Home care workers' views of employment conditions: private for-profit vs public and non-profit providers in Ireland

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Abstract

Purpose – The purpose of this paper is to compare home care workers' views of their employment conditions by provider type – private for-profit vs public and non-profit – using the case study of Ireland.
Design/methodology/approach – An online survey was distributed to care workers ($n = 350$) employed by private for-profit, public and non-profit home care providers in Ireland. Returned questionnaires were analysed statistically in R using chi-squared tests to systematically compare key aspects of employment conditions.
Findings – Analysis shows that conditions are perceived to be significantly worse for those employed by private for-profit providers (and to a lesser extent non-profit organisations) compared to the public provider. There are wide disparities between public and private sector conditions in terms of contracts, pensions, unsocial hours pay and travel time allowances. The main area of convergence is in relation to employer support, where although the public sector performed better, the difference between the three provider types is smaller.
Originality/value – Relatively little research compares working conditions in private for-profit providers vs public and non-profit providers in Ireland and other countries. The findings can be understood in the context of marketisation reforms and may partly be explained by a lack of regulation in Ireland's home care sector and low unionisation rates amongst care workers employed by private for-profit providers.

Keywords Employment conditions, Private for-profit providers, Care workers, Home care, Precarious employment, Marketisation, Privatisation

Paper type Research paper

Introduction

Home care workers experience some of the worst employment conditions amongst the health and social care workforce (Addati *et al.*, 2018). Home care work is increasingly characterised by precarious employment, which can be defined as work that has several key features of poor job quality, for instance, employment insecurity (e.g. temporary contracts), poor terms (e.g. low pay and lack of benefits) and limited rights and protection (e.g. lack of unionisation and regulatory support) (Hussein, 2017; Rubery *et al.*, 2011; Strandell, 2020). Existing studies on precarious employment consistently link labour precarity to commoditization, privatisation and marketisation – highlighting the role of the market in creating and sustaining a globalised "precariat" (Aulenbacher *et al.*, 2018; Giordano, 2021; Standing, 2011).

In recent decades, home care employment conditions have deteriorated in several countries due to marketisation reforms, cost-cutting policies and New Public Management

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(NPM) – which aims to make public services more "business-like" and efficient by using private sector management models (Aronson, 2006; Aulenbacher *et al.*, 2018; Carbonnier and Morel, 2015; Christensen and Pilling, 2017; Denton *et al.*, 2002; Yakerson, 2019). The consequences of those processes on working conditions can differ depending on the institutional context in which they are implemented, as well as workers' immigration status (Doerflinger *et al.*, 2021; Shutes and Chiatti, 2012; Theobald *et al.*, 2018). Employment in the home care sector has become commodified and fragmented (Meagher *et al.*, 2016; Ungerson, 2003), leading to work intensification and time constraints (Atkinson and Crozier, 2020; Chowhan *et al.*, 2019; Rubery *et al.*, 2015; Strandell, 2020; Stranz and Szebehely, 2018). Home care work also been subjected to increased casualisation, including lower pay and benefits (Aronson and Neysmith, 2006; Cunningham, 2016; Hussein, 2017; Rubery and Urwin, 2011; Theobald, 2012), job dissatisfaction and increased stress (Denton *et al.*, 2002; Giordano, 2021; King *et al.*, 2013; Trydegard, 2012). The coronavirus disease 2019 (COVID-19) pandemic has worsened these key issues relating to precarious care work (Eurofound, 2020; Hudson, 2021; Leiblfinger *et al.*, 2021; OECD, 2020). The pandemic compounded pre-existing structural problems in health and social care systems globally – such as underfunding, expenditure cuts and labour shortages (Navarro, 2020; OECD, 2020; World Health Organisation, 2020).

Within this context, our article compares home care workers' views of their employment conditions by provider type (private for-profit vs public and non-profit) using the case study of Ireland. Hereafter, we use the terms "private providers" and "for-profit providers" interchangeably to refer to commercial, private for-profit companies that provide domiciliary home care services for older people. The article contributes to limited existing research that focusses directly on working conditions in private for-profit home care providers. It can be difficult to document employment conditions empirically from the perspective of care workers when they are employed by private providers, due to a paucity of data and lack of access to employees of private businesses (Atkinson and Crozier, 2020; Burau *et al.*, 2007). In particular, the article adds to the growing number of studies that compare, with varying degrees of systematicity, working conditions by provider type (Giordano, 2021; Grimshaw *et al.*, 2015; Hussein and Manthorpe, 2014; Rubery and Urwin, 2011; Theobald *et al.*, 2018). We use an exploratory survey with care workers employed by private for-profit, public and non-profit home care providers to begin to understand the differences and commonalities between providers in an Irish context.

