Running to stand still? Two decades of trade union activity in the Irish long-term care sector

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Summary
This article examines the ongoing efforts of trade unions in Ireland to protect and improve the working conditions of personal care workers amid employment and social policy regimes associated with a liberal welfare state. Comparatively low public expenditure on care and the increasing marketisation of care services have undermined the provision of decent work. This article assesses two major union campaigns related to personal care workers over two decades, and reviews the key priorities that have emerged for unions during the COVID-19 pandemic. We consider whether the outcomes of these campaigns have been converted into enhanced rewards for workers and discuss the continuing challenges for union campaigning.

Résumé
Cet article examine les efforts déployés actuellement par les syndicats irlandais pour protéger et améliorer les conditions de travail des travailleurs du secteur des soins aux personnes dans le contexte de régimes d’emploi et de politique sociale associés à un État-providence libéral. Le niveau relativement faible des dépenses publiques consacrées à la prestation de soins et la commercialisation croissante des services de soins ont compromis la qualité des soins et la possibilité d’un travail décent. Cet article évalue deux grandes campagnes syndicales concernant les travailleurs du secteur des soins aux personnes, sur deux décennies, et examine quelles sont les principales priorités qui ont émergé pour les syndicats pendant la pandémie de COVID-19. Nous examinons si les résultats de ces campagnes ont pu se traduire par des améliorations concrètes pour les travailleurs et nous analysons les défis auxquels les campagnes syndicales sont confrontées en permanence.

Zusammenfassung
Der vorliegende Artikel untersucht die kontinuierlichen Bestrebungen der Gewerkschaften in Irland, in einem Umfeld von beschäftigungs- und sozialpolitischen Rahmenbedingungen eines
liberalen Wohlfahrtstaates die Arbeitsbedingungen in Pflegeberufen zu schützen und zu verbessern. Vergleichsweise niedrige öffentliche Ausgaben im Pflegesektor und die zunehmende Vermarktlichung der Pflegedienste haben dazu geführt, dass eine Pflege unter menschenwürdigen Arbeitsbedingungen immer schwieriger wird. Der vorliegende Artikel beurteilt zwei wesentliche und über zwei Jahrzehnte durchgeführte Gewerkschaftsinitiativen zur Verbesserung der Situation in den Pflegeberufen und untersucht die wichtigsten Prioritäten, die sich für die Gewerkschaften aus der COVID-19-Pandemie ergeben haben. Wir gehen der Frage nach, ob die Ergebnisse dieser Kampagnen zu konkreten Verbesserungen für die Arbeitnehmer:innen geführt haben und erörtern die beständigen Herausforderungen gewerkschaftlicher Kampagnenarbeit.

**Keywords**
Long-term care, personal care, trade unions, working hours, pay cuts, non-profit, COVID-19

**Introduction**

Population ageing and a rising demand for long-term care provision were significant challenges in many developed nations before 2008, but were exacerbated during the global financial crisis, when reductions in public spending created a care gap, leaving insufficient resources to meet demand (Daly and Armstrong, 2016; Lehnert et al., 2019). Similar trends are evident in Ireland, where there will be an estimated 20 to 25 per cent growth in the population aged over 65 years by 2041, with the number of those aged over 80 expected to more than treble (Brown, 2016). ‘Long-term care’ refers to services for people dependent on help with the basic activities of daily living and personal care over an extended period of time. Personal care workers are critical to long-term care, accounting for 70 per cent of the workforce in the OECD (OECD, 2020). In terms of employment, the long-term care sector in Ireland and internationally is associated with poor quality jobs (Müller, 2019; Spasova et al., 2018; Timonen and Doyle, 2007). The sector presents significant challenges to union organising, often in contexts of neoliberal restructuring of public health services. Research, however, shows a potential for mobilisation and the collective agency of care workers (Murphy and Turner, 2014; Rogalewski, 2018; Schwiter et al., 2018).

