously or with any intended malevolence by those in positions of power in the government. Instead, it suggests that the course taken, the deployment of institutional actors and agencies in the way that they were deployed, exposes a reflex deeply embedded in Ireland's state institutions, in its structures and processes.

As recently as the 1990s, the state endorsed the total institutions known as the Magdalen Laundries or Asylums, and Mother and Baby Homes, to control—and yes, to discipline and punish—women and girls who deviated from social norms of womanhood, motherhood, marriage, and family (Mother and Baby Homes Commission of Investigation, 2020; Foucault, 1977). A less extreme parallel can be found in the institutional model of the nursing home that persists to this day in Ireland. While most other developed, high-income countries have cottoned on to a need, a preference, for a broader range of residential care and support options for older persons—for example, assisted living communities, small group homes—not to speak of home care services and respite services to enable people to remain at home for longer—the vast majority of Ireland's residential care homes (public and private/voluntary) still adhere to the traditional, nursing home model. Only recently has there been a significant push to remodel outdated facilities and develop new ones with majority single-occupancy rooms, citing the principle that, "a nursing home should be seen as a resident's 'home' and not an 'institution'" (Covid-19 Nursing Homes Expert Panel, 2020: 90). In reality, however, infection control and the 'continued protection' of residents seems to be driving this reform as much if not more so than the vision of remaking residential institutions into 'homes' (Covid-19 Nursing Homes Expert Panel, 2020).

Ireland is not a welfare state in the post-war European tradition and its categorisation as a liberal regime in the mould of the UK and the US is complicated by, among other idiosyncrasies, the significant power wielded historically by the Catholic Church in nearly every facet of the country's social and political life. Catholic social teaching and ideology heavily informed the country's social norms and the fledgling political institutions of post-independence and post-civil war Ireland, and these in turn reinforced each other. Social and cultural norms have shifted dramatically in Irish society in recent decades, not least in the wake of sexual abuse scandals engulfing the Church from the mid-1980s on, which hit painfully close to home. Despite meaningful social change in some areas, the state's institutions, the balance of power within its governance structures, the dominance of certain corporatist interests, including the medical lobby, and a political culture which eschews transparency and accountability have been slower to change (Daly & Edwards, 2022). Despite significant legislative achievements in recent years, notably in the areas of same-sex marriage[31] and women's reproductive rights[32], the country's constitution *still* includes an article affirming women's 'natural' 'place in the home'[33]. While the latter is widely considered an artefact of another time,

[31] *The Marriage Act 2015* was signed into law on October 29, 2015, removing the impediment to marriage for same sex couples. Source: https://www.oireachtas.ie/en/bills/bill/2015/78/

[32] *The Health (Regulation of Termination of Pregnancy) Act 2018* was signed into law on December 20, 2018, enshrining the right to abortion services in the constitution. Source: https://www.oireachtas.ie/en/bills/bill/2018/105/

[33] *Article 41.2* of Ireland's Constitution states: "1. In particular, the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved. 2. The State shall, therefore, endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home." Source: https://www.irishstatutebook.ie/eli/cons/en/html#article41

safely in the past, the gender inequalities engendered by this view of women's role in society, intersecting with other social inequalities, are felt to this day in—among other areas—the disproportionate burden shouldered by women as main informal providers of all forms of care. Despite the perception internationally that the country has made strides towards being a socially progressive society, Ireland's social and economic policies in the past half decade have perpetuated stark social inequalities, with successive governments overseeing a years-long housing crisis and care crises across multiple sectors—health care, social care, childcare—that the coronavirus pandemic has only exacerbated.

The legacy of the state's adherence to the Catholic social teaching of subsidiarity, according to which families, local communities, and 'subordinate organisations' are responsible in the first order for caring for sick, poor, and ageing members, with the state stepping in only as a last port of call, continues to loom large in the organisation and delivery of welfare services (Fahey, 1998). Perhaps nowhere is this more evident than in the health and social care sectors. Going back decades, efforts to reform the country's systems of care have repeatedly been stymied (O'Shea & Hughes, 1994; Mercer Report, 2002). This has occurred for a variety of reasons, including but not limited to entrenched interests of the medical lobby opposing certain aspects of proposed reforms, and the broader economic policy of austerity in the wake of the 2008 financial crisis, which affected all areas of public welfare spending, and which has led to ever-increasing privatisation in the health and social care sectors since (Burke et al., 2014; Malone & Millar, 2020). The government's pandemic era emergency measures in the acute sector in particular have led to cautious optimism among some analysts that gains towards a more integrated, universalistic system will continue apace, yet some of these same scholars recognise that without the urgency and momentum supplied by the coronavirus pandemic, implementation of proposed reforms continues to be a sticking point (Parker et al., 2023; Burke et al., 2021; Thomas et al. 2021). Considerably less analysis has been offered on developments specifically in the area of social care.

While many interrelated factors are at work in creating Ireland's care situation, it is hard to dismiss the enduring legacy of the subsidiarity principle in defining the (limits of the) state as social care provider. Dating back at least to the Catholic Primate of Ireland John Charles McQuaid's involvement in the drafting of the Republic's Constitution, the state has only too closely embraced subsidiarity, refraining from interfering in what individuals and families can "achieve on their own initiative," and largely letting "subordinate groups handle matters and concerns of lesser importance" (Pius XI, 1931: Art. 80). While the direct influence of the Catholic Church might have faded away in twenty-first century Ireland, within the social care sector, its imprint is evident in the weakness of the state as a provider or even organiser of care services. Social care remains, it would seem, a concern of "lesser importance".

The vast majority of nursing home care providers are non-state agencies, many run by Catholic religious orders, and increasing numbers are private companies. It is worth recalling that more than 80 percent of the nursing homes in the state are privately owned and operated (COVID-19 Nursing Homes Expert Panel; August 19, 2020). While the state has implemented some limited mechanisms to regulate private residential care providers through its regulatory body, HIQA, in an effort to guarantee at least a baseline of quality, home care services continue unregulated, operating with virtually no public oversight. The pandemic underlined just how limited HIQA's authority is over the private nursing home sector (COVID-19 Nursing Homes Expert Panel; August 19, 2020; HIQA; July 21, 2020). The sector's poor performance in terms of infection control and preparedness in the early stages of the pandemic led the COVID-19 Nursing Homes Expert Panel (August 19, 2020) to conclude that HIQA is not empowered to do much more than monitor and provide recommendations. In essence, the Irish state continues to position itself at a remove to the provision and organisation of social care for older adults, continuing to rely on families and on the private/voluntary sector to provide care.

The government's reaction to the pandemic in the area of social care and care for older persons in particular is a display of remarkable continuity. Yes, the political discourse around care has changed in recent years, as evidenced by the countless position papers, policy papers, and government-commissioned studies leading up to and trailing the passage of Sláintecare. Public funding for social care, including home care, has increased, with more 'hours' of home care funded in the 2021 Budget than in previous years, though critics argue that the increase is insufficient to keep up with demand (Social Justice Ireland, 2020). 'Person-centred care', 'wellbeing', 'community first', 'independent living', for older people and other concepts from the field of human rights and from a biopsychosocial model of care have become policy buzzwords. Yet the fundamental structures and processes underlying the governance and delivery of care, and the dominant actors embedded in those structures and processes have only marginally changed, as evidenced by which voices were most powerful in the discourses, and which were largely absent. The coronavirus serves as something of a heuristic device, highlighting how quickly more critical discourses around care receded, and how seamlessly the medical-institutional model slipped into ascendancy. The state's historical detachment as provider of care services was on full display, revealed through the vulnerability of its care infrastructure to the effects of the virus.

7.4.2 A multifaceted assault on older people's autonomy and agency

In the official discourses emerging during the pandemic, the actors and actants with greatest agency were those government actors with decision-making authority, the experts selected to advise them, and the virus itself. Designated a 'vulnerable' group from almost the beginning, older people's agency was limited by official actors seeking to guard against the virus's attacks on vulnerable state institutions, notably its health and social care institutions, and derivatively, on the government's own

political power and survival. The construction of older people as a vulnerable group in need of the state's protection and intervention, reinforced by a series of other devices discernible in the discourses, constituted a significant challenge to older people's agency and autonomy.

Fricker's (2007) theory of epistemic injustice shows us how the agency of older persons is impaired by way of testimonial and hermeneutical injustices levied against them by questioning their credibility as knowers and excluding them from the space in which knowledge-making is taking place (Fricker, 2007). By treating older people as an epistemic 'other', their agency is only partially recognised. Testimonial injustice, in which older people's credibility as knowers/speakers is questioned, was achieved in the discourses by marginalising older people's experiences and voices and that of their family members and advocacy groups. Older people were similarly exposed to hermeneutical injustices in that their ability to understand or express some important aspect of their own experience was impaired due to a gap in the shared tools of social interpretation. In giving primacy to the epistemologies of 'science' and scientific expertise, to 'data' as objective evidence, to medical professionals and epidemiologists and to a very narrow understanding of public health that excluded social aspects of health, older persons and their advocates were excluded as knowers from the arena. Citing Fricker, Valkenburg (2022) argues that a person's agency and political freedom is impaired by epistemic injustices, "Such freedom requires the ability to contest domination, which is impossible if one either lacks access to the arena where contestation is possible, or is deprived of the intellectual tools to do so. Thus, the potential of knowledge to defuse power can become compromised: both the construction and the abolition of power through knowledge are in themselves acts of power" (Valkenburg, 2022: 441). No social workers, social gerontologists, or representatives of older people themselves had a place at the decision-making table in order to enable them to contest the dominant discourses.

Perhaps the most obvious way in which older people's autonomy and agency were challenged was in the control of their physical bodies. This control over older people's material selves was powerfully expressed in the discourses, with the constructions of older people as 'bodies' and 'patients' and 'cases' being shuttled between institutional settings and under the authority of various responsible agencies. Reducing older persons to their physical bodies, as vectors for infection and disease, in separating them from other population groups, in 'grey-washing' the diversity and multiple identity categories that exists among this 'group', notably gender, socio-economic status, and health status among others, and singling them out for their special vulnerability, the official discourses and the agentic actors that dominated them succeeded in dehumanising and de-agentifying members of the older population. Instead of being represented as autonomous and agentic individuals, they were primarily acted upon in a clear exercise of biopower.

The use of temporality as a discursive tool, what Wigen and colleagues refer to as 'temporal technologies', was also wielded by powerful actors in the discourses and challenged older people's autonomy and agency. The construction of the pandemic as a 'crisis' (White, 2021) and the 'urgency' of action repeatedly called for by government officials, both explicitly and implicitly (in the proceedings of meetings marked frequently by a 'running out of time', for example), dictated a collective experience of pandemic time. And for those not in a position to participate discursively in the construction of the pandemic's temporality, as older people were not able to do, a de-synchronization and disorientation occurred, an experience of having to adjust one's experience of daily life to a temporal framework created by others with greater agency and power (Fuchs, 2013). In constructing the pandemic as a crisis, as an emergency, which demanded an urgent response, older people were shut out of 'the arena where contestation is possible' in both a spatial and temporal sense. Importantly, temporal technologies were also wielded discursively in the avoidance by official actors of accountability and transparency, by largely denying critical voices time and access to the testimonial arena to critical voices.