Ireland's home care sector and the growth of for-profit provision

The literature on European care regimes (Bettio and Plantenga, 2004; Fischer *et al.*, 2021) facilitates comparison of long-term eldercare systems and allows us to situate Ireland's home care sector in the context of Europe. Ireland has traditionally been classified as a residual long-term care system that relies significantly on women and the family, with the government taking a laissez-faire approach to home care (Genet *et al.*, 2012). Historically, the minimalist role of the state was supported by the Catholic principle of subsidiarity, which argued that home care was the responsibility of informal or family carers (largely female) as well as religious voluntary organisations and churches (Timonen and Doyle, 2008). In this sense, Ireland's care regime is similar to that of Italy, Spain, Portugal and Greece (Ilinca *et al.*, 2015). However, Ireland also shares historical similarities with the UK system (Bettio and Plantenga, 2004); in recent decades, it developed significant public provision of home care and residential nursing homes that has been transformed by marketisation in recent years (Ariaans *et al.*, 2021; Lolich, 2019; Mercille and O'Neill, 2021).

The neoliberal nature of the Irish state has driven the growth of private for-profit home care provision through market-based outsourcing policies such as competitive tendering and "home care packages" (Mercille and O'Neill, 2021). The implementation of the home care

package scheme in 2006 represents a key policy milestone in the development of Ireland's home care sector because it provided impetus to the initial growth of the private for-profit sector. The policy rationale behind the home care package scheme was cost containment. The government did not want to increase the care worker head count in the public sector because this results in costly benefits (e.g. pensions) that are paid for by public funds (Mercille and O'Neill, 2021). Thus, instead of the state investing in public care provision to address capacity issues, public funds have been channelled towards private providers to meet demand for home care. The austerity years that followed the 2008 economic recession served as fertile ground for the growth of private providers. Public expenditure and employment were scaled back, and this served as an ideal environment for the private sector to gain a strong position in the industry. The competitive tendering system was implemented in 2012 and has underpinned the deepening and accelerated expansion of the private for-profit sector over the last decade. Tendering is the key mechanism through which care is contracted and outsourced in Irish home care. Tendering allows private sector providers to compete for service provision based on criteria of price and quality requirements. It further reorients the state's role away from providing care publicly by outsourcing care to private providers instead.

This is highlighted by the proportion of annual public expenditure allocated to private providers, which has increased dramatically from 5% in 2006 to 40% in 2019 (Mercille and O'Neill, 2021). Conversely, the proportion of public expenditure allocated to public provision of home care declined from approximately 85% in 2006 to 50% in 2019. Non-profit providers remained at around the same level over this period (10%). In terms of total hours delivered, private sector providers now account for 58% of total hours delivered, whilst the public provider [the Health Service Executive (HSE)] accounts for 42% (Health Service Executive, 2020). Private for-profit providers are now dominated by a few global chains (e.g. Home Instead, Comfort Keepers, Bluebird Care), alongside a few smaller family owned firms. The trend in Irish home care is towards concentration of ownership and the large multinational care operators have consolidated in recent years. Private providers have gained "institutional business power" and are now key actors in home care who have significant influence over policy (Mercille and O'Neill, 2022).

In Ireland, home care provision is still provided on a non-statutory basis (although a statutory home care scheme is currently at an advanced stage of development (Department of Health, 2022b). This means that there is no national definition of eligibility and entitlements to home care, in contrast to the nursing home sector where the nursing home support scheme (or "Fair Deal") underpins provision. Ireland's home care sector is largely unregulated and fragmented, and there is no social insurance system (Kiersey and Coleman, 2017). Currently, clients can receive publicly funded home care through an assessment by the Health Service Executive (HSE) that determines how many weekly hours they can receive – which is free for clients. There is also a significant market whereby clients pay private and non-profit providers out of their own pockets. A typical example is that a client might be entitled to 10 h per week approved by the HSE and for free, and then the client/their family will pay a private provider out of pocket for an additional 5 h of home care per week (15 h of care total). The main private providers do both publicly funded care (through the tendering system) and some purely private hours. Roughly 75% of private providers' income is from the state and 25% is from the private pay market (Mercille and O'Neill, 2021). There is also a growing trend towards "live-in" home care in recent years, and private for-profit providers are starting to capitalise by pursuing their business interests in this area (Mercille, 2023). This article focusses on "formal" home care, which is significant in Ireland, though "informal" (family) carers have traditionally provided most of the care in the home (Daly, 2018).