This article assesses the nature and outcomes of two trade union campaigns concerning personal care workers. One long-running campaign has focused on the working hours of home care workers (also known as home helps) in work characterised by variable and insecure hours. A second campaign emerged because of pay cuts imposed on personal care workers in non-profit organisations during the global financial crisis. The article also reviews new concerns that have materialised for unions during the COVID-19 pandemic, which has highlighted the vulnerability of the long-term care workforce, particularly in nursing homes. Ireland’s long-term care model has similarities with those of southern European countries, with a strong role for the family and relatively low provision of formal care (Ilinca et al., 2015). This article can offer insights for unions in those countries on the importance of a multi-faceted approach to organising in the sector, targeting public, private and non-profit employers concurrently, on a range of different issues. Union organising efforts in the Irish context are worthy of examination because of the complexity of the sector historically in terms of its employment characteristics and its subsequent rapid marketisation.

The article is based on extensive documentary analysis of informed sources. Contextual information on the development and characteristics of the care sector were provided by the annual reports and research reports of government bodies, care providers, provider representative bodies
and civil society organisations. A search was undertaken for any information relating to union campaigns on care work from 2000 to 2020 in the reports and press releases of the two largest unions that represent care workers, as well as the news source of record, the Industrial Relations News, other reputable news sites, parliamentary debates and decisions of state dispute resolution bodies that intervened in disputes during the campaigns.

The article is structured as follows. It begins with an overview of the key features and developments in the care sector in Ireland, with a particular focus on home care, care services provided by non-profit bodies, and nursing homes. The article then discusses major union campaigns over the past two decades, before reviewing union actions during the COVID-19 pandemic. The final section discusses lessons from the union campaigns and considers the challenges and opportunities for unions in their efforts to advance decent work in long-term care.

The Irish long-term care sector

Historically, the care sector has had a strong element of familial care as well as religious and volunteer non-profit care provision, but, over time, the state has increasingly shifted towards expanding coverage and resources, but also towards marketisation of care provision (Cullen, 2019; McInerney and Finn, 2015; Merceille and O’Neill, 2020). Cullen (2019: 610) argues that ‘path dependency in non-profit delivery of care shifted in the early 1990s as the Irish Government embarked on an extensive programme of public sector reform’, which included more outsourcing and the deeper integration of private sector management principles. The austerity policies implemented in the wake of the financial crisis further reduced social investment and exacerbated the marketisation of public services (Dukelow and Kennett, 2018). In the area of home care, the sector quadrupled in size in Ireland between 2000 and 2010 (Mulkeen, 2016) and private providers, particularly large ones, were able to exploit the opportunities by being commercially minded and having international capital investment (Merceille and O’Neill, 2020). The private sector accounted for less than 5 per cent of public expenditure on home care in 2006, but by 2019 this had risen to 40 per cent, while public expenditure on publicly delivered home care declined from 85 per cent in 2006 to 50 per cent in 2019 (Merceille and O’Neill, 2020). Unlike other areas of care, the home care sector is unregulated, which means ‘there are no statutory requirements around who can provide home care’ and there is no independent oversight body to monitor compliance with quality care standards (HCCI, 2019: 25). A consequence of the current system is that there is ‘huge competition’ between providers, resulting in a race to the bottom in the cost of services, negatively affecting working conditions (MRCI, 2015).

Many non-profit organisations that receive public funding are referred to as ‘Section 39 agencies’, so-called because Section 39 of the Health Act 2004 allows the statutory health agency – the Health Service Executive (HSE) – to fund organisations to provide health and care services. There are approximately 1900 such agencies, primarily in older people’s care and community care, and they receive substantial funds from the HSE, historically through grants, but more recently through competitive tendering processes (McInerney and Finn, 2015; Merceille and O’Neill, 2020). The relationship between the state and non-profit organisations has been described by one such organisation as based on ‘command and control’ principles, and characterised by managerialism, a value-for-money ethos, accountability, compliance and regulation (Rehab Group, 2018).