7.5 Moving beyond 'lessons learned': The need for critical analysis of assumptions and norms underlying state's care policies

Much of the research on how governments have responded to the pandemic has sought to generate 'lessons' for future policymaking, to highlight good practices that should be upheld, and to underline missteps to be avoided going forward. Learning from experience and learning from mistakes is certainly something to aspire to in life, just as it can be a valuable tool in successful policymaking. When it comes to Ireland's health and social care policies, however, and specifically its policies for older adults with care and support needs, this rhetoric has been trotted out so often that it is tinged with not a small amount of irony. For over thirty years, certain factions, from the political sphere to civil society, have pushed for a more equitable and a more humane care system, geared towards people's needs rather than operating at the discretion of the election cycle and what is politically expedient. Some progress has been made, but as the pandemic has made very clear, a public system operating in 'normal' times at full capacity, with significant shortages in every dimension of care service provision, and a private system running in parallel and accessible only to those with financial means, is not indicative of meaningful reforms having been achieved. Instead of banking lists of 'lessons' and filing them away for the next pandemic, for the next external threat, the best preparation would be to implement the much-needed Sláintecare reforms, to build a care system that is fit for purpose. An extensive body of evidence has been amassed in the last decades and is at the disposal of those in government. Reforming the system is a matter of political will and no longer a matter of needing more information or more research. One important contribution of this thesis, its main implication for policy, if you will, has been to highlight what has been reiterated in countless policy reports and analyses, and to suggest that the focus on repeated policy analysis is misplaced. Yes,

public investment in home care and support infrastructure is needed, and yes, improving working conditions for care workers and professionalising the workforce is needed, instead of relying on family members and other informal carers, for whom providing care is often not much of a choice. And yes, alternatives to nursing home care should be made available to people who opt for residential care. The list goes on, and is well documented, as are proposals for putting them in place. Instead, what is truly needed, is for government to disrupt the moral assumptions underlying the subsidiarity model which have shaped the country's care system.

FitzGerald (2020) argues that the social sciences should carry out 'normative policy analyses', or policy analyses that evaluate policy in reference to basic values or ethical principles. As she writes, "the identification of problems, the definition of well-being, and the decision that well-being should be promoted, all of which form the basis of policy development, are themselves normative judgments, based on a certain set of ethical standards. Further, once problems are identified and solutions suggested, the implementation of policy has a normative dimension: to implement one policy is to assert that it is better than another, and such an assertion must also be based on a particular set of ethical values" (FitzGerald, 2020: 253). In a world in which 'evidence-based policy' is *de rigueur*, the fact that public policy is based on normative judgements is often forgotten or ignored, with the discourse being that decisions are taken based on objective truths about economic and social phenomena. But as FitzGerald states, "such appearances of objective economic and policy development are false; these processes always-already involve questions of morality and make ethical assumptions" (2020: 253). The sooner we adjust our thinking and our critique of social policy, specifically about how we care for older people, the sooner we can move past the gridlock and discuss the *values* underpinning policies and what needs to be done to achieve the systems of care that reflect people's needs and preferences. We cannot ignore that this is a moral and ideological question.

7.6 Limitations of the study and avenues for future research

This research has a number of limitations that warrant mention. Firstly, in terms of its scope, the focus on the official discourses has meant that other discourses, such as those emanating from the public domain, from news media and social media, from civil society, have not been considered. The *official* discourses clearly demonstrate the absence of older people's voices and experiences, and it would be of great value to bring these different discourses into conversation with each other in future research. Given the time constraints on this doctoral research, it was not possible to include broader discourses in the analysis here. Similarly, time constraints meant that the data collection period was limited to the first fifteen months of the pandemic. While this was a critical period in terms of pandemic decision-making related to older adults and their care, it is possible and indeed likely that new insights could be gleaned from following the discourses into the next, less acute phase of the pandemic, to investigate how the construction of older persons may have shifted or remained

constant. Despite the fact that people continue to contract coronavirus, that outbreaks continue to occur, foremost in hospitals and nursing homes, and that older people continue to be disproportionately affected, the pandemic no longer dominates official discourses as it once did, and the laser focus on health and social care, and on residential care in the country's nursing homes, has dissipated. That said, at the time of this writing, the government, under pressure from a broad coalition of stakeholders is 'quietly' agreeing the terms for a public inquiry into the overall pandemic response. An investigation of how older people have been constructed in these more recent discourses, would be of value.

While this study focussed on constructions of older persons and the significance these hold in the Irish context, a great deal could be learned in the future by considering other groups portrayed as vulnerable in pandemic discourses. These include people working in meatpacking factories, people experiencing homelessness, people in prisons, asylum seekers in direct provision centres, people with disabilities, and so on. What might similarities and differences in how these diverse populations were constructed during the pandemic tell us about assumptions underlying the country's broader social welfare system? It would also be interesting to juxtapose the portrayals of the old and the young, and to study what these might mean for intergenerational relations in Irish society. Despite the supposed lack of vulnerability of younger age groups, particularly very young children, they were made vulnerable in significant other ways by the government's one-disease public health focus, most obviously in the massive disruption of their education. Lastly, this research has analysed the official discourses in Ireland exclusively, again, a decision taken due to time constraints. There is much to be gained from a comparative perspective, and it would be interesting and of value to be able to compare how older people and their care were constructed in other countries, thereby gaining an understanding of the extent to which differing social, cultural and political norms, different social policies, structures and processes, and different historical contexts, create parallel and diverging discourses to the ones emerging from the Irish context.

7.7 Conclusion

The discourses analysed in the course of this research reveal a construction of older people's vulnerability that is over-simplified, one that problematises ageing bodies and pathologises older individual's care and support needs. The vulnerability discourse that materialises from official government texts is reductive and generalising, fostering the idea of older people as a monolithic group, all frail, all dependent, all lacking agency, and it fails to recognise the vast diversity of this so-called group. Staying close to its roots in a Critical Realist ontology, this study examines the social and political context of the pandemic and of social care in Ireland and engages abductively with relevant theory to ultimately contend that the construction of older people's vulnerability is predicated on the very real institutional vulnerability of the Irish state, specifically its systems of

care. This is a vulnerability more than a century in the making, underpinned by the Catholic principle of subsidiarity, which defines care as the responsibility of the private, family sphere, and the state as a provider of last resort. Despite long-standing calls for reform of Ireland's health and social care sectors, and the discursive construction of the virus/pandemic as a catalyst for meaningful reforms, the analysis suggests that until certain assumptions underlying care and the vulnerability of older people change, and until certain entrenched interests make room for a broader stakeholder group, little is likely to change for the better: older people will continue to be made vulnerable and their agency will continue to be challenged.

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Appendices

Appendix A: Tables and Figures relating to the epidemiology of the coronavirus in Ireland

Table 4. Number of deaths in all COVID-19 cases by sex and age group notified in Ireland between Week 10 2020 (March 1-7, 2020) and Week 11 2021 (March 14-20, 2021)

Age group (years)	Female	Male	Total	Percent
<45 years	24	26	50	1.1
45-54 years	26	48	74	1.6
55-64 years	85	148	233	5.1
65-74 years	247	456	703	15.3
75-84 years	666	892	1,558	34.0
85+ years	1,124	844	1,968	42.9
Unknown	2		2	0.0
Total	2,174	2,414	4,588	100.0
Percent	47.4	52.6		

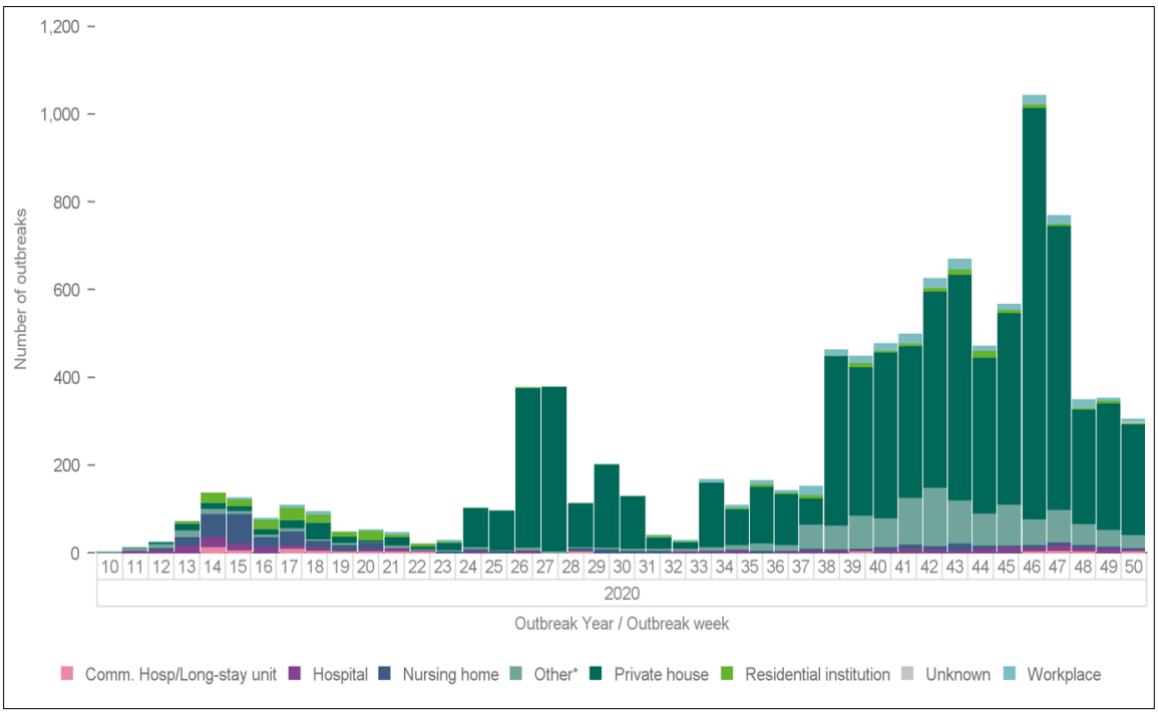
Source: Adapted from Health Protection Surveillance Centre (HSPC) data, as of midnight on March 20, 2021 (HSPC, March 22, 2021a). Data Source: Computerised Infectious Disease Reporting (CIDR) system.