There is a lack of scholarship on employment conditions in Ireland's home care sector, although eldercare advocacy groups have reported relevant issues (Conyard *et al.*, 2020; Migrant Rights Centre Ireland, 2015). Yet, the main study (Timonen and Doyle, 2007)

comparing employment conditions by provider type was conducted before the most acute period of marketisation and privatisation in the home care sector (i.e. 2012 to present). Recent work has surveyed COVID-19's impacts on health workers and service users in eldercare (Mercille *et al.*, 2022; Pierce *et al.*, 2020). Unsurprisingly, home care workers faced difficult and precarious conditions during the pandemic. For instance, there was a lack of key protections supplied to workers against COVID (e.g. adequate personal protective equipment), demands on care workers increased drastically, and a large proportion of private sector care workers received no sick pay (Mercille *et al.*, 2022). The pandemic has laid bare deep systemic flaws in Ireland's home care sector and exposed the significant impacts of cost-cutting policies and undervaluing the care workforce (O'Neill, 2020). European population ageing and the pandemic have highlighted the importance of home care and pushed community-based eldercare approaches to the forefront of domestic health policy agendas across Europe. Moving forward, private for-profit providers and their care workers are expected to meet substantial portions of future needs. This underlines the necessity of systematic research that focusses on private providers, the employment conditions they offer and how care work compares with public and non-profit providers.

Methodology

Our questionnaire asked care workers about their employment conditions through 51 questions including Likert-type and multiple-choice questions. Given the exploratory nature of the study and the focus on perceptions, a quantitative survey design was most appropriate for our research objectives. The survey questions and corresponding hypotheses were formulated in advance and clearly delineate the scope of the project. The questions used in the survey were crafted to address specific issues related to the employment conditions of care workers in Ireland. They were validated by two management figures highly experienced with home care work (an HSE manager and a person associated with health care assistants (HCA) and Carers Ireland).

Hypothesis formulation was aimed at comparing several key aspects of home care workers' employment conditions by provider type (H1-H6):

H1. There will be a significant difference in how care workers perceive their employment conditions by provider type – public vs private vs non-profit.

H2. There will be a significant difference in the contractual situations of care workers by provider type.

H3. Whether care workers receive a pension entitlement or not will differ significantly by provider type.

H4. Whether care workers receive travel time pay or not will differ significantly by provider type.

H5. Whether care workers receive unsocial hours pay or not will differ significantly by provider type.

H6. The level of employer support received by care workers will differ significantly by provider type.

Two organisations served as gatekeepers for our study – the Services Industrial Professional and Technical Union (SIPTU) and the advocacy group HCA and Carers Ireland. They are the

two main representative bodies for professional home care workers in Ireland with members working for all three types of providers (private, public non-profit). SIPTU gave access to its 6,000 home care public sector workers, representing 95% of all unionised home care workers in Ireland (most work for public providers and some for non-profit organisations). HCA and Carers Ireland, an advocacy group and social network, committed to the education, support and well-being of care workers has about 15,000 members (mostly home care and nursing home care workers), including many care workers employed by private for-profit and non-profit home care providers. It constitutes an effective channel to access care workers employed by private for-profit providers, who are otherwise difficult to reach. Precise data are unavailable in Ireland, but it is estimated that there are 9,000–10,000 publicly (HSE) employed care workers, 6,000–14,000 privately employed and 3,500 working for non-profit organisations (Murphy and O'Sullivan, 2021).

Eligibility to participate in the survey required respondents to have worked as a professional care worker for a home care employer that is either private, non-profit or public (HSE) during the last year. The survey was anonymous and distributed in December 2020 and ended in January 2021. It received ethical approval by University College Dublin and conforms to all General Data Protection Regulation requirements. Care workers chose to participate without any pressure from the researchers.

We received 350 questionnaires in total and are confident that this is an adequate number for the study. We performed power analysis to determine the appropriateness of our sample size, given our distributions of group sizes and hypothesised contrasts (set at 0.5, 0.5 and 1 for non-profit, private and public employees, respectively) for Kruskal–Wallis tests. These contrasts indicate that we expected variance within each group and differences in results between public employees and each of the other two groups (Field *et al.*, 2012). We found that 80% power would be attained to detect significant effects at a sample size of 170, making our sample size of 350 more than adequate to carry out these tests. The determination of 80% power follows best practice (Cohen, 1992) and means that if a genuine effect exists in the statistical tests selected, we expect an 80% chance of detecting it at the selected sample size.