Ireland has the second highest rate of nursing home and hospital residency for the over 65s in the EU (Cardi, 2011). Approximately 80 per cent of nursing homes are operated by mainly private providers, and their average weekly charge rates are 62 per cent lower than in public homes (Comptroller and Auditor General, 2020). Among the reasons for the higher charge rates in public
homes are their location in geographical areas that are not deemed to be ‘commercially viable’ and the superior pay and working conditions of staff (Comptroller and Auditor General, 2020: 27).

The composition of the long-term care workforce in Ireland is similar to that of other countries, such as the United Kingdom and the United States (Montgomery et al., 2005; Vandean and Allan, 2017). Workers are predominantly female, almost one-third are immigrants, they generally have a low level of education, have limited access to higher-paid jobs and/or seek flexible work that can be fitted around other responsibilities (TASC, 2020). Home care workers are represented primarily by Ireland’s largest trade union, SIPTU, while supervisory-level home care organisers are represented by the largest public sector union, Fórsa. In line with national union membership trends, the unionisation of home care workers is concentrated in the public sector. Estimates suggest that union density among HSE-employed home care workers ranges from 50 to over 80 per cent, while in non-profit organisations it is estimated at 29 per cent. Density among private providers, by contrast, is low or non-existent (Sheehan, 2014).

**Trade union campaigns**

**Home care workers**

Home care workers’ employment arrangements are characterised by low formalisation, low pay, low and fragmented working hours, ad hoc employment arrangements, high staff turnover and unsociable hours (MRCI/SIPTU/Carers Association, 2015; National Council for the Elderly, 1994). The statutory health agency, the HSE, historically regarded home care workers, known as home helps, as self-employed, but unions pushed to formalise their working conditions, and collective agreements in 2000 and 2004 recognised public home helps as employees and aligned their terms of employment with directly employed HSE support staff. There is no obligation on non-public service providers to align terms and conditions with publicly employed staff, however. A long-running union campaign has centred on working hours insecurity and unions raised the issue of ‘zero-hours’ work among home care workers long before it achieved prominence in national media and public policy.

In 2006, SIPTU organised a protest of 200 home helps outside the Department of Health offices over cuts to funding for home-help hours, the prevalence of zero-hours work, and situations in which workers could lose hours when a care recipient was hospitalised or died (Dobbins, 2006). Almost 10 years after the protest, a union survey found that over a third of home helps worked on average four hours per week, and 20 per cent worked less than their contracted hours (Sheehan, 2014). Two types of contract are prevalent in home care, which are associated with high schedule irregularity and instability (O’Sullivan, 2019). So-called ‘if and when’ contracts are a form of zero-hours work, whereby employers are not obliged to offer work and individuals are not legally obliged to accept it, but receive no compensation if they are not allocated working hours. Up to one-third of home care workers in non-profit providers were estimated to have no guaranteed hours (SIPTU, 2015).

A second relevant type of contract are ‘hybrid if and when’ contracts, whereby workers are guaranteed some hours, but employers can offer additional working hours on an ‘on demand’ basis. Unions and civil society organisations representing migrant workers have been very critical of the impact of these contracts on workers, referring to financial precarity, the lack of adequate notice of hours, the lack of perceived fairness in the distribution of work, workers’ difficulties in accessing state income support, and employers’ use of working hours as a form of control (Murphy et al., 2019). In relation to control, home care workers have underlined their fear of losing hours if they
advocate for clients and make a complaint, or if they refuse working hours that have been offered (MRCI/SIPTU/Carers Association, 2015; O’Sullivan et al., 2015). Trade union strategies have differed depending on the type of employer. They have sought to improve working hours security for publicly employed home care workers through collective agreements with the HSE and for privately employed workers through political lobbying for employment legislation.

