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ARTICLE



# The discursive politics of marketization in home care policy implementation in Ireland

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## ABSTRACT

Ideational and gender discursive approaches are used to examine how implementing actors discursively engage with processes of marketization within home care policy in Ireland. Front line service providers, including private actors, non-profits and migrant care workers' problem representations, solutions and underlying assumptions about what a care market is and should be offer insights into how practical experiences of market mechanisms are perceived to shape policy implementation. A focus on how implementing actors mobilize discursively on home care underlines how implementation should be viewed as a process that continues to be negotiated, often contested or even resisted, as it is implemented. Implementing actors' legitimize, contest and adapt to the marketization of home care in divergent and overlapping ways as discursive agents that mediate between policy design and implementation reproducing in turn gendered and racialized ideas about care and care work.

## KEYWORDS

Home care; policy implementation; Ireland; marketization; discourse; gender equality

## Introduction

Policy implementation research has evolved to address top-down concerns including risks associated with long and complex implementation chains, bottom-up factors such as the discretionary influence of street-level actors and compliance issues related to target groups and private stakeholders (Ansell, Sorenson & Torfing 2017). Yet, implementation problems continue with significant implications for those who suffer as a result of policy failure. Discursive approaches offer key insights into how 'upstream' policy actors frame policy design in ways that make implementation difficult. Yet aside from street level approaches (Brodin, 2017) 'downstream' actors involved in policy implementation including end users and service providers, have been neglected as discursive agents and implementation processes as sites of discursive struggle that if analysed could help address policy failure.

Home care policy is a complex and contested policy area where front-line or 'downstream' policy actors charged with implementation confront the 'crisis of elder care' as rising demand for care unfolds alongside efforts to control costs. Market ideas and discourses are central to how states address associated policy implementation problems in elder care (Brennan, Cass, Himmelweit, & Szebehly, 2012). Marketization of care refers to the processes where care is

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governed by market-like mechanisms, the growing presence of private providers and the increasing influence of market ideas and logics within public service delivery (Anttonen & Meagher, 2013). Front line actors encounter the material and discursive logics of marketization, as they interact with market forces that shape their access to resources, conditions of service delivery and governance of occupational roles and duties (Dahl, 2017). Marketization of home care is often analysed using institutional or regime analysis that produces typologies of countries grouped by traditions of state provision and the degree to which market forces shape care policy (Ranci & Pavolini, 2013; Theobald & Luppi, 2018). These analyses establish the broad contours of change yet place little emphasis on care policy implementation or how ground-level implementing actors interpret such changes. As home care policy implementation can reinforce and/or relieve familial and especially women's responsibilities for care, ideas about marketizing home care have relevance for challenging or reproducing dominant gendered ideas of care (Eggers, Grages, Pfau-Effinger, & Och, 2018). In this research, I draw on ideational and gender discursive approaches to examine how implementing actors discursively engage with the marketization of home care policy in Ireland. Centring analysis on front line including civil society actors as they translate policy into practice offers a new perspective on the social politics of care policy implementation.

Burau, Zechner, Dahl, and Ranci (2017) draw attention to how ideas and discourse have shaped the marketization of elder care. Adopting the 'What is the problem' approach developed by Bacchi (2009) they assess how policy makers discursively framed the market as the solution to problems in elder care in Denmark, Finland and Italy. They identified problem representations and solutions used by policy makers, to construct and legitimate markets at the level of discourse. Overall, they found commonality in arguments that defined public systems as old-fashioned, costly and bureaucratic, contrasted with markets as modern, efficient, responsive and cost-saving. While they identified the main ideas used to legitimate care markets, they also identified silences about the consequences of markets for care workers including migrants and informal carers. The result they argue is that marketization is presented as a solution which built on rather than challenged dominant ideas of care (Burau et al., 2017, p. 1037).

In this analysis, I rescale Burau's et al (2017) approach applied to the Irish home care sector, where a quasi-market system historically dominated by the family, non-profit associations and the state incrementally shifts towards greater marketization (Mulkeen, 2016). In their analysis, Burau et al (2017) focus on problem definitions that shape policy design and agenda setting, here my emphasis on implementation moves beyond this to the post-adoption phase. Departing from Burau et al. (2017) who looked at policy actors engaged in market legitimating discourse I examine how ground-level actors, private, non-profit and migrant care workers discursively embrace, adapt to or contest marketizing processes as they execute their policy implementation roles. Front line service providers' problem representations, solutions and underlying assumptions about what a care market is and should be reveal how experiences of market mechanisms such as tendering and contracting are perceived to shape policy implementation. Including downstream actors interpretations of marketization illustrates their influence as discursive agents that mediate between policy design and implementation.