We analysed data in R version 4.0.3 (R Core Team, 2020), primarily involving three types of statistical tests: Chi-Squared tests, Kruskal–Wallis tests and Skillings–Mack tests. Chi-squared tests are non-parametric tests used to compare counts of categorical data types (Field *et al.*, 2012; Siegel and Castellan, 1988). Kruskal–Wallis tests are conservative, non-parametric alternatives to ANOVA tests allowing for comparisons of means of numerical data between groups when distributions are not normal (Field *et al.*, 2012). Skillings–Mack tests are non-parametric tests used to compare means of numerical data between groups for data in which subjects may belong to more than one group (Skillings and Mack, 1981; Srisuradetchai, 2015). Finally, we used non-parametric post-hoc multiple comparisons tests to assess differences between groups following Kruskal–Wallis and Skillings–Mac tests (Siegel and Castellan, 1988). Kruskal–Wallis and Skillings–Mac tests are like ANOVAs in that they are omnibus tests; their results indicate that a difference exists between the means of several groups, but they do not indicate the source of that difference (Field *et al.*, 2012). Post-hoc tests allow for pairwise comparisons between groups to determine which pairs of groups differences exist between.

It is important to point out the limitations of our methodology. First, SIPTU distributed the online questionnaires by email and via private internal messaging (WhatsApp group) to a random sample of 500 of its members working for the HSE. We received 163 questionnaires from SIPTU (a response rate of 163/500 or 32.6%). Second, HCA and Carers Ireland distributed the questionnaires to its professional home care workers through its social media (Facebook) page. We received 187 questionnaires, a relatively low number given the group's total number of members. It is not possible to know how many care workers received the

questionnaire (i.e. true sample size) because we do not know if they visited HCA and Carers Ireland's Facebook page during the days when the questionnaire was available or whether the social media algorithm made the questionnaire visible to all care workers. Communication within both groups is not formalised, so we viewed these recruitment channels as the best means to get large samples of care workers although we acknowledge that this may introduce unsystematic selection bias.

In an Irish context, we consider this methodology acceptable. However, the survey was not as effective to reach workers as could have been possible through formal distribution channels. Moreover, social media does not permit precise tracking of a defined sample and response rate, and HCA and Carers Ireland's membership is not systematically compiled in a formal database. A bias possibly present in the sample is that care workers who are members of either a trade union or advocacy group would tend to be concerned about working conditions because both organisations have the ethos to advocate on their behalf. Our sample may thus under-represent care workers who are satisfied with their working conditions and who do not wish to advocate for home care workers or are unable to do so. Our total sample also over-represents unionised workers because they were easier to access than non-unionised ones, who tend to work for private providers. We also assume that privately employed non-unionised workers may have been less confident in taking part in our survey because their jobs are more precarious than those of unionised workers and they may not wish to comment negatively on their private employer. There is also the possibility that care workers with the worst conditions may not have responded to the survey because of too difficult conditions (e.g. not having time, work intensification and stress). This is especially true given the timing of the survey (December/January 2020), when care workers were overloaded due to COVID-19 and in precarious situations. Finally, whilst we took care to apply Bonferroni corrections to account for the familywise error rate when making multiple hypothesis tests, we acknowledge that testing several hypotheses in a single study is prone to false-positive results.

Findings

We received 350 questionnaire responses. Amongst these respondents, there were 332 female, 13 male and 5 "preferred not to say". Also 195 reported working primarily for the HSE, 106 primarily for a private provider and 46 primarily for a non-profit provider. In our sample, trade union membership was 90% for carers working primarily for the HSE (public provider), with corresponding numbers of only 9% for carers employed by private providers and 57% for those employed by non-profit providers. In terms of working hours, 75% of public care workers, 59% of private care workers and 59% of non-profit care workers would all like to work more hours per week. These findings, taken in conjunction with the high proportion of care workers with multiple employers (27%), suggest that workers are not provided with enough hours across all three provider types.