The trade unions SIPTU and Fórsa concluded agreements with the HSE in 2007 and 2009. They laid down that HSE-employed home helps should be redeployed or financially compensated if their hours were reduced. With the onset of the global financial crisis and cuts to public expenditure, however, the HSE ‘felt unable to comply with historic moral obligations’ and ‘could not consent to any measure with cost-increasing implications’ (Labour Court, 2012). Negotiations on a new home-help agreement were not concluded until 2013, after the state dispute resolution body, the Labour Court, issued a binding recommendation on the issue. The 2013 terms of agreement provided for the introduction of annualised hours contracts for home helps, with guaranteed minimum hours that would be calculated as 80 per cent of the actual hours worked by home helps over a six-month reference period. There would be a minimum floor of seven hours per week, with a commitment by the HSE to increase the number of minimum weekly working hours to 10. While unions decried the increasing prevalence of for-profit private providers, the HSE stated that they would remain part of the home care system, although it did commit itself to redirecting home care hours from privatised services to publicly employed home helps (Prendergast, 2013). Home helps also gained by securing payment for their travel time between clients, travel expenses and wage premiums, such as for weekend working. These terms applied only to home helps directly employed by the HSE and it has been acknowledged that non-public home care workers ‘continue to work off “if and when” contracts, work unsociable hours and are not reimbursed for travel costs’ (Family Carers Ireland, 2017: 8). Non-public organisations attribute these conditions to the state home care funding model, however, and criticise the HSE’s commitment to redirect home care hours to directly employed staff. They argue that this provision ‘disadvantages care workers employed by non-HSE agencies (who are being used to shield the working conditions of HSE care workers)’ (Family Carers Ireland, 2017: 8). Despite the collective agreements, a trade union survey in 2015 noted that almost seven out of 10 home care workers had fewer than 20 hours work per week and that 80 per cent were underemployed (SIPTU, 2015). A further HSE–union agreement in 2017 aimed to review home-help contracts and it provided for an increase in contracted hours for the majority of employees, the introduction of rostered arrangements to give workers greater certainty over scheduling, and for travel time to be counted as work time (McGrath, 2018). Unions later argued, however, that the agreement had not been implemented and SIPTU threatened industrial action by home helps in 2018. This led to another collective agreement, brokered by the state dispute resolution agency, the Workplace Relations Commission. The agreement included a HSE commitment to provide an additional 670,000 home-help hours, the creation of 800 directly employed home-help positions and the inclusion of travel time in pay and working hours (SIPTU, 2018; 2019b).

To improve the security of working hours beyond public employers, trade unions representing home care workers, as well as precarious workers in other sectors, lobbied the government to introduce employment legislation on zero-hours (or on-call) and low-hours work. SIPTU (2015) argued that legislation on zero-hours work was necessary because such contracts ‘subjugate and impoverish vulnerable workers. This situation has trapped hundreds of mainly women workers who are providing community health services on a third party contracted basis’. Union demands for legislation heightened as the country was beginning to recover from the global financial crisis and unions leveraged the presence of the Labour Party as a minor party in government from 2011.
to 2016 to deliver improved workers’ rights. The government in 2015 commissioned a study on zero-hours and low-hours work and the subsequent report recommended strengthening employment legislation to provide workers with greater security of hours (O’Sullivan et al., 2015). A newly formed government in 2016 introduced the Employment (Miscellaneous Provisions) Act 2018, which may have a positive impact for workers on low-hours or with ‘hybrid if and when’ contracts. The law stipulates eight bands of hours, ranging from Band A (3–6 hours) up to Band H (36+ hours) and it gives workers a general entitlement to enter a higher band of hours where they regularly work more hours than are stated in their contract. MacMahon (2019: 465) notes, however, that a ‘fundamental shortcoming’ of the legislation is the exclusion of casual workers – such as those on ‘if and when’ contracts – so that they remain vulnerable to economic risk in the labour market.