Ireland's elder care policies support traditional structures of gendered care, with modest familial care supports and meagre extra-familial care that result in poor alternatives and supports for women carers (Eggers et al., 2018, p. 13). Migrant care workers



are also evident especially in the private sector (MRCI2015). Marketization has specific implications for how policy implementation affects the gendered and racialized organization of care (Vaittinen, Hoppania, & Karsio, 2018). Burau et al. (2017) found some reference to the gendered nature of informal care and female labour market participation in the discourse on marketization, especially in Nordic contexts. However, they also observed silences around the gendered reality of care work in a care market and benign neglect at best on the implications of marketization for migrant carers, especially in Italy (p.1033). In the analysis here I examine how such inequalities are recognized, denied or instrumentalized in implementing actors' discourse on home care to understand how care policy implementation can transform or reproduce asymmetries in access to and responsibility for care. Gender discursive approaches examine how gender norms shape implementation processes alongside other inequalities including race and ethnicity (Bacchi, 2017; Verloo & Lombardo, 2007). Building on these assessments I explore how front line actors' interpretations of and engagement with the marketization of home care may also underline, challenge or reproduce gendered and racialized ideas about care and care work.

In what follows I outline the theoretical frameworks applied followed by a review of the context for and current system of home care provision in Ireland. Next, I outline the rationale for the chosen case, the methods employed and the main interests and actors and involved in employment and service provision. In this section, I analyse the discourse of non-profit, private actor and migrant care workers on home care policy implementation with a specific focus on their engagement with aspects of marketization. In this analysis I explore the process of problem representation, solutions offered and silences present to assess the gendered and/or racialized aspects. The final section reflects on the discourse of implementing actors to understand them as a discursive force in the politics of home care and broader processes of care policy implementation in Ireland.

## **Discourse, problem representation and the implementation of marketization**

Feminist perspectives on implementation draw attention to the complex network of actors involved and how different norms, values and cultures within public, private and non-profit sectors come together or conflict to shape policy in practice. Changes to public service environments have compounded this complexity with challenges for implementation actors and processes (Carey, Dickinson, & Olney, 2017, p. 5). Normatively feminist approaches underline how diverse groups including less visible street-level actors drawn into policy processes improve implementation as they challenge the often partial knowledge of powerful state or market actors (Carey et al., 2017, p. 12).

Alongside a more agentic and expansive model of interests, gender discursive approaches include the interpretative frameworks, problem representation and processes of subjectification communicated by state, market and civil society actors as factors shaping implementation processes (Bacchi, 2017 p. 34; Verloo & Lombardo 2007). Discourses are then the contexts where problems become constructed, represented and legitimated, with consequences that are differencing and gendering (Bacchi, 2017, p. 21). In policy contexts that are contested better understanding of how different actors frame policy problems and solutions can help us understand the



privileging of particular interpretations of policy problems and systematic marginalization of others.

Analysis of how implementing actors translate certain underlying problem representations into principles that guide implementation complicates assessments of implementation problems as standard 'policy execution problems'. It also encourages a move away from separating policy design and policy execution, and politics from administration. A better understanding of ground-level actors' 'translation' processes may in turn support forms of collaborative policy design and adaptive policy implementation, seen as essential to avoid policy failure (Ansell, Sørensen, & Torfing, 2017, p.468).

New Public Management (NPM) a central element of marketization aims to solve implementation problems with performance management techniques. In home care policy implementation, NPM elements including bureaucratization, auditing and compliance are applied to increase efficiencies and improve policy output. Managerialism is advanced to remove administrative blocks while recalcitrant target groups are given a 'stake' and ownership over policy solutions through user satisfaction surveys and increased choice in forms of 'regulated self-regulation' (Ansell et al., p. 273–4). Implementation is then improved as front line actors deliver these reforms and policy design is left unproblematic. Analysis of front-line actors' discursive engagement on these elements of marketization reveals the limits of NPM remedies to policy implementation problems. It also underscores how such front-line actors discursively constitute such reforms as both solutions to and/or causes of implementation problems.