Respondents' characteristics are displayed in Table 1. It reveals a largely female care workforce and that public sector care workers tend to be older and have more experience. It

Table 1. Respondents' characteristics

Employer type	Number of female/total respondents	Average year of birth	Average years of experience	City/town/rural (number of respondents)	QQI qualification full/partial/none (number of respondents)
Private	101/106	1973	7.6	29/37/40	70/29/7
Non-Profit	44/46	1969	12.5	14/21/11	39/7/0
Public (HSE)	187/195	1966	16.7	27/55/113	159/23/13

also demonstrates that private and non-profit employers tend to be dominant in urban areas, whereas the public provider (HSE) is the main employer in rural areas. These characteristics are largely expected. Private providers are typically concentrated in cities/urban areas, whilst home care provision in remote/rural areas (which is more expensive to access) is often left to the public provider. Private sector employees occupy more precarious jobs, resulting in more staff turnover and younger individuals like students taking up employment for a few weekly hours. With respect to training and qualifications, most care workers have a full Level-5 award in health care from Quality and Qualifications Ireland (QQI) – which is the national agency responsible for qualifications. Though in relative terms, this is less likely to be the case for those working for private providers. To clarify, as per HSE tender guidelines, home care workers in Ireland are required to have achieved at least a QQI Level-5 certificate (what we refer to as a "partial QQI qualification") and be working towards a QQI Level-5 major award in health care (what we refer to as a "full QQI qualification"). The partial QQI qualification requires care workers to complete two modules ("Care Skills" and "Care of the Older Person"), whilst the full QQI award requires completion of eight/nine modules.

Our survey also asked respondents about their main tasks as care workers. The most common tasks were "activities of daily living" (for example, personal care, assisting with meals, washing and dressing) (mentioned by 98% of HSE care workers, 100% of private care workers and 98% of non-profit care workers); moving people (89%, 91% and 93%, respectively); medication prompting (84%, 77% and 93%, respectively); cleaning tasks (51%, 78% and 89%, respectively); companionship (46%, 85% and 80%, respectively) and nursing tasks (34%, 28% and 35%, respectively).

Care workers' views of employment conditions

To address our first hypothesis (H1) that there is a significant difference in how care workers perceive employment conditions between public, private and non-profit providers, we asked two Likert-type questions which participants answered on a five-point scale. First, "*How would you rate the working conditions offered by your employer?*" and second, "*Ideally, for which type of provider would you like to work?*" In relation to the second question, the assumption is that a care worker wishes to work for a certain type of employer because they feel that working conditions are better there.

We found that working conditions were rated highest by public (HSE) care workers (mean [M] = 3.69 and standard deviation [SD] = 1.03) followed by those working for non-profit organisations (M = 2.86 and SD = 1.20) and private providers (M = 2.78 and SD = 1.22) (Table 2). To determine if these results were significant, we intended to perform a one-way independent-means ANOVA, looking only at participants' perceptions of their primary employers, but we found that distributions of scores within each employment type were not normally distributed (Shapiro–Wilk's test of normality $p < 0.05$), so we elected to use a more conservative, non-parametric Kruskal–Wallis test (Field *et al.*, 2012). We found that there was a significant difference between working conditions by employer type, Chi-squared statistic (2) = 45.21 and $p < 0.001$.

To determine the source of the difference, we performed post-hoc non-parametric pairwise Wilcoxon rank sum tests with Bonferroni-Holm corrections. We found that there are no

Table 2. Working conditions by primary employer type

	Public (n = 195)	Private (n = 106)	Non-profit (n = 46)	p-value (chi-squared (2))
Mean	3.69	2.78	2.86	<0.001
SD	1.03	1.22	1.20	

significant differences between care workers' perceptions of working conditions with private and non-profit providers ($p > 0.05$), but there are significant differences between both public and private ($p < 0.001$) and public and non-profit ($p < 0.001$) perceptions of working conditions. Public sector workers report better working conditions than those employed by private and non-profit providers.

As a confirmatory step, we also performed a non-parametric Skillings–Mack test comparing those care workers who worked for multiple employers ($N = 96$). Our results for multiple-employer participants similarly found that there was a significant difference in working conditions by provider type, Skillings–Mack statistic (2) = 17.71, $p < 0.001$. Non-parametric post-hoc multiple comparisons tests (Siegel and Castellan, 1988) for this group also showed no significant differences between care workers' perceptions of conditions in private and non-profit providers ($p > 0.05$), but there are significant differences between both public and private ($p < 0.05$) and public and non-profit ($p < 0.05$).

Finally, we performed a Chi-squared test comparing participants' answers for which type of provider they would ideally like to work for. We found that there was a statistically significant difference between provider types, Chi-squared statistic (4) = 73.95 and $p < 0.001$. As shown in Table 3, 70% of non-profit care workers (32/45) and 71% of private care workers (75/106) would ideally like to work for the public provider, whilst 96% of public sector care workers chose their current employer as their ideal type.