Table 5. Number of clusters/outbreaks COVID-19 by location up to midnight 20/03/2021

Outbreak location	Total
Private house	9,367
Workplace	604
Residential institution	580
Nursing home	578
Extended family	530
Hospital	390
School	351
Community outbreak	288
Childcare facility	242
Other healthcare service	155
Retail outlet	117
Other	93
Travel related	88
Social gathering	84
Restaurant/ Cafe	83
Religious/ Other ceremony	57
Community hospital/Long-stay unit	54
University/ college	43
Public house	35
Sporting activities/ fitness	29
Transport	19
Hotel	16
Personal grooming service	7
Not specified	4
Guest house/ B&B	2
Other recreation activity	1
Unknown	1
Total	13,818

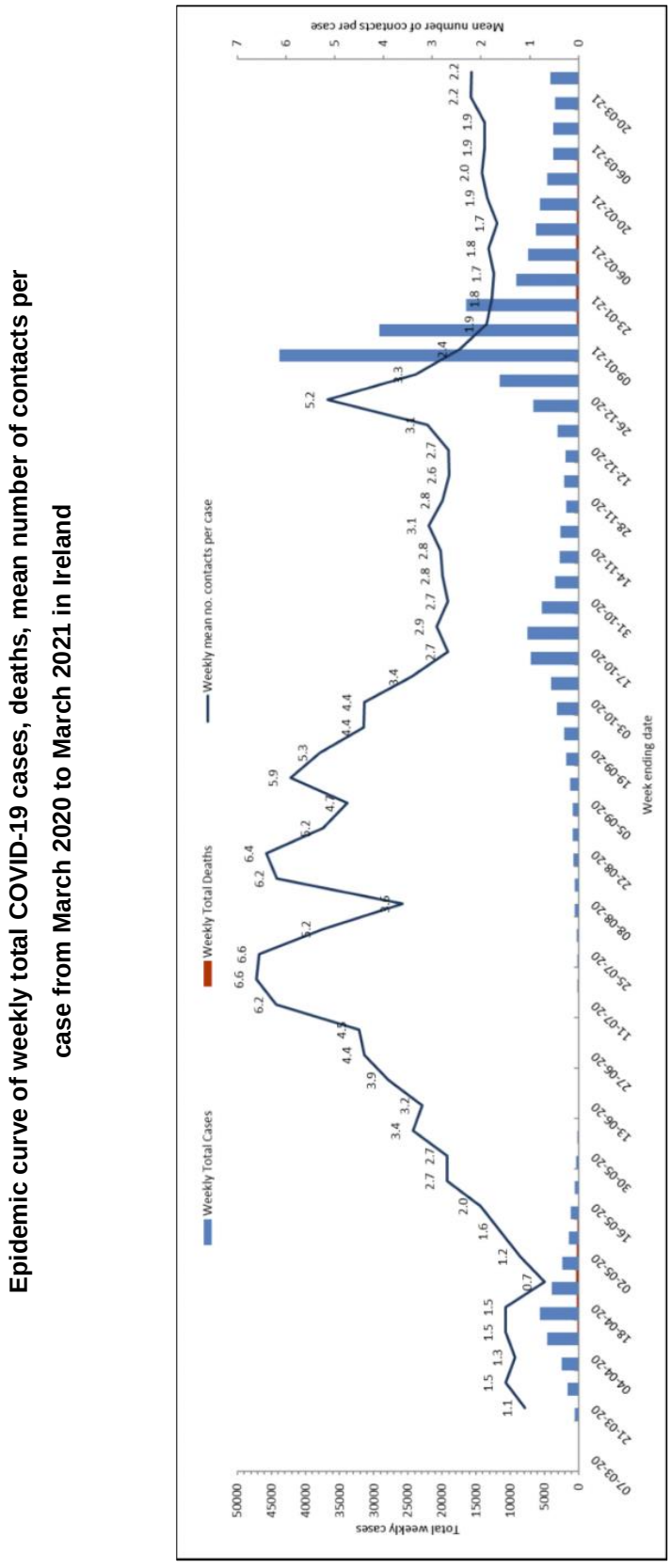
Source: Adapted from Health Protection Surveillance Centre (HPSC) data, as of March 20, 2021 (HSPC, March 22, 2021b). Data source: CIDR

Figure 4. Trend in number of COVID-19 clusters by location and week notified up to midnight 09/12/2020



Source: Figure 5, Health Protection Surveillance Centre (HPSC) data, as of December 9, 2020 (HPSC, December 11, 2020: 10).

Figure 5. Epidemic curve of weekly total COVID-19 cases, deaths, mean number of contacts per case from March 2020 to March 2021 in Ireland



Source: Adapted from Kelly et al. (2022). Figure 1, p. 4.

Table 6. Number and proportion of confirmed cases of COVID-19 notified in Ireland by age-group, hospitalisation, ICU admission and vital status up to midnight 09/12/2020

	0-4 yrs	**5-14 yrs**	**15-24 yrs**	**25-34 yrs**	**35-44 yrs**	**45-54 yrs**	**55-64 yrs**	**65-74 yrs**	**75-84 yrs**	**85+ yrs**	**Unknown**
Number of cases (n)	1997	4937	13077	12614	11791	11338	8026	4323	3771	3293	28
Cases hospitalised (n)	59	52	173	336	425	671	773	980	1191	730	2
Cases hospitalised (%)	2.95	1.05	1.32	2.66	3.60	5.92	9.63	22.67	31.58	22.17	7.14
Cases admitted to ICU (n)	2	4	8	18	57	114	165	183	82	8	0
Cases admitted to ICU (%)	0.10	0.08	0.06	0.14	0.48	1.01	2.06	4.23	2.17	0.24	0
Deaths (n)	0	0	2	6	11	32	83	286	641	800	0
Case fatality ratio (%)	0	0	0.02	0.05	0.09	0.28	1.03	6.62	17.00	24.29	0

Source: Health Protection Surveillance Centre (HPSC) data, as of December 9, 2020 (HSPC, December 11, 2020).

Appendix B: Membership of Ireland's National Public Health Emergency Team (NPHET) and its subgroups

Table 7. Name, position and institutional affiliation of the National Public Health Emergency Team (NPHET) for Covid-19, as of June 26, 2020

Name	Position	Institution
Dr Tony Holohan (Chair)	Chief Medical Officer	DOH
Mr Paul Bolger	Director, Resources Division	DOH
Dr Eibhlin Connolly	Deputy Chief Medical Officer	DOH
Ms Tracey Conroy	A/Sec, Acute Hospitals Division	DOH
Mr Colm Desmond	A/Sec, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division	DOH
Dr Ronan Glynn (acting Chair July 3-Oct 5)	Deputy Chief Medical Officer	DOH
Mr Fergal Goodman	A/Sec, Primary Care Division	DOH
Ms Marita Kinsella	Director, National Patient Safety Office	DOH
Dr Kathleen Mac Lellan	A/Sec, Social Care Division	DOH
Ms Kate O'Flaherty	Head of Health and Wellbeing	DOH
Dr Darina O'Flanagan	Special Advisor to the NPHET	DOH
Dr Siobhan O'Sullivan	Chief Bioethics Officer	DOH
Dr Alan Smith	Deputy Chief Medical Officer	DOH
Ms Deirdre Watters	Head of Communications	DOH
Dr Jeanette Mc Callion	Medical Assessor	Health Products Regulatory Authority (HPRA)
Dr John Cuddihy	Interim Director	Health Protection Surveillance Centre (HPSC)
Mr Phelim Quinn	Chief Executive Officer	HIQA
Dr Máirín Ryan	Deputy Chief Executive and Director of Health Technology Assessment	HIQA
Dr Lorraine Doherty	National Clinical Director for Health Protection	HPSC, HSE
Dr Colm Henry	Chief Clinical Officer	HSE
Dr Kevin Kelleher	Asst. National Director, Public Health	HSE
Mr David Leach	Deputy National Director of Communications	HSE
Mr Tom McGuinness	Asst. National Director, Office of Emergency Planning	HSE
Dr Siobhán Ní Bhrian	Lead for Integrated Care	HSE
Dr Breda Smyth	Director of Public Health Medicine	HSE
Mr David Walsh	National Director, Community Operations	HSE
Mr Liam Woods	National Director, Acute Operations	HSE
Dr Michael Power	National Clinical Lead, Critical Care Programme / Consultant in Anaesthetics, Intensive Care Medicine	HSE / Beaumont Hospital

Dr Mary Favier	President	Irish College of General Practitioners (ICGP)
Prof Philip Nolan	President	National University of Ireland Maynooth
Dr Cillian de Gascun	Director / Consultant Virologist	National Virus Reference Laboratory (NVRL) UCD
Prof Colm Bergin	Consultant Infectious Diseases / Professor of Medicine	St. James's Hospital / Trinity College Dublin

Source: (NPHET; June 26, 2020)

Table 8. Name, position and institutional affiliation of the Expert Advisory Group (EAG) of the National Public Health Emergency Team (NPHET) for Covid-19

Name	**Position**	**Institution**
Dr Cillian de Gascun (Chair)	Director / Consultant Virologist	NVRL
Dr Ronan Glynn	Deputy CMO	DOH
Dr Vida Hamilton	National Clinical Advisor and Group Lead, Acute Hospitals	HSE
Dr Joanne O'Gorman	Consultant Microbiologist	HPSC and Rotunda Hospital
Dr Colman O' Loughlin	Consultant Intensive Care Medicine	Mater Hospital
Dr Gerard O'Connor	Consultant Emergency Medicine	Mater Hospital
Prof Aurelie Fabre	Consultant Pathologist	St Vincent's Hospital
Dr Derval Igoe	Consultant Public Health Medicine	NVRL/HPSC
Dr John Cuddihy	Director	HPSC
Dr Aoife Cotter	Consultant Infectious Diseases	National Isolation Unit
Prof Colm Bergin	Consultant Infectious Diseases	St James's Hospital
Prof Martin Cormican	Consultant Microbiologist, National Clinical Lead	HCAI/AMR
Ms Josephine Galway	Director of Nursing for HCAI/AMR, AMRIC Team	HPSC
Dr Jeanette McCallion		Health Products Regulatory Authority
Dr Jeff Connell	Head of Testing	UCD NVRL
Dr Margaret O' Sullivan	Chair / Consultant Public Health Medicine	National Zoonoses Committee
Mr Robert Glennon (Admin Secretary)		Immunisation Policy Unit DOH
Dr David Hanlon	National Clinical Advisor and Group Lead for Primary Care	HSE
Prof Karina Butler	Chair / Consultant Paediatric ID	National Immunisation Advisory Committee

Source: (NPHET; June 26, 2020).

Table 9. Name, position and institutional affiliation of the Vulnerable People Subgroup of the National Public Health Emergency Team (NPHET) for Covid-19

Name	Position	Institution
Dr Kathleen MacLellan (Chair)	Assistant Secretary, Social Care Division	DOH
Dr John Devlin	The Irish Prison Service	Department of Justice and Equality
Ms Carol Baxter	Assistant Secretary	Department of Justice and Equality
Mr Michael Kirrane	Assistant Secretary	Department of Justice and Equality
Albert O'Donoghue	Principal Officer	Department of Children and Youth Affairs
Mary Hurley	Assistant Secretary	Department of Housing, Planning and Local Government
Eileen Gleeson	Director of the Dublin Region Homeless Executive	Local Government Management Agency
Daltan Tattan	Assistant Secretary	Department of Education and Skills
David Buckley		Department of Defence
Bairbre Nic Aonghusa	Assistant Secretary	Department of Rural and Community Development
Jim Ryan	Head of Operations, Mental Health	Community Operations - Health Service Executive
Dr Margaret Fitzgerald	National Public Health Lead Social inclusion and Vulnerable groups	Public Health Specialist
Sean Moynihan	CEO	ALONE
Brigid Doherty	Public (patient) Representative	
Mary Dunnion	Chief Inspector of Social Services and Director of Regulation	Health Information and Quality Authority
Dr Caitriona Mc Carthy		National Cancer Control Programme
Joan Johnston	Chronic Disease (COPD) Representative	DOH
Berneen Laycock	Chief Nurses Officer	DOH
Sarah Cooney	Principal Officer, Older Persons Projects	DOH
Andy Conlon	Principal Officer, Primary Care	DOH
Celeste O'Callaghan	Principal Officer, Acute Hospitals	DOH
Dave Maguire	Principal Officer, Mental Health Unit	DOH
Clare Lewis	Deputy Chief Nursing Officer	DOH
Louise Carrigan	Accountant, Finance Unit	DOH
Malachy Corcoran	Governance and Performance Division	DOH
Mairead Emerson	Civil Service HR	Department of Public Expenditure and Reform
Klare Havelin	Civil Service HR	Department of Finance
Dr Joanne Mc Carthy	Disability Umbrella Groups Representative	Disability Federation of Ireland

Dr Máirín Ryan	Deputy Chief Executive and Director of Health Technology Assessment	Department of Health/HIQA
Rosemary Smyth	Director Standards & Quality Assurance, Training & Development	Mental Health Commission

Source: (NPHET; June 26, 2020). Available at: https://www.gov.ie/en/publication/de1c30-national-public-health-emergency-team-nphet-for-covid-19-governance-/.