**Clawing back pay cuts in non-profit organisations**

In addition to reducing public expenditure on services such as home care, a second government response to the economic recession from 2008 was to cut public sector pay. When the economy later showed signs of improvement, public sector unions negotiated the restoration of pay through public sector-wide collective agreements (the so-called Landsdowne Road Agreements 2016–2018 and 2018–2020). While HSE-employed home care workers had the same schedule for pay restoration as the general public sector, care workers in Section 39 non-profit agencies were in a more precarious position. During the economic recession, three-quarters of Section 39 agencies experienced reductions in public funding (McInerney and Finn, 2015). The HSE took the view that as Section 39 employees should have received the pay increases that public servants had received in the past, then they should also expect to be part of the public sector pay reduction policy (McInerney and Finn, 2015). Forty per cent of agencies reduced working hours and over half cut employee pay, with home care workers experiencing pay cuts averaging 4.6 per cent (McInerney and Finn, 2015; Sheehan, 2018c). Once pay restoration was agreed for the wider public sector, unions began a ‘pay justice’ campaign for care workers and other staff in Section 39 agencies. The negotiations between the unions, SIPTU and Fórsa, and the HSE were fractious, with unions threatening strike action on several occasions. This was unsurprising given that full pay restoration was projected to cost almost €68m (Sheehan, 2018c). The state dispute resolution agency, the Workplace Relations Commission, intervened to help avoid industrial action in critical services and it brokered an agreement in October 2018. The agreement between unions and the HSE and Department of Health provided for pay restoration over three years, initially in 50 of the larger Section 39 agencies that accounted for half of HSE funding (Sheehan, 2018a). The agreement contained pay ‘increases’ of up to 6.5 per cent and the HSE committed to providing additional funds to Section 39 bodies (Sheehan, 2018b). It was expected that another 252 agencies that receive HSE funding would follow with a pay restoration schedule. By the end of 2019, however, the HSE (2019) stated its plan to limit cost growth by seeking further engagement over the feasibility of extending pay restoration to the remaining agencies. In this regard, SIPTU claimed that the government had frustrated the pay restoration process and, in addition, it argued that pay restoration had not begun in some of the original 50 bodies because they had not drawn down the additional funding from the HSE (Miley, 2020a; SIPTU, 2019a). This led to SIPTU and Fórsa engaging in a one-day strike in a small number of agencies in February 2020. This was followed by another agreement on pay restoration between SIPTU and a small number of larger Section 39 organisations in the Dublin region only. Two developments in 2020 delayed the achievement of full pay restoration across all Section 39 bodies: (i) a general election and slow formation of
a government, and (ii) COVID-19. In late 2020, SIPTU and Fórsa reignited the campaign and announced further industrial action, which was called off following another agreement brokered by the Workplace Relations Commission. This provided for two phases of pay restoration in 2021 to restore the pay of 7000 workers in Section 39 organisations and a commitment to further negotiations on remaining retrospective payments (Miley, 2020b; SIPTU, 2020e).

**Trade union responses during the COVID-19 pandemic**

Research on the occupational differences in COVID-19 outcomes in Ireland indicates that workers in caring personal services have a high risk of contracting the virus because of their greater exposure, and they face a greater risk of negative outcomes because of the relatively high proportion of such workers who have underlying health conditions (22 per cent) and live in areas of high deprivation (28 per cent) (Walsh et al., 2020). Personal service workers have faced numerous issues arising from COVID-19, and trade unions have prioritised three in their representation activities. The first concerns the health and safety of staff. A survey of carers and health-care assistants in April 2020 found that 70 per cent had limited or no training in COVID-19 (HCA and Carers Ireland, 2020). Unions severely criticised the lack of sufficient masks and sanitiser, especially in the early phases of the COVID-19 pandemic, and they called on the HSE to test and monitor health-care workers, and especially home care workers, given their proximity to high-risk care recipients (SIPTU, 2020d).