In short, all three statistical tests provide evidence supporting H1 that there is a significant difference in perceptions of working conditions between public, private and non-profit providers. All three had $p < 0.001$, meaning they are significant at Bonferroni-corrected alpha criterion 0.017 (0.05/3 tests).

Contractual situation

To address our second hypothesis (H2) that there is a difference in the contractual situations of care workers employed between public, private and non-profit providers, we asked one question, "*What type of contract are you on*?" Participants answered by choosing one of the three main contract types in Irish home care: "*full/part time permanent contract*", "*if and when type contracts*" or "*contracted hours contract*". To clarify, "if and when" type contracts are essentially zero-hour contracts with no guaranteed hours. We performed a Chi-squared test on this group and found that "if and when" type contracts differed significantly by employer type, Chi-squared statistic (2) = 49.81 and $p < 0.001$.

We chose to focus on this group of participants who are on "if and when type contracts" ($N = 62$) because this grouping offers the most important results for comparison. Care workers employed by private providers make up 61% of those on "if and when" type contracts (38/62), whilst publicly employed (16%) and those employed by non-profit providers (23%) represent relatively low proportions of care workers on these contracts. As shown in Table 4, "if and when" type contracts are highly prevalent amongst workers employed by private providers, 38/106 (36%) and non-profit providers, 14/45 (30%).

Table 3.
Ideal employer by current employer type

	Public (HSE) ($n = 192$)	Private ($n = 106$)	Non-profit ($n = 45$)	p-value (chi-squared (4))
Non-profit ideal employer	3	10	13	<0.001
Private for-profit ideal employer	4	21	1	
Public (HSE) ideal employer	188 (96%)	75 (71%)	32 (70%)	

Conversely, only 10/195 (5%) of care workers employed by the public provider are on "if and when" type contracts.

Pension entitlement

To address hypothesis three (H3) that pension entitlement differs by provider type, we asked one question, "*Do you have pension entitlements*?" to which participants answered yes or no. We performed a Chi-squared test by employer type and found a significant difference in pension status (Chi-squared statistic (2) = 170.06, $p < 0.001$), thus supporting H3. Only 4/106 private care workers (4%) and 2/46 non-profit care workers (4%) receive a pension entitlement in comparison to 144/195 (74%) public care workers (Table 5).

Travel allowances

To address our fourth hypothesis (H4) that whether travel time is paid differs by employer type, we asked one question, "*Is your travel time paid*?" to which participants answered yes or no. We performed a Chi-squared test and found a significant difference in paid travel time by employer type (Chi-squared statistic (2) = 154.65, $p < 0.001$), thus supporting H4. As highlighted in Table 6, 172/195 public care workers (88%) receive paid travel time, whereas the corresponding figure for private care workers is 18/106 (16%) and 18/46 (39%) for non-profit care workers.

Unsocial hours pay

To address hypothesis five (H5) that whether care workers are paid extra for unsocial hours worked differs based on if they are employed by a public, private or non-profit provider, we asked one question, "*Do you get paid extra for unsocial hours worked*?" to which participants answered yes or no. Again, we ran a Chi-squared test by employer type and found a significant difference, Chi-squared statistic 2 (2) = 79.64 and $p < 0.001$, which supported H5. Public care workers are once again the standout group with 148/195 (76%) reporting that they receive extra pay for unsocial hours worked (Table 7). On the other hand, only 24/106 (23%) workers in the private sector reported that they are paid extra for unsocial hours worked. Non-profit workers are split evenly between yes and no with about the same proportion receiving extra pay for unsocial hours worked as not.

Table 4. "If and When" type contracts by employer type

	Public (HSE) (n = 195)	Private (n = 106)	Non-profit (n = 45)	p-value (chi-squared (2))
"If and When" type contract	10 (5%)	38 (36%)	14 (30%)	<0.001

Table 5. Pension entitlement by employer type

	Public (HSE) (n = 195)	Private (n = 106)	Non-profit (n = 46)	p-value (chi-squared (2))
Yes	144 (74%)	4 (4%)	2 (4%)	<0.001
No	42	99	42	
Prefer not to say	9	3	2	

Level of support

To address H6 that there is a difference in the level of support received by workers employed by public, private and non-profit providers, we asked two questions: first, "*Do you feel supported by your employer?*" which is a Likert-type question that participants answered on a five-point scale ranging from "very little" to "very much"; second, "*Is your employer responsive to employees' feedback on work-related issues?*" which participants answered yes or no. First, we found that levels of support were rated highest by public care workers (mean [M] = 3.28 and SD = 1.22) followed by care workers employed by non-profit providers (M = 3.06 and SD = 1.20) and private providers (M = 2.95 and SD = 1.32) (Table 8). To determine if these results were significant, we performed a non-parametric test to compare ratings of support by provider type. There was no significant difference, Chi-squared statistic (2) – 4.51 and p = 0.10.