Burau et al. (2017, p. 1025) adaptation of Bacchi (2009) identifies two specific discursive processes: construction (How is the market constructed politically?) and legitimatization (How is the market thought of? What problems is the market supposed to address and how?). Posing these questions reveals the problem representations, solutions, underlying assumptions and silences in policy discourse. Problem representations relate to the character of the problem to be solved, norms and values to be considered and instruments to be used. For Burau et al. (2017) in familial care contexts such as Italy, the lack of public funding together with the declining caring capacity of families emerged as the central problem representation. In this context, an informal, flexible market is portrayed as the solution to the 'problem of elder care' and as a natural extension of the existing family-based system although under new circumstances. This form of marketization is based on relationships of paternalistic dominance between employer-families and an extensive, cheap migrant labour force with no social rights that combine to preserve family ties (2017,p.1031, 1038). In Finland and Denmark competition and choice are key to empower and satisfy demanding and diverse users and improve the functioning of the public system in elder care (p. 1034). These problem representations communicated and constituted through policy maker discourse worked to legitimize mechanisms of marketization (p.1028).

Marketization is also contested by policy actors, including civil society organizations, with a stake in solving the 'problem of home care'. Service providers enter into public and political debates where they discursively communicate ideas about funding models, instruments for service provision including whether public sector and non-profit providers retain a special status, the choice of service for care recipients and care worker recruitment and retention. Front line actors also operate with underlying assumptions often historical, cultural and societal 'public philosophies' that are rarely articulated yet inform debates on policy. These relate to the function of markets and



competition, care as a commodity or public good, and ideas that place families and women (and increasingly migrants) as naturalized carers.

In focussing on market legitimizing discourse, Burau et al. (2017) revealed silences around poor working and social conditions of migrant care workers in Italy, realities facing female entrepreneurs in the Finnish care market and Danish care workers who work under strict managerial control. The everyday experiences of users of care services, and informal carers under market forces were also largely absent. In this research, the inclusion of discourse generated by implementing, non-profit and care worker actors allows for the conceptualisation of how often silenced constituencies engage with marketization with effects for policy implementation. Yet, doing so reveals how such mobilizing actors can generate additional silences in their engagement with market ideas.

## Case selection

Case study method is used to generate practical, concrete and context-dependent knowledge (Flyvbjerg, 2006). Ireland is understood to be a critical case illustrative of broader trends. It has not adopted the depth and intensity of marketization seen in the contexts such as the United Kingdom and retains special status for the public sector and traditional non-profit providers (Mulkeen, 2016). This is in part a function of its small state status and an incapacity to construct a full-scale market, opting instead to construct quasi-markets. In home care a quasi-market can be defined as planned and internal public sector institutional structures that have some market features but where state imperatives enable or restrict the extent of its full functioning (Wiggan, 2015). An extensive role for the traditional non-profit providers also endows such actors' forms of discursive power absent in more fully marketized systems and may make certain aspects of marketization an uneasy fit. Strategies of discursive construction and legitimization of marketization may then take on particular salience (Burau 2017 et al.). While marketization in Ireland has been explored in public sector administration (Ní Lochlainn & Collins, 2015) the community and voluntary sector (Harvey, 2015) and other public services (Murphy & Hearne, 2019) there is little analysis of the implications of marketization for care policy implementation (but see Mulkeen, 2016). The most recent analysis of home care in Ireland found that care recipients and home help employees have experienced an erosion of the quality of work and care (Migrant Rights Centre Ireland (MRCI), 2015; Dempsey, Normand & Timonen 2016) Other comparative assessments analysed the rapid expansion of the sector in the absence of regulatory frameworks (Timonen & Doyle, 2007; Timonen & Rostgaard, 2018). However, intensification of market thinking including the expansion of competitive tendering in 2016, the long-term implications of austerity, the entrance of additional private actors, and the mobilization of service organizations representing client groups and migrant care workers warrant updated analysis.

## Irish home care in context

Irish public spending per capita is the fifth lowest in the European Union 15 'peer group' (TASC, 2018, p. 94). As a low tax economy with a conservative gender regime,



Ireland lacks capacity and political will to fund socially necessary reproductive and care work, and as a result, such work remains feminized in the sphere of the private household (TASC, 2018, p. 92). The incidence of low pay in Ireland is 23% of the workforce, the highest in the EU 15 with women disproportionately represented. State transfers improve this figure and poverty rates, suggesting the state subsidises a low pay economy that supports the market by reducing labour costs through enabling employers to pay low wages that maintain a gender pay gap particularly in service work (TASC, 2018, p.81).

While a carer's benefit exists, it is less than half of the average weekly salary, and otherwise, carers leave is largely unpaid and time-limited. An increase in private sector home care providers and poor public subsidization of childcare coupled with a decline of the male breadwinner model has driven demand for migrant care workers as women enter the workforce and source paid care (Murphy & Turner, 2017).