A second priority for unions was to achieve adequate staffing levels and working conditions in non-public health settings, such as Section 39 agencies and nursing homes. Nursing homes have received significant media attention because of their high rate of infections and mortality, accounting for over half of COVID-related deaths by mid-2020 (Coughlan, 2020). In April 2020, trade unions came to an agreement with the HSE on the redeployment of public health workers to private nursing homes. This was to operate on a voluntary basis and workers were to remain under the management of the HSE while redeployed (SIPTU, 2020b). During the COVID-19 pandemic, union interactions with political forums have highlighted the differences between working conditions in public and non-public settings. For example, unions have pointed to care workers’ lack of access to sick pay schemes in many private nursing homes in contrast to HSE-employed staff. Going further, SIPTU (2020c) called on the government to bring the private nursing home sector into state control for the period of the COVID-19 crisis ‘to ensure the most effective examination and oversight of the private nursing home sector’. Similarly, Fórsa (2020) proposed that Section 39 agencies and their staff be brought under the remit of the HSE for the duration of the crisis as they needed ‘maximum stability’. These demands did not seem so radical in the context of the state effectively taking over 19 private hospitals in preparation for anticipated large numbers of in-patients. Neither the government nor the HSE accepted the proposals, however.

A third problem presented by unions was the lack of child-care services for health-care workers, particularly in highly feminised roles such as home care, in which women constitute 96 per cent of the workforce (SIPTU, 2020a). During the first lockdown, the HSE estimated that 8000 health-care workers needed child-care support and unions demanded that the government and the HSE introduce special child-care measures (Wall, 2020). Government emergency plans to have registered child-care services provide child care in health workers’ homes were abandoned, however, after low participation by child-care services because of their concerns over virus protection and fulfilling their legal obligations as employers in homes.
Discussion and conclusion

What lessons can be learned from the trade union campaigns to improve the quality of jobs in care? The care sector presents unions with significant organising challenges: a precarious and dispersed workforce with weak associational power and a sector characterised by marketisation and privatisation, which weaken workers’ social rights (Mulkeen, 2016; Murphy and Turner, 2014). Unlike other sectors characterised by precarious work such as hospitality, the care workforce is divided between public, non-profit and for-profit private employers. The extent to which unions have achieved effective outcomes on terms of employment has depended on the type of employer, in turn reflecting union organising strength. With regard to the home care campaign, incremental improvements in pay, travel time and minimum working hours are valuable, particularly in relation to minimum working hours, which is a necessary companion to pay rates for achieving decent income and gender equality (Charlesworth and Heap, 2020). These advances have been primarily confined to publicly employed home care workers, however, among whom union organising has been led by large unions with a strong public sector presence, although there has been some spillover into non-profit organisations, some of which align employee terms of employment with those of HSE staff. Unions have been unable to gain sufficient organising strength to take industrial action or reach collective agreements with private employers. Their strategy for improving private workers’ job quality has been to join forces with unions representing precarious workers in retail and pursue political action for enhanced legal protections. The unions were successful in lobbying for a new employment law which extends some protection on working hours to non-unionised workers. With regard to the Section 39 campaign, sustained union mobilisation of workers in non-profits led to a pay restoration schedule and shows union effectiveness.

Notable features of both campaigns include their longevity, their use of militant tactics and the confrontational nature of their engagements with public sector employers. The improvements the unions achieved have been the result of extensive negotiations, strikes and strike threats, and therefore have required significant resources. Such intense mobilisation has been necessary because each ‘win’ achieved by unions through collective agreements has been conditional and tenuous. Pressures on the national health budget have led to fragile commitments by the HSE and the government, so that over the past 15 years, much of the industrial action engaged in or threatened by workers has been for the purpose of enforcing previous commitments reneged on by public employers. The workers already work in pressurised environments in the long-term care sector and this strain can be amplified by turbulent conditions in the broader health-care system (Cramm et al., 2013).