Appendix C: Sittings and membership of select debates of the Houses of Oireachtas Special Committee on Covid-19 Response

Table 10. Debates of the Special Committee on Covid-19 Response, with relevance for older persons and their care

Debate title	**Witnesses**	**Date (2020)**
Briefing by Department of Health Officials; Briefing by HSE Officials	Jim Breslin (Secretary General, DOH), Tony Holohan (Chief Medical Officer, DOH and Chair, NPHET), Paul Reid (CEO, HSE), Anne O'Connor (Testing and Tracing Lead, HSE), Colm Henry (Chief Clinical Officer, HSE).	May 19
Congregated Settings: Nursing Homes and Direct Provision Centres	Tadhg Daly (CEO, Nursing Homes Ireland), Mervyn Taylor (Executive Director, Sage Advocacy), Phelim Quinn (CEO, HIQA), Mary Dunnion (Chief Inspector of Social Services and Director of Regulation, HIQA); David Walsh (National Director of Community Operations, HSE), Sandra Tuohy (Assistant National Director of Older Persons Services, HSE), Siobhan Kennelly (National Clinical Advisory Group Lead Older Persons, HSE).	May 26
World Health Organization: Public Health Advice	David Nabarro (World Health Organization Covid-19 Special Envoy)	June 11
Congregated Settings: Nursing Homes (Resumed)	Jim Breslin (Secretary General, DOH), Kathleen MacLellan (Assistant Secretary, Social Care Division, Dept of Health), Niall Redmond (Principal Officer of Social Care Division, DOH), Paul Reid (CEO, HSE), Colm Henry (Chief Clinical Officer, HSE), David Walsh (National Director of Community Operations, HSE)	June 18
Impact of Covid-19: People with Disabilities; Non-Covid Healthcare Disruption: Waiting Lists and Screening	Frank Conaty (Acting Chief Commissioner, IHREC), Caroline Fennell (Commission Member, IHREC), John Dolan (CEO, Disability Federation of Ireland), Joanne McCarthy (Head of Policy, Research and Advocacy, Disability Federation of Ireland); Enda Egan (CEO, Inclusion Ireland), Mark O'Connor (Community Engagement Manager, Inclusion Ireland).	July 17
Infection Rate Among Healthcare Workers	Catherine Keogh (Assistant General Secretary, Fórsa), Eamon Donnelly (national secretary, health division, Fórsa), John King (deputy general secretary, SIPTU), Michele Monahan (honorary vice president, SIPTU and a frontline worker), and Phil Ní Sheaghdha (general secretary, Irish Nurses and Midwives Organisation), Siobhán Murphy (staff nurse infected by Covid-19, INMO)	July 21
State Response to Recent Spike in Covid-19 Cases	Paul Reid (chief executive officer, HSE), Anne O'Connor (chief operations officer, HSE), Colm Henry (chief clinical officer, HSE), and Niamh O'Beirne (lead for testing and tracing, HSE)	August 26
Legislative Framework Underpinning the State's Response; Covid-19: Human Rights and Civil Liberty Considerations	Gianni Buquicchio (president of the Venice Commission of the Council of Europe), Lord Sumption (retired justice, UK Supreme Court), Maura McNally (chair of the council, Bar of Ireland), Joseph O'Sullivan (chair of the human rights committee, Bar of Ireland), Michele O'Boyle (president, Law Society), Ken Murphy (director general, Law Society), David Kenny (assistant professor, Covid-19 law and human rights observatory of Trinity College	September 9

Examination of HIQA Report on the Impact of Covid-19 on Nursing Homes in Ireland	Phelim Quinn (chief executive officer, HIQA), Mary Dunnion (chief inspector and director of regulation, HIQA), Susan Cliffe (deputy chief inspector for social services, HIQA)	September 10
Final Report of Nursing Homes Expert Panel	Professor Cecily Kelleher (chair, Expert Panel), Professor Cillian Twomey (member, Expert Panel), Brigid Doherty (member, Expert Panel), Kathleen MacLellan (assistant secretary, social care division, Dept of Health), Niall Redmond (principal officer of the social care division, Dept of Health), David Walsh (national director of community operations, HSE), Sandra Tuohy (assistant national director of older persons services, HSE), Siobhan Kennelly (national clinical advisory group lead older persons, HSE).	September 16
Strategic Options for Government Plan to Eliminate Community Transmission	Johan Giesecke (member of the strategic and technical advisory group for infectious hazards with the World Health Organization, former chief epidemiologist of Sweden and former chief scientist with the European Centre for Disease Prevention and Control) from Sweden, Professor Sam McConkey (head of the department of international health and tropical medicine at the Royal College of Surgeons in Ireland, consultant in general medicine and tropical diseases at Beaumont Hospital), Professor Tomás Ryan (associate professor of biochemistry at the Trinity College Institute of Neurosciences), and Professor Kirsten Schaffer (professor of the UCD school of medicine, president of Irish Society of Clinical Microbiologists, consultant in St. Vincent's University Hospital in Dublin)	September 23
Update on Testing and Tracing and Rising Incidence in the State	Paul Reid (chief executive officer, HSE), Anne O'Connor (chief operations officer, HSE), Dr. Colm Henry (chief clinical officer, HSE), Niamh O'Beirne (national lead for testing and tracing, HSE), Dr. John Cuddihy (director, HPSC)	September 29
Minister for Health, CMO, NPHET	Stephen Donnelly (minister for health, Department of Health), Dr. Ronan Glynn (acting chief medical officer, Department of Health), Professor Philip Nolan (NPHET), Dr. Cillian De Gascun (NPHET)	September 30

Source: Information in table is taken from the website of the Houses of the Oireachtas Special Committee for Covid-19 Response. Available at: https://www.oireachtas.ie/en/committees/33/special-committee-on-covid-19-response/debates/

Table 11. Membership of the (Parliamentary) Houses of the Oireachtas Special Committee on the Covid-19 Response, May 7 – September 4, 2020.

Deputy Name	Political Party
Colm Brophy	Fine Gael
Colm Burke	Fine Gael
Mary Butler	Fianna Fáil
Jennifer Carroll MacNeill	Fine Gael
Matt Carthy	Sinn Féin
Michael Collins	Rural Independent Group
David Cullinane	Sinn Féin
Pearse Doherty	Sinn Féin
Stephen Donnelly	Fianna Fáil
Norma Foley	Fianna Fáil
John McGuinness	Fianna Fáil
Michael McNamara (Chair)	Independent
Fergus O'Dowd	Fine Gael
Louise O'Reilly	Sinn Féin
Matt Shanahan	Regional Independent Group
Roisin Shortall	Social Democrats
Brid Smith	Solidarity – People Before Profit
Duncan Smith	Irish Labour Party
Ossian Smyth	Green Party

Source: (Houses of the Oireachtas Special Committee; July 31, 2020). Available at: https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/reports/2020/2020-07-31_interim-report-on-covid-19-in-nursing-homes_en.pdf

Table 12. Membership of the (Parliamentary) Houses of the Oireachtas Special Committee on the Covid-19 Response, September 4 – October 8, 2020.

Deputy Name	Political Party
Colm Brophy	Fine Gael
Colm Burke	Fine Gael
Jennifer Carroll MacNeill	Fine Gael
Matt Carthy	Sinn Féin
Michael Collins	Rural Independent Group
David Cullinane	Sinn Féin
Cormac Devlin	Fianna Fáil
Pearse Doherty	Sinn Féin
Neasa Hourigan	Green Party
Paul McAuliffe	Fianna Fáil
Michael McNamara (Chair)	Independent
Jennifer Murnane O'Connor	Fianna Fáil
Fergus O'Dowd	Fine Gael
Louise O'Reilly	Sinn Féin
Pádraig O'Sullivan	Fianna Fáil
Matt Shanahan	Regional Independent Group
Roisin Shortall	Social Democrats
Brid Smith	Solidarity – People Before Profit
Duncan Smith	Irish Labour Party

Source: (Houses of the Oireachtas Special Committee on Covid-19 Response; October 9, 2020). Available at: https://www.oireachtas.ie/en/committees/33/special-committee-on-covid-19-response/

Appendix D: Select speeches by Ireland's Taoisigh on the coronavirus pandemic

Document 1. Statement by An Taoiseach on measures to tackle Covid-19. March 12, 2020.

"Good morning,

I need to speak to you about Coronavirus and COVID-19.

For the past few weeks, the government and our public services have been focused on the impact of the virus.

In that time, we have taken several important and unprecedented measures to protect public health.

We have been preparing for all eventualities.

Yesterday, the World Health Organisation formally described it as a pandemic and the European Centre for Disease Prevention and Control (ECDC) updated it guidelines advising us all to act early to be effective.

Our own National Public Health Emergency Team met last night and has issued new advice to Government. We are acting on that advice today.

There will be many more cases.

More people will get sick and unfortunately, we must face the tragic reality that some people will die.

The virus is all over the world. It will continue to spread but it can be slowed. Its impact can be reduced making it easier for our health service to cope and giving our scientists more time to develop better testing, treatments and a vaccine.

It is important to remember that the disease effects will be mild for the majority of people especially the young and healthy.

We know that older people and those with chronic diseases are at real risk. We have a duty as a society to protect ourselves and above all to protect others - our parents and grandparents, our family and friends, co-workers and neighbours.

We have not witnessed a pandemic of this nature in living memory. This is unchartered territory.

We said we would take the right actions at the right time.

We have to move now to have the greatest impact.

So, from 6pm today, the following measures are being put in place. They will stay in place until March 29th.

Schools, colleges, and childcare facilities will close from tomorrow. Where possible, teaching will be done online or remotely. Cultural institutions will close.

Our advice is that all indoor mass gatherings of more than 100 people and outdoor mass gatherings of more than 500 people should be cancelled.

Arrangements are being made to ensure that everyone entering Ireland through our ports and airports is fully informed and self-isolates if they develop symptoms.

You should continue to go to work if you can but where possible should work from home. In order to reduce unnecessary face to face interaction in the workplace, break times and working times should be staggered and meetings done remotely or by phone.

Public transport will continue to operate.

The shops will remain open and we have plans to ensure that supply chains will not be interrupted.

We need the public and businesses to take a sensible and level-headed responsible approach.

Restaurants, cafes and other businesses can stay open but should look at ways that they can implement the public health advice on social distancing.

As a general rule, outside of work people should seek to reduce social interactions as much as possible.

You can play your part by hand washing, coughing and sneezing into your elbow, and seeking medical advice if you develop symptoms. This is now more important than ever.

The Cabinet will meet later today.

Opposition party leaders and our counterparts in Northern Ireland and Britain will be briefed.

In the period ahead, the government will deploy all the resources we can muster, human and financial, to tackle this threat head-on. Those resources are extensive but not unlimited.

Healthcare workers have been at the forefront of this crisis since it started. They will be at the frontline of the crisis in the time ahead. We must do all we can to help them, so they can help those who need help the most.