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. This included outsourcing care services and deeper integration of private sector management principles in both public and non-profit sector provision (Mulkeen, 2016). Austerity (with a ratio of one third tax increases to two-thirds expenditure cuts) is also argued to have supported reductions in social investment and enhanced marketization of public services (Kennett & Dukelow 2018). While greater marketization of public services including labour market activation and social housing are evident with commissioning and service level agreements in place, they have yet to replace all traditional block funding supporting non-profits. Pathways to marketization have differed across sectors with uneven results, evident in a failure to privatize water and the health care system (Murphy & Hearne, 2019).

## Home care in Ireland

Home care policy evolved in a legacy of reliance on religious orders and unpaid feminized care work in familial contexts to absorb care needs (Meirmans, 2018, p. 5). The first for-profit provider of home care was established in Ireland in the late 1980s as a quasi-market was established that shifted the role of public authorities from the provider to the purchaser of services. In Ireland, home care services are not means tested but administered through a high threshold needs assessment. Home care policy, in line with other contexts, rests on a fundamental contradiction between this form of universalism, and an increasing trend of controlling demand and rationing services (Timonen & Rostgaard, 2018).

Between 2001 and 2008 public expenditure on home care tripled, and the proportion of the 65+ population covered by home care quadrupled, albeit from a low base (Timonen, Doyle, & O'Dwyer, 2012). While home care provision increased between 2006 and 2008, it is estimated due to austerity that care hours fell by almost a million a year between 2008 and 2014 (HSE 2014). Recent estimates suggest an increase of almost 65% in home care hours since 2012. Home care provision consumed 48% of the total budget for supports services to older people in 2017 (Meriman 2018, p. 14). In 2018, approximately €408 million of the Health Service Executive (HSE) Older Persons' Services budget provided over 17 million home support hours to approximately 50,000 people (Meirmans, 2018, p. 9). Forecasts indicate a 120% increase in home care services required



in 2019 (IPH, 2018). Pressure from an overcrowded acute care context in hospitals has also increased economic and political pressure to expand options for home care (ESRI, 2017).

Home care policy commissioning is located in the State Department of Health and the administrative body for health care in Ireland the Health Service Executive (HSE) although it is articulated on the ground through nine Community Health Organizations (CHOs) and a dense web of state, non-profit and private organizations. The HSE directly employs social care staff that cover around half of all home care recipients, contracting care to non-profit and private sectors for the remainder (Oireachtas, May 30 2018). Because the home care budget falls short of covering the need for home care, CHO's ration home care by employing localised eligibility criteria that creates uneven spatial coverage. The high threshold used in the needs assessment results in an average of between six and four hours of care a week (though often less in 15- and 30-minute increments). Families that are able then turn to the non-profit, private sectors or grey economy to top up provision (Merimans 2018).

Non-profit organizations have received special treatment by the state (via section 65 annualised grants) to deliver home care services and were funded exclusively by these block grants until 2010. Different funding mechanisms exist that make payments directly to recipients (allowing them to choose their own providers of care) while other care recipients choose from a list of approved providers and in other areas care is delivered by pre-contracted private or non-profit providers. The private sector has been the main beneficiary of the move to cash for care, while the non-profit sector has struggled to meet capacity and compliance costs (Timonen & Doyle, 2007, p. 13). A more expansive form of competitive tendering was introduced alongside the maintenance of block grants in 2016. Public financing has then played a powerful role in altering the profile of providers.

In 2018 a new tender specification was introduced for non-profit and private providers (HSE, 2018). New specifications include guarantees of scale and capacity, lowest cost estimates with smaller and non-profit organizations encouraged to collaborate to satisfy compliance requirements. Traditional non-profit providers in receipt of block grants can compete for these tenders, but will have their grant aid reduced if successful. The tender also marks the rollout of personalised budgets with Consumer Directed Home Care (CDHC) (HSE, 2018). Increased use of competitive tendering has promoted the use of low-hour contracts as private sector employees seek to reduce costs. Workers employed by for-profit home care providers are required to be more flexible, and on average have lower wages and weaker social rights than their non-profit or public sector counterparts (Mulkeen, 2016, p. 42).