Second, we ran a Chi-squared test by employer type to compare employer responsiveness to care workers' feedback. We found a significant difference, Chi-squared statistic (2) = 9.14 and p = 0.01. As shown in Table 9, 128/195 public care workers (66%) stated that their employer is responsive to feedback on work-related issues. The corresponding figure for care workers employed by private providers is 55/106 (52%) and for non-profit care workers is 21/46 (46%).

Therefore, H6 is partially supported. One of two questions found significant differences, with Bonferroni-corrected alpha criterion of p = 0.025 (p = 0.05/2 tests).

Discussion

Our findings reveal that several key aspects of care workers' employment conditions are perceived to be significantly worse by private sector care workers than those employed by the public provider (HSE). There is a particularly stark difference between the terms and

Table 6. Travel allowances by employer type

	Public (HSE) (n = 195)	Private (n = 106)	Non-profit (n = 46)	p-value (chi-squared (2))
Yes	172 (88%)	18 (16%)	18 (39%)	<0.001
No	23	88	28	

Table 7. Extra pay for unsocial hours worked by employer type

	Public (HSE) (n = 195)	Private (n = 106)	Non-profit (n = 46)	p-value (chi-squared (2))
Yes	148 (76%)	24 (23%)	24 (52%)	<0.001
No	47	82	22	

Table 8. Levels of support by employer type

		Public (HSE) (n = 195)	Private (n = 106)	Non-profit (n = 46)	p-value (Chi-squared (2))
Level of support	Mean	3.28	2.95	3.06	0.10
	SD	1.22	1.32	1.20	

Table 9. Employer responsiveness to worker feedback by employer type

	Public (HSE) (n = 195)	Private (n = 106)	Non-profit (n = 46)	p-value (Chi-squared (2))
Yes	128 (66%)	55 (52%)	21 (46%)	0.01
No	67	51	25	

conditions of care workers employed by for-profit providers versus the public sector, with non-profit workers somewhere in the middle. Our findings extend previous research that has focussed on the working conditions of unionised public and non-profit care workers (Meagher *et al.*, 2016; Trydegard, 2012) by deepening our understanding of care workers employed by private for-profit providers and how their conditions compare. The results also corroborate existing research on the implications of home care marketisation for the employment conditions of care workers (Rubery and Urwin, 2011; Stranz and Szebehely, 2018; Theobald *et al.*, 2018).

The central findings of our study reveal the perceived precarity and inferior terms faced by care workers employed by private providers (and to a lesser extent non-profit providers) compared to the public provider. Zero-hour, "if and when" type contracts are significantly more prevalent amongst care workers employed by private companies and non-profit providers than the public provider. Our findings also highlight the lack of benefits for workers employed by private providers in contrast to their counterparts in the public sector. Pension entitlement amongst public care workers is very common, but barely any private or non-profit care workers have a pension entitlement. Extra pay for unsocial hours worked is also much more common for public care workers than those who are employed by private or non-profit providers. This public-private disparity is also evident in terms of travel time allowances – most public care workers receive paid travel time allowances, whereas very few care workers employed by private providers do.

These findings support previous research which shows that outsourcing home care exposes care workers to increased levels of job insecurity and poor conditions because it incentivises employers to adopt leaner forms of work organisation to remain competitive (Aronson and Neysmith, 2006; Boris and Klein, 2006). Private home care providers often operate within a rigid public funding structure (typically a competitive tendering system), leaving them to enhance their profit margins through low wages, minimal employment terms/benefits and maximising the productivity of their workers (Brennan *et al.*, 2012; Denton *et al.*, 2006; Simonazzi, 2008). Our findings align with this body of research and suggest that marketisation degrades the working conditions of care workers, with lower labour costs (through savings on contracts, pensions, pay and benefits) acting as a source of profit for private care providers.

There are two key factors that help to explain these findings. First, there is a lack of regulation and monitoring in the private home care sector (Daly, 2018). As highlighted earlier, Irish home care is provided on a non-statutory basis and is lightly regulated. The Irish state has been reluctant to govern home care services; however, that is not to say that regulation alone would guarantee better protection and conditions for care workers. The role of state regulation can be contradictory in that it can both improve worker protections and create precarity depending on context and the type of regulation that is implemented (Matilla-Santander *et al.*, 2022; Siegmann and Schiphorst, 2016).