Unions’ organising challenges are likely to be exacerbated by the increasing privatisation of home care services, which has created a segmented workforce. Accurate employment data are difficult to obtain but estimates indicate that 9000–10,000 home care workers are publicly employed and 3500 are employed in Section 39 agencies, while figures on home care workers in private companies range from 6000 to 14,000 (Frawley, 2015; HCCI, 2019; Mazars, 2016). Home care workers in private organisations have low pay, irregular and insecure working hours and few benefits, such as sick pay. Personal care workers receive an average of €10.40 per hour in the private long-term care sector, which is 6 per cent above the national minimum wage, but substantially lower (23 per cent) than publicly paid rates (OECD, 2020). If the trend in the direction of public health spending towards private providers remains a key element of care policy, union gains through collective agreements will have limited impact if they apply to a smaller share of the workforce. In the face of increasing marketisation, the challenge for unions will be to organise greater numbers of workers in the private sector. This challenge has been impaired to date by...
unions’ need to mobilise significant resources in their disputes with public employers, diverting resources from organising in private employment.

Razavi and Staab (2010) contend that three factors in particular affect the employment of care workers: broader labour market structures which shape pay and conditions; social care policies; and the role of the state as an employer, funder and regulator of the sector. Arguably the state is the most influential factor, as it primarily shapes social care polices and labour market structures. It has been argued that the Irish state has prioritised competitiveness over social equity, leading to weak labour market regulation and a lack of state policies to improve the quality of precarious jobs (O’Sullivan et al., 2020). Similarly, political choices have served to detach the state from care provision. Ireland ranks below the OECD average for health expenditure on long-term care (OECD, 2017), and political pressure to reduce the cost of the public health-care system has resulted in increased outsourcing of HSE care services to a highly competitive market (Mulkeen, 2016). The marketisation of care services facilitates the expansion of the segmented workforce by undermining the ability of non-profit organisations to sustain terms of employment aligned with the public sector. Non-profits have been forced to compete with private providers for funding through competitive tendering after some private organisations took legal action against the HSE, arguing that state grants to non-profit organisations were a form of ‘unlawful state aid’ under EU competition law (Merceille and O’Neill, 2020). Section 39 organisations argue that public funding is insufficient, and for some services, the state’s price-setting process does not allow them to introduce pay parity with the HSE (Department of Health, 2015; Independent Review Group, 2018). Indeed, workers in non-profit organisations have borne the brunt of state policy, which is increasingly focused on a market logic and cost cutting. Non-profit organisations themselves recognise that when the state reduces their funding, it is subject to less negative commentary than if it cut publicly provided services and this:

is especially the case when the twin mantras of efficiency and effectiveness are rolled out alongside suggestions that it is profligacy on the part of service providers that has to be fixed as opposed to remedying weaknesses in the State’s economic and social planning. (Rehab Group, 2018: 52)

During the global financial crisis Section 39 agencies were under pressure from government departments to reduce their pay, but workers were excluded from pay restoration plans because they are not classified as public servants. The status of Section 39 workers contrasts with that of workers in ‘Section 38’ organisations. This latter group are also non-profit organisations, but their employees are classified as public servants and they enjoy associated public sector pay scales. The reason for this difference stems from the fact that Section 38 organisations provide a defined level of service on behalf of the HSE, while the service provided by Section 39 agencies can be more variable. Kessler et al. (2020) argue that greater alignment of employment practices between public, private and voluntary sector service providers is necessary in the health and social care sector. Ultimately, a union strategy that aims to move Section 39 workers to the same terms as Section 38 employees could prove fruitful in delivering long-term improvements to employment standards in the sector.

An ongoing challenge for trade unions is to contest the privatisation of long-term care services in a context of enduring neoliberal political choices, that have been reinforced by the actions of a progressively more organised and mobilised group of private employers. As in other countries, private providers often point to a lack of funding in the system as a constraint on decent working conditions. Similar arguments put forward in the United Kingdom, however, have been identified as part of a narrative that suits the interests of large private care providers and oversimplifies the
issues of how much money goes into the care system and where that money goes (Burns et al., 2016). Trade union campaigns in Ireland have increasingly been framed around a message that public provision offers superior value for money than private provision. Unions have highlighted the profit-making function of private providers, and have noted that, even though the government has been increasing expenditure on home care in recent years,