## Method and data

This work draws on a qualitative assessment of the discourse of front line actors including non-profit organizations, private care companies and migrants care workers on home care provision in Ireland between 2009 and 2018. Documents inclusive of expert policy reviews, policy submissions, parliamentary debates and press releases (see appendix for full list) are analysed in terms of the conceptual framework of problem representation, solutions and underlying assumptions. Documents were selected as corresponding to specific political opportunities or controversies



surrounding home care provision and discursive communication around these developments. These include periodic state initiatives (between 2009 and 2018) to deal with the absence of regulatory structures in home care, campaigns around austerity era cuts to home care provision, the introduction of competitive tendering in 2016, a new tender specification launched in 2018 alongside the rollout of consumer-directed home care programmes. Broad underlying assumptions are derived from analysis over time of policy positions and claims-making for service providers and their constituents. Salient quotations from implementing actors, specifically those generated in more recent engagements (for example, contributions to Parliamentary Committees), are included to illustrate problem representation. Interviews with migrant care workers, non-profits working with older people, and carers (paid and unpaid) supplement document analysis to extend, deepen and nuance our understanding of how markets ideas influence non-profit actors.<sup>1</sup> Participant observation took place at five migrant home care workers organizing groups held between April 2016 and May 2018 supplemented with analysis of public protests of older people and carer organisations on home care provision between 2012 and 2016. Questions posed to documents/interview data include: What is/are the problem(s) represented in home care? In such problem representation, is there evidence of ambivalence, resistance or support for market ideas? What are the underlying assumptions? What understandings of care are communicated? What aspects of carer and care recipient experience are naturalized or valorized? What is not talked about, left unproblematic or unquestioned, in what ways are gender, race/ethnicities absent or present, mentioned implicitly or explicitly?

### Private care providers

Private care agencies range from small enterprises operating locally to multinational chains and franchises including Home Instead, Comfort Keepers (a Sodexo corporation) and Blue Bird care.<sup>2</sup> The Home and Community Care Ireland (HCCI) (formerly the Irish Private Home Care Association) is the trade association representing the largest private home-care providers in Ireland.<sup>3</sup> In testimony to the Irish parliamentary health committee, the HCCI problem representation of home care is one of demographic crisis and a state unable to respond. ‘Every 15 minutes someone in Ireland turns 65 and every 30 minutes someone turns 80. Projections of demand for healthcare in Ireland 2015–2030, indicate that demand for home care will increase by 50% in the next 11 years. The Department of Health acknowledges that it is unable to keep up with demand’ (Oireachtas 30 May 2018, p.5). Notably the HCCI supported the initiation of tendering for home care evident in a 2009 submission ‘we suggest the HSE, as the largest purchaser, could yield significant benefit from introducing competition in the market if all HSE-funded home care were outsourced to the private sector’ (IPHCA, 2009, p. 7). In line with Bureau et al. (2017) competition is understood as essential to solving the ‘problem’ of elder care.

<sup>1</sup>Interviews with migrant care workers took place in December 2015, August 2016, December 2016, January 2017 and July 2018 and civil society organizers for migrant rights and older people in December 2015, March 2017, May and July 2018.

<sup>2</sup>Sodexo is involved in multiple public-private partnerships in Ireland from food services to construction management in offices, schools, prisons, hospitals and army bases.

<sup>3</sup>There is no reliable data on the number of private sector operators in Ireland, although representative organizations list 70 private sector members.



The preferential treatment of public sector workers and traditional non-profit providers is singled out for critique with non-profits framed as 'lacking quality standards and costly to tax payers.' Competitive neutrality is desired in the statement 'we recommend the end of arrangements where commissioning maintains some providers receiving very preferential terms due to historical precedent' (Oireachtas May 30 2018, p. 15). Smaller non-profits are framed as not for fit purpose with the state warned to 'draw from the experience of 2016 by not granting licenses to providers who cannot illustrate they have the infrastructure, systems and personnel to provide the scale and quality of care the HSE needs' (2018, p. 16).

Care workers are framed as 'the primary factor driving higher costs in the public and non-profit sectors' (IPHCA 2009, p. 6). The level of state funding specifically the exclusion of payments for travel time is framed as contributing to low wages in the sector and problems in care worker recruitment and retention. Private sector firms claim they are unable to improve these in the absence of additional state monies 'if the HSE is not paying for transport costs it is difficult for us to do so' (Oireachtas May 30 2018, p. 17). They do not suggest increasing pay rates but rather ask for 'Change in HSE commissioning procedures to allow care workers operate a workable block weekly schedule. Many carers need support from the Department of Social Protection. Currently, if these carers work just half an hour a day, as often occurs under current commissioning practices, they lose their full daily social welfare entitlement' (HCCI, 2018, p. 5). Here they seek income support from the state to compensate for low wages, in a form of corporate welfare.