Second, workers' ability to ask for and obtain better working conditions is hindered by low unionisation rates in the private (and non-profit) sectors. Unionisation rates of only 9% for carers employed by private providers and 57% for those employed by non-profit providers contrast sharply with the 90% unionisation rate in the public (HSE) sector. There have been significant moments in recent years when trade unions (such as SIPTU) have successfully negotiated better rights and protections for public sector (HSE) care workers. For example, home care working conditions were formalised in the early 2000s following trade union campaigns and collective agreements to recognise care workers as professional employees. Prior to those union campaigns in 2002 and 2004, home care workers were deemed as self-employed by the HSE. In subsequent years, unions also negotiated better employment conditions for workers in the public sector. Specifically, those improved terms included guaranteed minimum hour contracts, paid travel time between clients, travel expenses (e.g. fuel allowances) and unsocial hours pay (e.g. working on Sunday's) (Murphy and

O'Sullivan, 2021). Many private sector care workers employed by non-profit and for-profit providers did not reap the rewards of those more favourable employment terms because their employers are not compelled to follow those agreements (Murphy and O'Sullivan, 2021). The benefits of union membership were also evident in relation to pay restoration post-2008 economic recession. Fiscal consolidation saw pay cuts applied to public and non-profit care workers during the austerity years. Public sector care workers had their pay automatically restored as the economy eventually began to recover but many working for non-profit employers did not. Unlike trade union members in the public sector, many care workers in the non-profit sector have no organised way to negotiate pay restorations and are not recognised as part of the public service.

Our results also call attention to the level of support received by care workers from their employer. Interestingly, there is a smaller difference in levels of support between employer types compared to the other aspects of care workers' employment conditions discussed so far. For instance, there is no statistically significant difference in how care workers rated the level of support they received by employer type. In relation to employer responsiveness to workers' feedback, less than half of care workers employed by non-profit organisations, half of those employed by private providers and two-thirds of those employed by the public provider stated that their employer is responsive to feedback on work-related issues.

These findings may be understood within the context of new public managerialism and increased administrative requirements for employers. Existing research highlights that the jobs of employers/managers have enlarged and changed significantly in recent years in terms of the management of increasing numbers of care workers and more responsibility for administration and financial management (Trydegard, 2012). Thus, home care managers spend increasingly more time on documentation (Mercille and O'Neill, 2021; Stranz and Szebehely, 2018) and are less present and available to support their staff (Strandell, 2020; Trydegard, 2012). There seems to be a lack of employer support across all three provider types with little difference between them. This suggests that the effects of NPM doctrines and the increased administrative burden pervades all sectors of home care and may explain the convergence on this issue.

Conclusion

This article has shown that care workers employed by private providers perceive their working conditions to be significantly worse compared to those employed by the public provider (and to a lesser extent non-profit providers). As we have outlined, the precarity and inferior terms faced by care workers employed by private providers corroborates existing research on the implications of home care marketisation for the employment conditions of care workers. However, it is important that future research takes into consideration the complexity and diversity within the private for-profit sector rather than assuming that it is homogenous. There is a trend in Ireland's private sector towards market concentration and the consolidation of ownership amongst the big multinational chains. Further research should investigate the consequences of these developments for care workers and how employment conditions in large corporate providers compare with smaller, family owned providers. This agenda could build on, and add to, work about the financialisation of nursing homes and how it has affected labour (Horton, 2022) as well as analysis of European care systems' reconfiguration through complex mechanisms of corporatisation and logics of profit making and labour cost-cutting (Farris and Marchetti, 2017).

Moreover, whilst Ireland's home care system is lightly regulated and fragmented, a major regulatory scheme for home care is currently at an advanced stage of development (Department of Health, 2022b). It would introduce stronger regulation of outsourced

services, which would affect private providers' operations (the scheme's precise parameters are now being finalised) (Department of Health, 2022a). Indeed, by regulating private providers' operations more tightly, the scheme could arguably roll back some of the excesses of marketisation implemented in recent years. Thus, the scheme is likely to impact working conditions and practices amongst all types of providers although the consequences are not yet clear. Therefore, researchers should pay close attention to the varied ways in which employment in each type of provider will be affected and whether the scheme brings convergence or divergence in working conditions amongst employer types.

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