I know that some of this is coming as a real shock and it is going to involve big changes in the way we live our lives.

I know that I am asking people to make enormous sacrifices.

We're doing it for each other.

Together, we can slow the virus in its tracks and push it back.

Acting together, as one nation, we can save many lives.

Our economy will suffer. It will bounce back.

Lost time in school or college will be recovered. In time, our lives will go back to normal.

Above all, we all need to look out for each other.

Ireland is a great nation. And we are great people. We have experienced hardship and struggle before. We have overcome many trials in the past with our determination and our spirit.

We will prevail."

Source: (Department of the Taoiseach; March 12, 2020). Available at: https://www.gov.ie/en/speech/5a280b-statement-by-an-taoiseach-on-measures-to-tackle-covid-19-washington/

Document 2. Speech of the Taoiseach Leo Varadkar TD, Government Buildings, 27 March 2020.

"Good Evening,

Tonight, I want to speak to you about the next stage in our national response to the Coronavirus Emergency.

Before I do so, I want to express my condolences to the families and friends of those who passed away today – one of whom was a health care worker.

I want to thank all of you for continuing to abide by public health advice.

By doing so, you are saving lives and protecting our health service and its staff.

Once again, thank you to everyone who is working as part of this Great National Effort whether at work or working from home.

Our country is rising to this challenge.

I am convinced that we shall prevail.

At the beginning of this emergency, I told you that there would be difficult days ahead.

We knew that the virus would spread in our country, that tragically, many of our citizens would suffer and that some would die.

I also promised that we would do all that we could do to protect the health of our citizens, to prepare our health service, to support our healthcare staff and to try to cushion the blow to the economy, our businesses and your livelihoods.

Today, with cross-party support, the Oireachtas has passed further emergency legislation.

This will help businesses to keep their staff in work, it will increase social welfare payments for people who lose their jobs, as a consequence of the emergency, including the self-employed.

Payments under these new schemes have already commenced.

Rents are frozen. There will be no evictions.

When I spoke to you on St Patrick's Day I said that more actions would be required in the coming weeks to slow the spread of the virus.

Over this month we have seen the numbers of people falling ill increase every day. We have seen loved ones die.

Guided by the expert advice of our Public Health Emergency Team, led by the Chief Medical Officer, we believe that this is now the time for these actions.

I also told you that there would be a calm before the storm.

The aim of every single action that we have taken is to reduce the impact of the storm on our country.

To slow down this virus, to push it back and contain it.

Throughout all of this, the government has acted on the advice of the Chief Medical Officer and the National Public Health Emergency Team - an expert team of public health doctors, virologists and scientists.

Today, they informed the government that:

The number of confirmed cases in Ireland exceed 2,100.

Sadly, the number of deaths is 22.

There is a day on day increase in the number of admissions to intensive care units, and the number has doubled since Monday.

Transmission in the community accounts for more than half of all cases.

There continues to be an increasing number of clusters, many of which are in nursing home and residential care settings.

The government has received further recommendations on the actions that we need to take to protect our people.

These are in addition to all of the existing measures that are already in place.

So, with effect from midnight tonight, for a two-week period until Easter Sunday, 12 April.

Everybody must stay at home in all circumstances, except for the following situations:

- *to travel to and from work, or for purposes of work, only where the work is an essential health, social care or other essential service and cannot be done from home. A list will be provided*
- *to shop for food and household goods or collect a meal*
- *to attend medical appointments and collect medicines and other health products*
- *for vital family reasons, such as providing care to children, elderly or vulnerable people*
- *to take brief individual physical exercise within 2 kilometres of your home, which may include children from your household, as long as you adhere to strict 2 metre physical distancing*
- *for farming purposes, ie food production or care of animals*
- *all public and private gatherings of any number of people outside a single household or living unit are prohibited. The virus might be in your household already – so don't spread it to someone else's*

Sadly, this prohibition includes social family visits that are not for the vital reasons I have already mentioned.

A further range of non-essential shops and services will be closed.

The guidance given earlier in the week, in respect of essential retail outlets will be revised, to reflect this.

Adult community education centres and local community centres will be shut.

All non-essential surgery, health procedures and other non-essential health services will be postponed.

All visits to hospitals, residential healthcare centres, other residential settings and prisons are to cease, with specific exceptions on compassionate grounds.

Shielding, or cocooning, will be introduced for all those over 70 years of age and specified categories of people who are extremely vulnerable to COVID-19. Detailed guidance will be available.

Travel to our offshore islands will be limited to residents of those islands.

Pharmacists will be permitted to dispense medicines outside the current period of validity of the existing prescription in line with the pharmacist's clinical judgement.

All public transport and passenger travel will be restricted only to essential workers and people providing essential services.

Apart from the activities I have listed, there should be no travel outside a 2 kilometre radius from your home for any other reason.

These are radical actions aimed at saving as many lives as possible in the days and weeks ahead. We are not prisoners of fate – we can influence what is going to happen. There is no fate but what we make for ourselves.

As we enter this most intensive phase of restrictive actions, the government's emergency response will be ramped up.

Local emergency response will be led by Local authorities who will bring together all the state agencies, as well as local community groups, charities and volunteers, to ensure that all of our citizens get the help they need at this exceptional time.

Freedom was hard won in our country, and it jars with us, to restrict and limit individual liberties, even temporarily. But freedom is not an abstract concept.

We give it meaning every single day – in the way we live our lives – and in the decisions we take willingly to protect our loved ones.

So I am asking people to give meaning to our freedom and liberty by agreeing to these restrictions. Restricting how we live our lives so that so that others may live.

I am asking us for a time, to forego our personal liberties and freedoms for a greater cause.

Tonight I am appealing to every man, woman and child in our country to make these sacrifices – not out of self-interest but for each other.

To begin each day knowing that every single imposition, every inconvenience, every irritation will save lives and help our health service cope.

The whole world is suffering during this pandemic, and Ireland is no different.

What happens now is up to each one of us.

Show your support to our healthcare staff.

Show your support for everyone who is working in essential services or looking after our vulnerable citizens.

Show that you care for your families and friends.

Stay at home.

Tá an domhain iomlán ag fulaingt agus níl Éireann difriúil.

Is ar gach éinne anois cad a tárlóidh.

Taispéain do chuid tacaíocht d'oibritheorí slántiúil.

Taispéain do chuid tacaíocht don seirbhisí riachtanach agus daoine atá ar lag/chuidiú.

Taispéain do bhféicfidh tú i ndhiadh do chlainn agus do chairde.

Fan abhaile.

Source: (Department of the Taoiseach; March 27, 2020). Available at: https://www.gov.ie/en/speech/f27026-speech-of-an-taoiseach-leo-varadkar-td-government-buildings-27-march/.

Document 3. Speech of An Taoiseach, Micheál Martin. December 22, 2020.

"Good afternoon

On each occasion when I have stood here and outlined the Government's strategy for managing the spread of this disease, I have put it very plainly.

We work to suppress the virus when it is growing and we work to reopen as much of society and economy as possible when it is safe to do so.

We will act quickly and decisively in response to every new development.

The one thing which remains absolutely consistent about this virus is that it is potentially deadly, and if it is left to spread unchecked it will reach the most vulnerable. And they will pay a heavy price.

A fortnight ago, after six weeks of very difficult restrictions, people were given the chance to prepare for Christmas and spend time together. The hospitality trade was reopened in a limited way and intercounty travel was permitted.

It was important for people's mental health and well being that there was some respite from the restrictions that had been in place.

It is also important that people have the chance to celebrate the Christmas period with their loved ones.

Unfortunately, in the last week, we have seen extraordinary growth in the spread of the virus. This is the same pattern that we have seen in the UK and across Europe.

Just this morning, figures suggest that we may now be seeing a daily growth rate of approximately 10%. This is very obviously a source of serious concern, and it is not sustainable.

While we do not yet have firm evidence that the new, more virulent, strain of the Covid virus is in our country, the rate of growth over the last week tells me that the safest and most responsible thing to do is to proceed on the assumption that it is already here.

Every time I have spoken to you, I have made it clear that I believe my first and most important responsibility as Taoiseach, and our first and most important responsibility as a Government, is to protect public health and well being.

We will do whatever it takes to get through this pandemic safely.

For that reason, the Government has agreed this morning to move quickly and meet the renewed threat aggressively and head on.

But before I explain to you what new restrictions will be introduced in the coming days, I want to say something which I feel is very important.

A lot of people will be receiving today's news with a heavy heart. I know that I bring it to you with one,

But, each and every one of us need to remember, that while it may not feel like it, what we have done to date, and what we are doing now is saving lives.

Because of the sacrifices that so many are making, because of the restrictions that we are accepting in our lives, many many people are alive today who would otherwise not be.

As a country and as a community of people working together, we have managed to sustain one of the lowest rates of Covid mortality in all of Europe.

And we want to keep it that way.

That's why, from Christmas Eve, until 12th January 2021 the Government has agreed to return to Level 5 of the Plan for Living with COVID with a number of specific adjustments:

- *Non-essential retail may remain open. However, the retail sector will be requested to defer January sales events.*
- *Gyms, leisure centres and swimming pools may remain open for individual training only.*
- *Hotels may only open for essential non-social and non-tourist purposes, except for guests who already have a booking and are due to check in up to and including St Stephens' Day.*
- *Schools, Early Learning and Childcare Services will remain open.*
- *Higher, further and adult education should remain primarily online.*
- *Non-contact training in pods of up to 15 may take place outdoors.*
- *No matches/events should take place except for professional and elite sports and horse racing and greyhound racing behind closed doors.*

The following transitional arrangements will also apply in respect of the Christmas period:

- *Restaurants and pubs operating as restaurants will close from 3pm on 24th December. Hotels may provide food and bar services to guests only after that point*
- *With regard to social and family gatherings, the current provisions, that is, visits from up to 2 other households, will remain in place up to and including 26th December.*
- *Visits to private homes/gardens will be allowed from one other household up to and including 31st December.*
- *In both cases, for those who are part of a support bubble, the bubble counts as one household.*
- *From 1st January onwards, no visitors are permitted in private homes/gardens, except for essential family reasons such as providing care to children, elderly or vulnerable people, or as part of a support bubble.*
- *Travel outside your county will continue to be permitted up to and including 26th December inclusive. People away from their place of residence after that period will be permitted to return to their place of residence.*
- *Christmas religious services may take place, however religious services will return online after 25th December when places of worship may remain open for private prayer.*

I know that these restrictions will pose huge challenges for some sectors of the economy but I want to reassure them that extra financial supports will be provided.
Yesterday, we marked the winter solstice, and in three days we will celebrate Christmas.

In any year, this is a week of light and hope, but those twin themes have never felt more important, more vital, than they do this year.

And as despondent as any of us might feel with the return of restrictions, it is important to remember that the hope is real.

There is a light at the end of this tunnel.

Vaccines are on the way.

Last night, I received confirmation that we will shortly receive delivery of almost 10,000 vaccines against this disease. The roll out of these will commence next week to our most vulnerable, and we will safely and swiftly build from there.

We first placed orders for vaccines back in July and we are mobilising an unprecedented national effort.

Vaccinating millions of people will take time and in the meantime we have to be very vigilant.

We cannot go any faster than we are allowed by the available supply of the vaccines and the dosing schedules required for them to be effective.