Care as a public good is deemed problematic 'The HSE home care budget is under growing pressure from an increasing number of home care users due to a long-standing belief that home care is an entitlement' (HCCI 2018, p. 26). Instead, means testing to increase the distribution of care and the handover of assets (used in nursing home schemes) are deemed solutions to increase state funds to compensate home care providers.<sup>4</sup> Means testing will 'increase fairness' yet also release high-income individuals to purchase additional hours of care alongside increased tax relief. Drawing on a discourse of consumer choice, they argue for the further individualization of home care provision in the form of CDHC (Home and Community Care Ireland(HCCI), 2018,p., p. 25). A shift to CDHC will require a 'forward thinking shift for the HSE to hand over choice, control and responsibility to families' (Home and Community Care Ireland(HCCI), 2018, p. 11). The CDHC model will move public funding away from one rate for all home care cases to higher rates charged for more 'difficult cases' (Oireachtas, Dec 2018.) Care is commodified, broken into predictable tasks with a variable pricing structure justified in terms of better outcomes for 'clients' in the form of a list of services offered including companionship as extras available in addition to the state stipend (Home and Community Care Ireland(HCCI), 2018, p. 26). The underlying assumptions here include choice framed as consumer freedom and care recipients framed as 'users' constructed as more demanding, more diverse and more expensive to care for.

The recruitment and retention of workers 'is the crisis in home care' (Oireachtas, May 2018, p. 6). Drawing on gendered ideas the solution lies with the untapped potential female workforce, an army of 'passive carers', those that have 'reared their families' and that could be enticed by media campaigns into paid work. They state 'we

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<sup>4</sup>Nursing home providers receive significant state and private funds through a scheme that allows older people to use the value of their property to pay for nursing home costs.



need to go on a war footing with the message “Your country needs you,” (Home and Community Care Ireland(HCCI), 2018 p., p. 9). Care workers are framed as ‘people who have 20 or 30 hours a week to give. They may not want to work in a nine-to-five type job and that is why they are carers in the first place. It is important not to lose sight of that flexibility’ (Oireachtas May 2018, p. 7). Care workers subjectivities are instrumentalized in this context as former homemakers, content to receive low hour and low wage contracts for ‘meaningful work’ combined with state benefits. They also recommend a supply of affordable natural care labour. ‘About 30% of carers are foreign nationals. We need to open up the possibility of getting more into the country and we need to make it easier. That will certainly increase the supply of carers’ (Home and Community Care Ireland(HCCI), 2018, p. 16).

Overall they employ discourse that reinforces further marketization of care and the privatization of responsibility that exposes carers and those in need of care to market forces. The state is asked to create special categories of care workers, part-time employees who qualify for social benefits and migrant labour.

### **Non-profit older peoples organizations**

Sage advocacy, AGE Action, Older and Bolder and Age and Opportunity are the most prominent non-profit organizations that act to represent older people and as service providers. They, employ rights-based discourse against involuntary institutionalization of older people. Home care is constructed as essential in vindicating older people’s right to liberty and dignity. In submissions and testimony to the Irish parliamentary health committee, these organisations support state entitlement to care but underline tensions existing between cost and demand. Policy implementation deficits are linked to problem representation where ‘Due to the dramatic demographic challenge, the projections for unmet need in home care supports are a cause of deep concern’ (Oireachtas, December 2018). In alignment with private interests, the public sector is critiqued as inefficient, inflexible and underfunding home care. Austerity era cuts to their block grant funding are cited as reasons for low rates of pay as employers they can offer. Shortfalls in funding are met through fundraising to ‘shore up state services’. While care as a public service is affirmed, the public sector industrial relations systems that guarantee workers standard contracts are critiqued as inflexible and unfair compared to their own staffing arrangements (Oireachtas, December 2018).

Tendering processes and forms of managerialism are cited as downward pressures on wages. ‘Additional expenses on compliance required for tendering is draining resources so that we cannot increase pay rates’ (Oireachtas December 2018). While tendering now requires workers to have specific qualifications ‘the cost of training is placed on providers, this means we have no incentive to offer any professional development, just the basic level of qualification’ (Oireachtas, December 2018). Competition is also framed as favouring private interests, ‘because we do not provide generic home care services like the private sector we did not get the tender. Our home care footprint is reducing by anywhere between about 8% and 12% each year’ (Oireachtas, December 2018). In contrast to private sector actors, tendering is not framed as promoting a more level playing field but rather as an unethical form of competition. Tenders advertised by email to a list of approved providers are awarded to those who reply first. This is viewed as undermining



a best practice that involves time spent to consider the clinical and social match between service provider and care recipient (Oireachtas May 2018).