The elephant in the room is that tens of millions of euros are being paid into private hands. The Government pays agencies up to €28 per hour to provide home support. The average wage for non-unionised home care workers is less than €12 per hour. These healthy profit margins should be curtailed and reinvested in the service. Otherwise, we will continue to go around in circles. Any new deal for home care must be run for people, not for profits. (SIPTU, 2019b)

Trade union arguments about the value of public over private services have been twinned with messages about the potential for home care workers to assist in alleviating the problems of delayed discharges of the elderly from hospitals and associated hospital overcrowding. These arguments have had some success in collective agreements, with the HSE committing to increase funding of home care provision and to direct job creation. A key lesson for unions may be the need not only to increase the public’s perception of the value of care work but also its understanding of how the sector is financed and how profit is generated in it. Lolich and Timonen (2020) cite the lack of transparency when it comes to the allocation of care. Their findings illustrate the importance of having carers that can advocate for older or vulnerable persons in obtaining access to care. Lack of clarity around the allocation of hours also affects workers in terms of security and earnings. This represents a tangible issue on which unions can campaign for improved transparency in the sector for the benefit of both carers and clients. The private for-profit provision of paid care assumes that care as a service is best managed through ‘the market’ (Meagher and Cortis, 2008), but the COVID-19 pandemic highlights the fact that private provision carries care risks and that it does not absolve the state of care responsibilities. Unions can build on broad political support for social policy changes as a recent cross-party report on the future of health care called for an end to the ‘over-reliance on market mechanisms to deliver new health-care services by the expansion of public nursing homes and home care’ (Houses of the Oireachtas, 2017: 77). This goal can also be viewed as highly aspirational, however, in the context of an institutional legacy in which: state policy on elder care is at a low level of generosity and funding (Eggers et al., 2020); there are a comparatively low number of long-term care workers (OECD, 2020); and state policies have become embedded that have led to a strong private sector presence in care services. In addition, the expansion of the national budget deficit as a consequence of COVID-19 may be exploited to reinforce state narratives on the need to contain costs and bolster the role of ‘the market’ in the delivery of care.

Hewko et al. (2015) described workers in the long-term care sector as a relatively invisible workforce in the eyes of the public, but the COVID-19 crisis has to some extent raised public awareness of work in the sector. In fact care work it could be argued is far from being ‘low-skilled’ and has sparked a growing debate about social changes that may be needed in the sector (Resolution Foundation, 2020). One of the greatest structural challenges to overcoming low pay and poor conditions in the sector is the lack of institutional recognition afforded to care work, which derives from the pervasive, gendered undervaluation of care (Atkinson and Lucas, 2013). Bergfeld and Farris (2020) suggest that the COVID-19 pandemic may facilitate the erosion of the high skill/low skill distinction and encourage a re-evaluation of the socio-economic worth of certain occupations. From a trade union perspective, taking advantage of this may entail pushing forward with efforts to
highlight the value of investing in workers in the sector. Spasova et al. (2018) contend that the attractiveness of the sector to workers remains low, so that union lobbying of government for changes that enhance the status of care workers is imperative to securing a high functioning care sector in the future.

There is a risk that organising fatigue may be setting in among workers in the sector. To counteract this, unions must remain innovative in how they design campaigns and continue to seek ways of advancing workers’ concerns in the private and non-profit sectors. The sudden onset of the COVID-19 pandemic illustrates how quickly changes can occur in any sector. Prior to the pandemic, collective action had already been taken on substantive issues, which meant that the demands being made were not viewed as new, which is potentially important in shaping public support. Finally, COVID-19 has revealed the extent of policy failure in the long-term care sector across a number of European countries. While unions in different countries have had some success in achieving change, the pandemic presents an opportunity for a new impetus for a coordinated European response to the care sector. A coordinated trade union, carer and patient representative body approach to lobbying for a European directive on care provision, rooted in higher staffing ratios and enhanced regulations, is one possible route to securing positive long-term changes in the sector.

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