But I am certain that our vaccination programme will bring us greater freedom in how we manage the virus in the year ahead.

The real strength of any nation is its people.

Everywhere we've looked over the last nine months we have seen the strength of the Irish nation – in the selfless dedication of our healthcare workers and the professionalism of our teachers and school staff.

We have seen it in the quiet army of cleaning staff and caretakers who have kept so many facilities accessible and safe, and in the shop workers who have kept essential retail open, without complaint, throughout the entire pandemic.

We have seen it in the resilience of our small business owners and the hospitality trade who have faced so many challenges and have shown the strength to keep going.

And we have seen it in our children's endless ability to adapt.

To all of these people, and to all the others who have followed the public health advice and done what was asked of them, I say Thank You.

Táim fíorbhuíoch diabh go léir, mar a dheireann an seanfhocal: Is ar scáth a chéile a mhaireann na ndaoine. Caithfaimid léanúint ag obair le chéile, chun cosc a chur ar an víreas seo.

Táim cinnte go dtiocfaimid slán. Tagann an ghrian i gconaí i ndiaidh na fearthainne.

The very idea of Christmas is about showing our love and respect for others. That is why in normal times we put so much effort into spending time with family and friends.

It's why we try to put away our everyday concerns and focus on the things we value the most.

This year, the way for us to show our love and respect for others is to act responsibly, to comply with the guidelines and to limit the spread of this virus.

This Christmas is going to be different, but it is also going to be very special.

We've lost many friends and neighbours to this disease, and many others didn't get the goodbye they deserved because of the restrictions that the disease required.

We remember all of them, and together we look forward to brighter days.

I want to wish everyone a peaceful Christmas and a happier, hopeful, New Year.

Nollaig shuaimhneach shona daoibh go leir

Go raibh maith agaibh."

Source: (Department of the Taoiseach; December 22, 2020). Retrieved from: https://merrionstreet.ie/en/news-room/news/spotlights/speech_of_an_taoiseach_michel_martin.html.

Document 4. Statement by An Taoiseach, Micheál Martin on the re-introduction of Level 5 restrictions of the Plan for Living with COVID-19. December 30, 2020.

"Just eight days ago, I stood here and explained why we needed to introduce a range of strict new controls in the effort to curb this latest wave of COVID infections.

I explained that while we didn't, at that stage, have evidence that the new, more virulent strain of COVID was in our country, the safest and most responsible thing to do was to proceed on the assumption that it was already here.

Unfortunately, that fear proved to be correct.

On Christmas Eve, we received the news we had feared – confirmation that the new strain is indeed in our country.

While international research into this new variant is ongoing, it is already very clear that we are dealing with a strain of the disease that spreads much, much more quickly.

Indeed, it is spreading at a rate that has surpassed the most pessimistic models available to us.

With the disease spreading much faster, the threat of our health system being overwhelmed and the risk of increased sickness and death among our vulnerable and older populations is obvious.

And it has become urgent.

In the week before Christmas, we were seeing about 5% of tests coming back as COVID-positive.

Yesterday, 18% of those tested were infected with the disease.

Over the last seven days, more than 8,000 cases have been confirmed. That is a 61% increase on the previous week.

This latest surge is different to the second wave. We are seeing rising incidence of the disease across all age groups, especially those aged 19-24 and a very worrying increase among those aged 65 and older.

During the second wave, there was a long delay between an increase in cases and an increase in hospital admissions.

This time is very different.

We are already seeing a sharp rise in the number of hospital admissions. This morning, there were 454 COVID patients in hospital. It has almost doubled in a week.

The Reproduction number is currently estimated at between 1.6 and 1.8.

The situation is extremely serious.

The numbers will deteriorate further over the coming days.

As we have navigated the different phases of this crisis together, I have always been clear that we will do what we need to do to suppress the virus when it is growing;

and it is now growing exponentially.

The truth is, that with the presence of the new strain and the pace of growth, this is not a time for nuance in our response.

We must apply the brakes to movement and physical interaction across the country.

We must return to full scale, Level 5 restrictions for a period of at least one month.

In practice, that will mean the following further restrictions:

- *from this evening, no visitors are permitted in private homes or gardens, unless they are providing care to children, the elderly or vulnerable, or are part of a support bubble*
- *no social or family gatherings should take place in any setting. There will be an exemption for weddings, where up to 6 guests will be allowed, and funerals, where up to 10 mourners will be allowed*
- *you should stay at home, except for travel for work, education or other essential purposes, or to take exercise within 5km of home*
- *all non-essential retail and gyms will close tomorrow at close of business*
- *all public health analysis is showing that schools are safe, and schools will reopen, but slightly delayed to 11th January*
- *by extending the break by 3 days the new restrictions I am announcing this evening will be in place for more than 10 days when schools open. Families will have had an opportunity to ensure that their contacts are minimised before children return to school.*

The last time that we faced such restrictive measures was when this disease first exploded in our midst in early 2020.

I am deeply conscious that we are in a very different space now.

We are all weary, from the bottom of our hearts, of this disease and the impact it has had on our lives.

The next month, as we face into these strictest controls in the depth of winter, is going to be very tough for everyone.

But there is another key difference between then and now.

After a year of the most extraordinary effort by the most talented scientific minds on earth, we have safe and effective vaccines.

We have the most technologically advanced factories in history working around the clock producing this life saving intervention, and we have a global supply chain distributing it around the world.

For the first time since this awful disease landed on our shores, we truly have an end in sight.

Thousands of vaccines are arriving here weekly, and by the end of January, I am confident that many tens of thousands of our most vulnerable citizens and our healthcare workers will have been vaccinated.

The vaccines are now being administered efficiently and safely, but this will take time. The virus can still do immense damage until we have progressed much, much further with the vaccination programme.

We are a society that looks out for the people around us.

And what we are doing now with these new restrictions is working to keep as many of our parents, grandparents, neighbours and friends safe until such time as they have been vaccinated.

This disease and the response it requires is causing massive disruption to our society and it is undermining our economy.

It is having an effect on the mental health of young and old that we will not understand for some time to come.

It is costing billions of Euro.

But the most important responsibility that we all share is to protect the lives of those we love.

The actions that we are taking – as a society and as individuals – is saving lives.

We will rebuild the economy, we will repair the damage to our society.

We will come to terms with this crisis and make sense of the trauma we have all been through in due course.

We will do all these things, and we will start them this coming year, because the vaccine now exists.

But right now, this is what we must do.

We must stay at home and eliminate contact with others now, to make sure that as many of our people as possible are still with us to enjoy the better, brighter days that are up ahead.

Beidh spiorad na meithle, aire, cúram agus foighne ag teastáil san míonna amach romhainn go dtí go dtiocfaidh éifeacht na vaisciní i bhfeidhm. Idir an dalinn, caithfimid a bheith ciallmhar agus cúramach agusna srianta Leibhéal a Cúig seo a leanúint. Táim cinntego dtiocfaimid slán. Caithfimid a bheith dóchasach.

Mar a deir an seanfhocal, is é an dóchas lia gach anró.

Beannachtaí na hAthbhliana oraibh uilig.

Go raibh maith agaibh."

Source: (Department of the Taoiseach; December 30, 2020) Retrieved from: https://www.gov.ie/en/speech/8753b-statement-by-an-taoiseach-micheal-martin-on-the-reintroduction-of-level-5-restrictions-of-the-plan-for-living-with-covid/.

Appendix E: Mapping the actors and actants in the 'situation' following Situational Analysis GT

Figure 6: Messy Situational Map (Clarke, 2005)

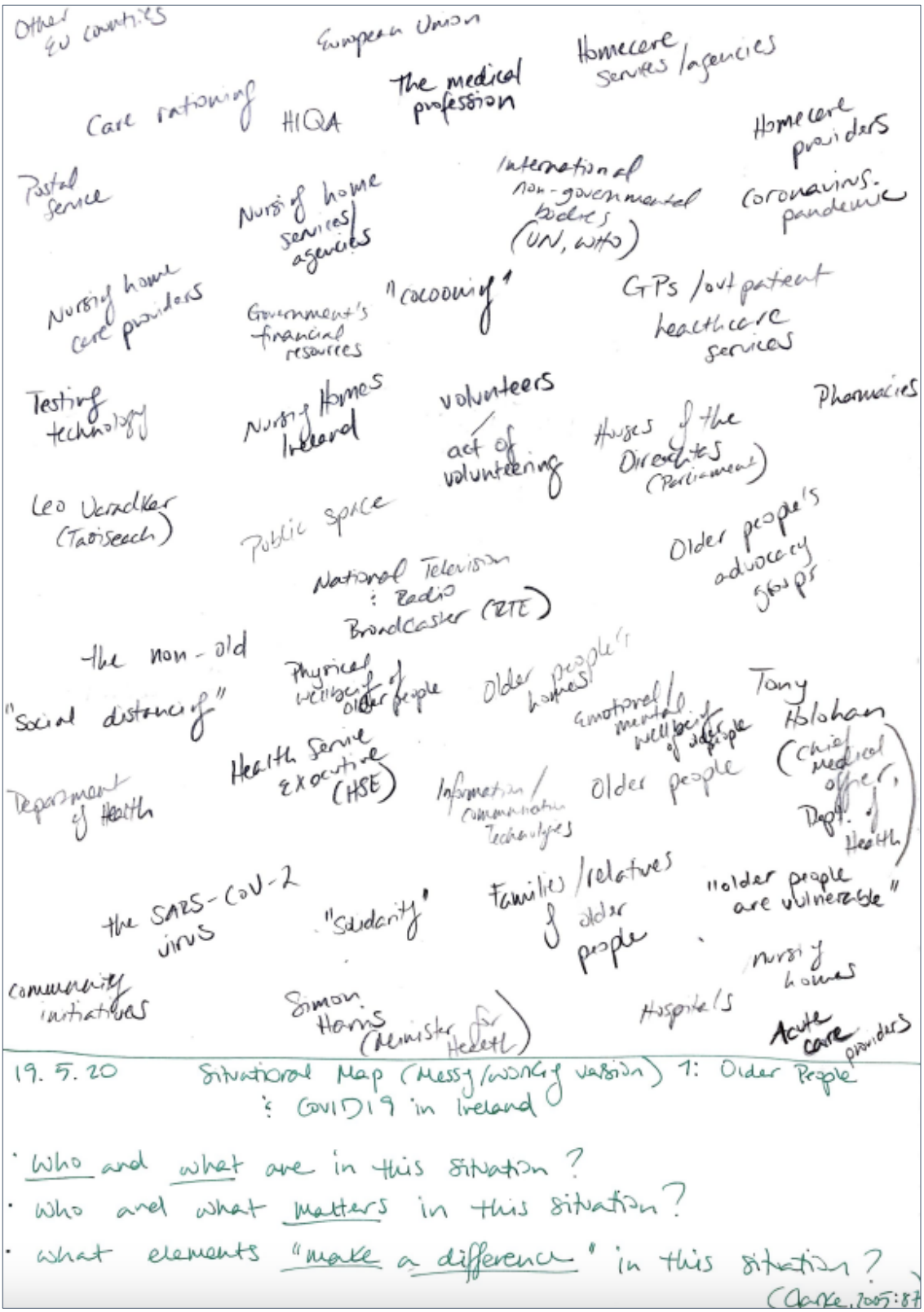


Figure 7: Ordered Situational Map (Clarke, 2005)