Yet with other aspects of marketization, specifically cash for care, older people's non-profits indicate ambivalence, reinforcing private sector analysis they frame public home care as standardized and unresponsive to care 'user' needs. Increased input for families and flexibility is demanded in the context of falling quality in public provision. Here choice is also viewed as empowerment and a source of independence, 'Older people should have a choice of providers' (Oireachtas, December 2018, p. 5). In this context choice over who provides assistance and control over when and how that assistance is provided is key. However, 'it is critical that the State does not seek to abdicate its responsibility in this regard' (Age Action, 2017, p. 17). Tensions arise then between seeking state support and frameworks that emphasize self-sufficiency that may responsabilize older people for their own care. Choice in the form of voucher systems are deemed problematic as 'Users of home care are not true consumers as, in practice, people have little opportunity to exercise real choice due to insufficient knowledge, physical and cognitive impairment and lack of alternatives for those with more complex needs' (Age Action, 2017, p. 13). Cash for care is also framed as risky in opening the way for service providers 'cherry-picking' those clients funded by public monies with less serious needs (Sage 2019).

Overall, care is constructed as a public service, where the state supports the non-profit sector to deliver superior care rooted in trust and moral obligation inoculated from market forces, 'Home care is not a commodity to be purchased like walking aids, it requires the building of trust between the care recipient and giver' (Age Action, 2017, p. 14). Although older people's organizations resist the commodification of care, they subscribe to the unsustainability of a universal tax-funded service. 'Total reliance on taxation can be a huge problem as available funding is related to exchequer funds – periodic service cutbacks are endemic in such a system. Increased spending arising from the shift in the age profile of the population could, if not properly managed, result in rapidly increasing public debt' (Sage 2019, p.4). They argue instead for a contributory system to establish a long-term care social insurance fund to solve the 'problem of home care.'

## **Non-profit carers organizations**

Family Carers Ireland (FCI) are the national representative body of carers, a service provider of home care and a member of a broader alliance, The Carers Alliance (CA). A 2017 'Share the Care' Campaign critiqued home care policy for constituting carers as stop gaps claiming, 'The present reality is that family carers prop up the health system' (FCI, 2017). The public sector is positioned as responsible for supporting carers and care workers, and as benefiting from unpaid and underpaid care provision.

Carers reliant on inadequate state home care are framed as forced to the market to purchase top up hours. How the state engages with the care market is deemed inherently problematic 'as the commissioner, direct provider and regulator of home care with a massive conflict of interest' (Oireachtas December 2018). Non-profits are affirmed as superior care providers 'Not-for-profit home care providers have been shown in recent years to be well placed to deliver high-quality home care' (Care Alliance 2018, p. 23). Carer's groups are critical of employment practices in the private sector – 'care workers



their most valuable asset – are seen as a variable cost to be turned on and off at their whim’ (Oireachtas May 2018, p. 7). Here problem representation on home care is directly connected to the role and function of the private sector, in argumentation that public funding needs to be directed to care workers’ wages rather than company owners. Carer groups reject the claims of private sector interests that commissioning needs to change to improve workers’ pay and conditions stating ‘The published accounts of providers show a high return to the owners in comparison with what they are paying their carers. They require a change that has less to do with HSE commissioning and more to do with profit’ (Oireachtas May 2018, p. 7). Tendering is also reframed as inefficient because ‘gaming of the scoring system in the tender process has resulted in higher cost service with poorer levels of service placed alongside increasingly complex cases’ (Oireachtas Dec 2018). Private sector efforts to create special categories of social welfare dependent carers were also critiqued ‘we have representatives of the private sector coming in and saying they want changes to the social welfare rules that speaks to a race to the bottom as regards terms and conditions’ (Oireachtas May 2018, p. 15).

Commercial providers are accepted as a reality of the sector yet state disciplinary mechanisms should tame unfettered market forces expressed in the statement ‘The new tender was a missed opportunity to introduce a minimum wage as a provider requirement’ (Oireachtas May 2018 p.9.) Overall ‘The power of providers must be rebalanced in respect of carers. The HSE must truly value front-line workers by ensuring more funds find their way to the carers and offer choice to families regarding the care they receive’ (Oireachtas May 2018, p. 9). This framing of choice is in contrast to state paternalism and predatory market logics. Although while aspects of marketization are critiqued, the market discourse of choice is taken at face value aligned with the demand that the state implement policy that ensures consumer sovereignty and carer wages. ‘Another way of encouraging providers to treat their carers better is by giving clients the choice of either a commercial provider or directly employing their own carer using state funds. People care about what their carers are being paid’ (May 2018, p. 8). CDHC is understood as offering the wrong sort of choice, ‘One of our worries where the HSE is struggling to deliver through contracted providers, CDHC, will mean responsibility suddenly passes to the family to secure services creating a huge amount of extra work and pressure’ (Oireachtas, May 2018, p. 11).