Individual Human Elements/Actors
Taoiseach (Leo Varadkar; Micheál Martin)
Minister for Health (Simon Harris; Stephen Donnelly)
CMO/ NPHET Chair Tony Holohan
Deputy CMO Ronan Glynn
Tadgh Daly (NHI)

Collective Human Elements/Actors
Irish Government
- Cabinet Committee
- NPHET
- Department of Health
- HSE/HPSC
- Special Committee of parliament

HIQA
Nursing Homes Ireland
Nursing homes
Hospitals
Healthcare workers
Local authorities
Families
Community volunteers
Older persons' advocacy groups
Independent experts
Professional medical groups

Discursive Constructions of Individual and/or Collective Human Actors
Social constructions of older persons
Social constructions of young persons
Social constructions of vulnerable people
Social constructions of experts
Social constructions of Irish society

Political/Economic Elements
Health- and social-care sector funding
Regulation of care sector
Acute sector capacity
Nursing home capacity
Access/affordability of home supports
Oversight of private care sector
Availability of PPE
Testing and Tracing Capacity
Reform of health- and social-care sectors
Formation of new government

Temporal Elements
Multiple prior attempts to reform care system
Chronic underfunding of care sector
'Waves' of the pandemic
Repeated entering and exiting restrictions
Preparing for winter

Major Issues/Debates
Balancing human/civil rights with protection of 'vulnerable'
Public versus private sector role in care of older persons
Human rights versus biomedical approach to care
Choice of care setting

Non-human Elements/Actants
Covid-19 virus
(Epidemiological) data
Covid-19 Testing technologies
PPE

Implicated/Silent Actors/Actants
Older persons
Family of older persons
Healthcare workers
Nursing home

Discursive Constructions of Non-human Actants
Social constructions of Covid-19 virus
Social construction of nursing home
Social construction of 'cocooning' and the home

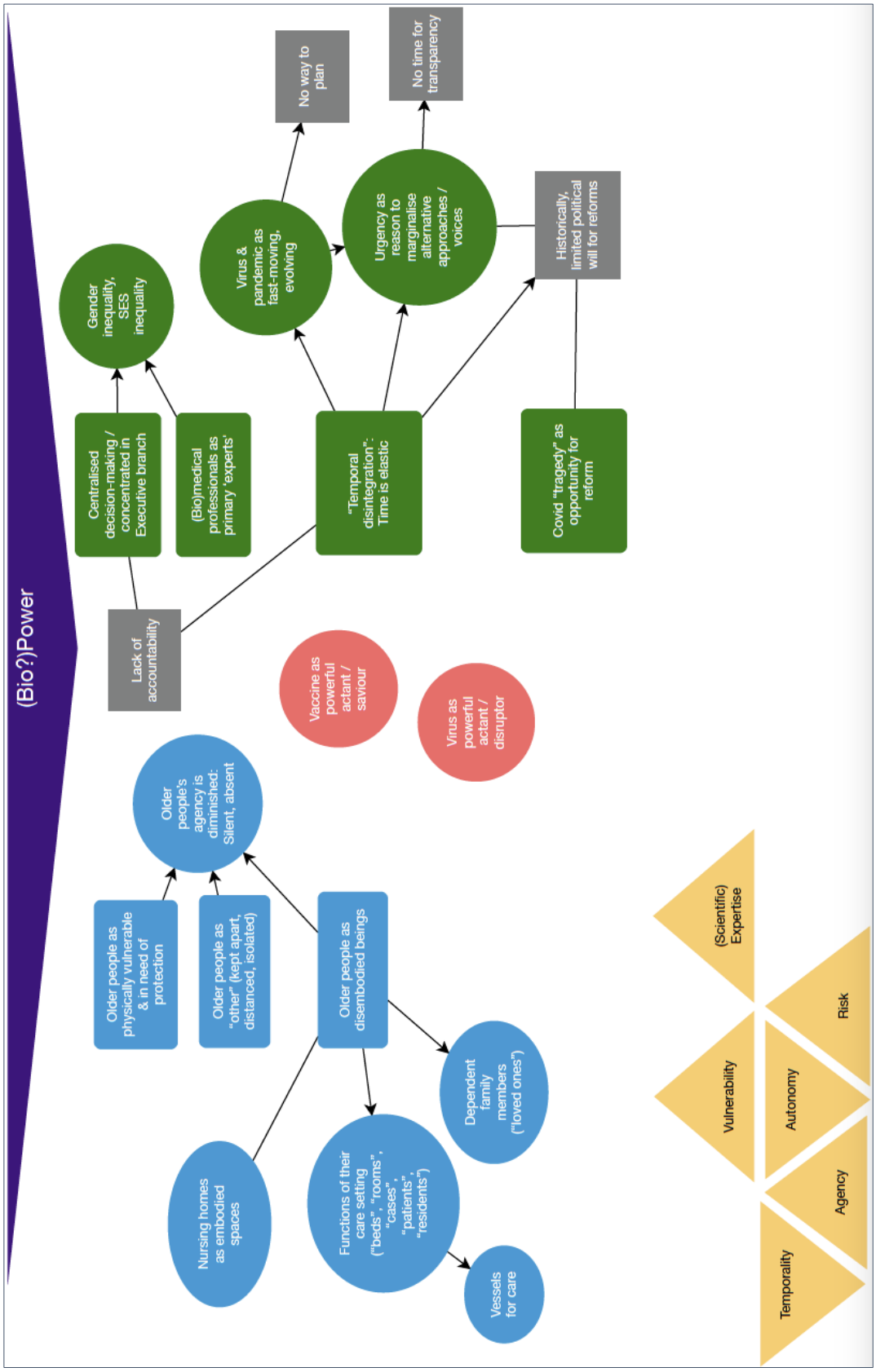
Sociocultural/Symbolic Elements
Morality of protecting society's 'vulnerable'
National identity and solidarity
Catholic identity

Spatial Elements
Acute care setting
Congregated settings (nursing homes)
Home/community
Virtual meeting
Social and physical distancing
Border with Northern Ireland
Geographic variation in cases/measures
Restrictions on international/domestic travel

Related Discourses (Historical, Narrative, and/or Visual)* Other Kinds of Elements*

Appendix F: Mapping emergent categories following GT

Figure 8: 'Mind map' of core emergent conceptual categories informing reviews of the literature



Appendix G: Texts included as data in this study

Table 13. Chronological list of texts included in the analysis of official discourses

Doc #	M	DD	Title	Authorship	Retrieved from
1	JAN 2020	27	NPHET Coronavirus (2019-nCoV) Meeting Note—27th January 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#documents-from-meetings-in-january
2		30	NPHET Coronavirus (2019-nCoV) Meeting Note – 30th January, 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#documents-from-meetings-in-january
3	FEB	29	Minister for Health Statement on confirmed case of COVID-19 (Coronavirus) in Ireland	Department of Health	https://www.gov.ie/en/press-release/4b2e8a-minister-for-health-statement-on-confirmed-case-of-covid-19-coronavi/
4	MAR	6	COVID-19 / Coronavirus: Visitor Restrictions announced by Nursing Homes Ireland	Nursing Homes Ireland (NHI)	https://nhi.ie/covid-19-coronavirus-nursing-home-care/
5		6	National Public Health Emergency Team – Coronavirus: Covid-19 Subgroup-Vulnerable People: Meeting 1 Note of Meeting and Actions Arising	NPHET Subgroup - Vulnerable People	https://www.gov.ie/en/collection/301f5e-the-national-public-health-emergency-team-nphet-subgroup-vulnerable-/#meeting-agendas-and-minutes
6		10	National Public Health Emergency Team – COVID-19 Meeting Notes	Department of Health/NPHET	https://www.gov.ie/en/publication/ce3fe8-previous-updates-on-covid-19-coronavirus/#january
7		10	Covid-19 NPHET Subgroup - Vulnerable People: Report - NPHET Meeting 10/03/2020	NPHET Subgroup - Vulnerable People	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#documents-from-meetings-in-march
8		12	Statement by An Taoiseach on measures to tackle Covid-19	Taioseach Leo Varadkar/Department of the Taoiseach	https://www.gov.ie/en/speech/5a280b-statement-by-an-taoiseach-on-measures-to-tackle-covid-19-washington/
9		12	Letter to Minister of Health Simon Harris from Chair of NPHET/Chief Medical Officer HSE Tony Holohan	Department of Health/NPHET	https://www.gov.ie/en/press-release/96eb4c-statement-from-the-national-public-health-emergency-team/
10		19	Guidance for Health and Social Care Workers who visit homes [V1.0]	Health Protection Surveillance Centre (HPSC)	https://www.lenus.ie/bitstream/handle/10147/627356/V1.0-Guidance-HealthSocialCareWorkersWhoVisitHomes.pdf?sequence=1&isAllowed=y
11		20	Government Action Plan To Support The Community Response	Department of Rural and Community Development/HSE	https://www.gov.ie/en/publication/70be56-government-action-plan-for-community-response-to-covid-19/

12		20	Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020	Houses of the Oireachtas	http://www.irishstatutebook.ie/eli/2020/act/1/enacted/en/html
13		24	Letter to Minister of Health Simon Harris from Chair of NPHET/Chief Medical Officer HSE Tony Holohan	Department of Health/NPHET	https://www.gov.ie/en/publication/a7e66d-latest-guidance-on-public-health-measures/
14		24	National Public Health Emergency Team (NPHET) COVID-19 Subgroup: Vulnerable People	Department of Health/NPHET	https://www.gov.ie/en/collection/301f5e-the-national-public-health-emergency-team-nphet-subgroup-vulnerable-/
15		27	Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19	Department of Health	https://www.gov.ie/en/publication/923825-guidance-on-cocooning-to-protect-people-over-70-years-and-those-extr/
16		31	Enhance Public Health Measures for COVID-19 Disease Management Long-term Residential Care (LTRC) NPHET 31st March 2020	NPHET Subgroup - Vulnerable People	https://www.gov.ie/en/collection/88795-published-documents-covid-19-social-care/
17		31	Statement from the National Public Health Emergency Team - Tuesday 31 March	Department of Health/NPHET	https://www.gov.ie/en/press-release/5ac125-statement-from-the-national-public-health-emergency-team-31-march-20/
18	**APR**	2	Government launches initiative to phone older people to check on wellbeing during COVID-19 crisis	Department of Rural and Community Development	https://www.gov.ie/en/press-release/eb8344-govt-launches-initiative-to-phone-older-people-to-check-on-wellbeing/
19		4	Minister for Health announces enhanced measures to support nursing home residents in response to COVID-19	Department of Health	https://www.gov.ie/en/press-release/228125-minister-for-health-announces-enhanced-measures-to-support-nursing-h/
20		10	Statement from the National Public Health Emergency Team - Friday 10 April	Department of Health/NPHET	https://www.gov.ie/en/press-release/895657-statement-from-the-national-public-health-emergency-team-friday-10-a/
21		16	Statement from the National Public Health Emergency Team - Thursday 16 April	Department of Health/NPHET	https://www.gov.ie/en/press-release/0906df-statement-from-the-national-public-health-emergency-team-thursday-16/
22		17	Statement from the National Public Health Emergency Team - Friday 17 April	Department of Health/NPHET	https://www.gov.ie/en/press-release/78ca7b-statement-from-the-national-public-health-emergency-team-friday-17-a/
23		20	Statement from the National Public Health Emergency Team - Monday 20 April	Department of Health/NPHET	https://www.gov.ie/en/press-release/b02c86-statement-from-the-national-public-health-emergency-team-monday-20-a/

24		21	Regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak	Health Information and Quality Authority (HIQA)	https://www.hiqa.ie/sites/default/files/2020-04/Assessment-framework-DCOP-covid19-preparedness.pdf
25		29	Statement from the National Public Health Emergency Team - Wednesday 29 April	Department of Health/NPHET	https://www.gov.ie/en/press-release/c8ab91-statement-from-the-national-public-health-emergency-team-wednesday-2/
25	MAY	1	Overview of Reopening Phases: Commencing May 18th	Department of the Taoiseach	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiQkqq_i-7rAhXUN8AKHdcXCXUQFjAAegQIAxAB&url=https%3A%2F%2Fassets.gov.ie%2F73823%2F075541bb68c146e09a31367b69c76621.pdf&usg=AOvVaw10NCNAKv6Fb2j_jQBDLSZR
26		1	Roadmap for Reopening Society & Business	Department of the Taoiseach	https://www.gov.ie/en/press-release/e5e599-government-publishes-roadmap-to-ease-covid-19-restrictions-and-reope/
27		19	Special Committee on Covid-19 Response: Briefing by Department of Health Officials; Briefing by HSE officials	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-05-19/
28		26	Overview of the Health System Response to date: Long-term residential healthcare settings	National Public Health Emergency Team (NPHET)/Department of Health	https://www.lenus.ie/bitstream/handle/10147/627723/overviewresponse.pdf?sequence=1&isAllowed=y
29		26	Special Committee on Covid-19 Response: Congregated Settings: Nursing Homes and Direct Provision Centres	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-05-26/
30		29	Statement from the National Public Health Emergency Team - Friday 29 May	Department of Health/NPHET	https://www.gov.ie/en/press-release/51402-statement-from-the-national-public-health-emergency-team-friday-29-may/
40	JUN	4	Ethical Considerations Relating to Long-Term Residential Care Facilities in the context of COVID-19	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/publication/37ef1-ethical-considerations-relating-to-long-term-residential-care-facilities/
41		8	Service Continuity in a Covid Environment	Health Service Executive (HSE)	https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/service-continuity-in-a-covid-environment-a-strategic-framework-for-delivery1.pdf
42		11	Special Committee on Covid-19 Response: World Health Organization: Public Health Advice	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-06-11/

43		18	Special Committee on Covid-19 Response: Congregated Settings: Nursing Homes (Resumed)	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-06-18/
44		26	National Public Health Emergency Team for COVID-19: Governance Structures	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/publication/de1c30-national-public-health-emergency-team-nphet-for-covid-19-governance-/
45	JUL	17	Special Committee on Covid-19 Response: Impact of Covid-19: People with Disabilities; Non-Covid Healthcare Disruption: Waiting Lists and Screening	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-07-17/
46		21	The impact of COVID-19 on nursing homes in Ireland	Health Information and Quality Authority (HIQA)	https://www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf
47		21	Special Committee on Covid-19 Response: Infection Rate Among Healthcare Workers	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-07-21/
48		28	Interim Public Health, Infection Prevention & Control Guidelines on: Admissions, Transfers to and Discharges from Residential Care Facilities during the COVID-19 Pandemic [v1.0]	Health Service Executive (HSE), Health Protection Surveillance Centre (HPSC)	https://www.lenus.ie/bitstream/handle/10147/627953/Guidelines on admissions transfers to and discharges from RCF.pdf?sequence=1&isAllowed=y
49		31	Interim Report on Covid-19 in Nursing Homes: Special Committee on Covid-19 Response	Houses of the Oireachtas	https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/reports/2020/2020-07-31_interim-report-on-covid-19-in-nursing-homes_en.pdf
50	AUG	19	COVID-19 Nursing Homes Expert Panel: Examination of Measures to 2021: Report to the Minister for Health	COVID-19 Nursing Homes Expert Panel	https://www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/
51		24	COVID-19 Guidance on visitations to Residential Care Facilities	Health Service Executive (HSE), Health Protection Surveillance Centre (HPSC)	https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Guidance on visiting residential facilities.pdf
52		26	Special Committee on Covid-19 Response: State Response to Recent Spike in Covid-19 Cases	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-08-26/
53		27	Note for NPHET meeting 27th August 2020 (updated): Governance and oversight structures for supporting Vulnerable Groups during COVID-19	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/

54	SEP	9	Special Committee on Covid-19 Response: Covid-19: Legislative Framework Underpinning the State's Response; Covid-19: Human Rights and Civil Liberty Considerations	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-09-10/
55		10	Special Committee on Covid-19 Response: Examination of HIQA Report on the Impact of Covid-19 on Nursing Homes in Ireland	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-09-10/
56		14	Cocooning [June 29? That's the date I put in Nvivo]	Health Service Executive (HSE)	https://www2.hse.ie/conditions/coronavirus/cocooning.html
57		15	Resilience and Recovery 2020-2021: Plan for Living with COVID-19	Department of the Taoiseach	https://www.gov.ie/en/publication/e5175-resilience-and-recovery-2020-2021-plan-for-living-with-covid-19/
58		16	Special Committee on Covid-19 Response: Final Report of Nursing Homes Expert Panel	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-09-16/
59		18	Speech by An Taoiseach announcing Dublin's move to Level 3 of the Framework for Restrictive Measures	Department of the Taoiseach	https://www.gov.ie/en/speech/8fd61-speech-by-an-taoiseach-announcing-dublins-move-to-level-3-of-the-framework-for-restrictive-measures/
60		23	Special Committee on Covid-19 Response: Strategic Options for Government Plan to Eliminate Community Transmission	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-09-23/
61		24	Winter Planning within the COVID-19 Pandemic: October 2020-April 2021	Health Service Executive (HSE)	https://www.hse.ie/eng/services/publications/winter-planning-within-the-covid19-pandemic-october-2020-april-2021.pdf
62		29	Special Committee on Covid-19 Response: Update on Testing and Tracing and Rising Incidence in the State	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-09-29/
63		30	Special Committee on Covid-19 Response: Minister for Health, CMO, NPHET	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/special_committee_on_covid_19_response/2020-09-30/
64	OCT	7	Joint Committee on Health: Review of Mental Health Services	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2020-10-07/

65		9	Final Report: Special Committee on Covid-19 Response	Houses of the Oireachtas	https://www.oireachtas.ie/en/committees/33/special-committee-on-covid-19-response/
66		14	Joint Committee on Health: Update on Sláintecare	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2020-10-14/
67		21	Ireland placed on Level 5 of the Plan for Living with COVID-19	Department of the Taoiseach	https://www.gov.ie/en/press-release/66269-ireland-placed-on-level-5-of-the-plan-for-living-with-covid/
68		21	Joint Committee on Health: Workforce Planning in Acute and Community Care Settings	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2020-10-21/
69		28	Joint Committee on Health: Covid-19 Contact Tracing: HSE	Houses of the Oireachtas	https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2020-10-28/debate/mul@/main.pdf
70	NOV	3	Covid-19 Pandemic, Dáil Éireann Debate, Tuesday 3 November, 2020	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/question/2020-11-03/1139/#pq-answers-1139
71		4	Joint Committee on Health, Update on Covid-19 and Review of Budget 2021: Minister for Health	Houses of the Oireachtas	https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2020-11-04/debate/mul@/main.pdf
72		26	Letter from CMO to Minister for Health re COVID-19 (Coronavirus) - 26 November 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#august-december-2020
73		27	Address by An Taoiseach, Micheál Martin TD, on Ireland placed on Level 3 of the Plan for Living with Covid-19 with special measures for a safe Christmas.	Department of the Taoiseach	https://www.gov.ie/en/speech/4f3c0-address-by-an-taoiseach-micheal-martin-td-on-ireland-placed-on-level-3-of-the-plan-for-living-with-covid-19-with-special-measures-for-a-safe-christmas
74		27	Safe Christmas [website]	Department of Health; Department of the Taoiseach	https://www.gov.ie/en/publication/e3b9e-safe-christmas/#safe-visiting
75		30	Statement from the National Public Health Emergency Team - Monday 30 November	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/press-release/6c415-statement-from-the-national-public-health-emergency-team-monday-30-november/
76	DEC	10	NPHET COVID-19 Meeting Minutes - 10 December 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#october-december-2020

77		17	NPHET COVID-19 Meeting Minutes - 17 December 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#october-december-2020
78		21	Letter from CMO to Minister for Health re COVID-19 (Coronavirus) - 21 December 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/
79		22	Speech of An Taoiseach, Micheál Martin	Department of the Taoiseach	https://merrionstreet.ie/en/news-room/news/spotlights/speech_of_an_taoiseach_michel_martin.html
80		23	NPHET COVID-19 Meeting Minutes - 23 December 2020	National Public Health Emergency Team (NPHET)	https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-covid-19-coronavirus/#october-december-2020
81		30	Statement by An Taoiseach, Micheál Martin on the re-introduction of Level 5 restrictions of the Plan for Living with COVID-19.	Department of the Taoiseach	https://www.gov.ie/en/speech/8753b-statement-by-an-taoiseach-micheal-martin-on-the-reintroduction-of-level-5-restrictions-of-the-plan-for-living-with-covid/
82	JAN 2021	7	Letter from CMO to Minister for Health re COVID-19 (Coronavirus) – 7 January 2021	NPHET	https://www.gov.ie/en/collection/ba4aa0-letters-from-the-cmo-to-the-minister-for-health/#2021
83		11	COVID-19 Guidance on visits to Long Term Residential Care Facilities (LTRCFs) V1.5 11.01.2021	Health Service Executive (HSE)	https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Guidance%20on%20visits%20to%20RCF.pdf
84		13	Home Support Services: Preparedness and impact of COVID-19 on services	Department of Health; Health Service Executive	http://assets.gov.ie [cached]
85		29	Joint Committee on Health, Covid-19 Vaccination Programme: Update	Houses of the Oireachtas	https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2021-01-29/debate/mul@/main.pdf
86	FEB	2	Joint Committee on Health, Update on Covid-19 in Nursing Homes	Houses of the Oireachtas	https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_health/2021-02-02/debate/mul@/main.pdf
87		9	Joint Committee on Health, Protection and Support for Covid-19 Front-line Workers: Discussion	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2021-02-09/
88		16	Joint Committee on Health, A Regulatory Framework for Adult Safeguarding: Law Reform Commission	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2021-02-16/

89		19	Immunisation Guidelines for Ireland: Chapter 5a COVID-19	National Immunisation Advisory Committee	https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/immunisationguidelines.html
90		23	Covid-19 Resilience and Recovery 2021: The Path Ahead	Department of Health; Department of the Taoiseach	https://www.gov.ie/en/campaigns/resilience-recovery-2020-2021-plan-for-living-with-covid-19/
91		23	Speech by the Taoiseach Micheál Martin - COVID-19 Resilience and Recovery 2021: The Path Ahead	Department of the Taoiseach	https://www.gov.ie/en/speech/147f5-speech-by-an-taoiseach-micheal-martin-covid-19-resilience-recovery-2021-the-path-ahead/
92	MAR	2	Joint Committee on Health, Covid-19 Health Related Issues: Update	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2021-03-02/
93		9	Joint Committee on Health, Covid-19 Public Health Measures: Update from Health Service Executive	Houses of the Oireachtas	https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2021-03-09/