The CA offers data on the gender balance of carers, estimating an increasing percentage of men although underlining that carers are predominantly female. While both the FCI and CA frame care work as a valued and essential if unacknowledged aspect of society, neither offers a gendered analysis of care. Notably, the CA also produced a submission on migration policy in 2018, acknowledging the role of undocumented migrant care workers as essential sources of private home care (Care Alliance, 2018, p. 5). They state ‘On the issue of foreign care workers, the reality is they will provide a future supply of care. Valuing that and giving people the legitimacy to be employed legally here is really important’ (Oireachtas December 2018).

Defining problem representations and assumptions rests on processes of silencing (Burau, 2017, p. 1036). While both older people and carer non-profit organizations make visible the implications of marketization for carers and workers, other silences exist. Both non-profit sectors employ broad frames to downplay class, gender, racial and ethnic differences amongst the older population and carers. Migrant carers feature in minor ways, while there is no gendered analysis of care.



Migrant care workers are frontline-implementing actors organized as a constituency by pro-migrant non-profit organizations. The Migrants Rights Centre Ireland (MRCI) uses community development associational models to ‘capacity’ build migrant carers to mobilise for better policy implementation on home care. As migrant care workers are predominantly employed by private providers, marketization of care work features in important ways in their experiences in the front line of policy implementation.

## Migrant care workers

Problem representation for migrant care workers rests primarily on connecting poor working conditions with poor quality home care. MRCI research on home care employment found many migrants employed by two or more private sector companies on the same day, paid only for the time spent in each client’s home, resulting in very low wages and weak forms of employment contracts (MRCI, 2015). Private care agencies and state tendering processes are central to problem representation, ‘Pressure for companies to secure business for the lowest possible cost is feeding the race to the bottom, sustaining precarious and insecure employment for home care workers and negatively affecting the quality of care being provided’ (Migrant Rights Centre Ireland (MRCI), 2015, p. 8). The state also features as problematic in the differential status between public and private sector pay rates, ‘with a hierarchy created with public sector workers on top and migrant workers on the bottom experiencing the least favourable conditions’ (Migrant Rights Centre Ireland (MRCI), 2015, p. 9). For the MRCI marketization of home care feeds informality and drives demand to employ undocumented migrants as live-in carers, often for less than the minimum wage. It calls for better training, a focus on interculturalism in policy implementation and employment and equality protections for home care workers (Migrant Rights Centre Ireland (MRCI), 2015, p. 9). Aside from commissioning research on migrant care work experiences the MRCI developed a community workers programme, the Domestic Workers Action Group (DWAG). Participant observation at DWAG meetings confirms these spaces as contexts for the processing of experiences, sharing stories of exploitation and expressing the deep care and affection that migrant care workers hold for ‘clients’. While migrant care workers testified to experiences of race- and gender-based harassment and discrimination, capacity building in these spaces was absent of critical gendered or racialized analysis.

Since 2017 the MRCI and DWAG have mobilized to influence policy implementation in a *My Fair Home Campaign*. Tactics include public protest, lobbying of politicians in the Department of Health and social media campaigns aimed at recruiting family employers to sign a *My Fair Home Pledge*. The solution to poor conditions then lies with families and care recipients who pay for or receive state care constructed as agents to improve policy implementation. Female migrant care workers, are rooted in strong cultural identifications and traditional gendered constructions of their unique capacity to care. The *My Fair Home* campaign materials reinforce these constructions with statements which include, ‘Members care about care standards in Ireland, and how older people and people of all ages with care needs feel and experience care.’ Such statements are reinforced by video segments showing care workers with their ‘clients,’ narrated with commentary such as, ‘Carers and people receiving care in Ireland speak about their daily lives, the bonds between them, and the importance of home care in allowing people to live with dignity and independence’ (MRCI



2018). A care ethic-related discourse contrasts moral frameworks of care as a familial obligation and reverence for older people with the marketized approach of the Irish state and economy to care.<sup>5</sup> Severe time restrictions with vulnerable clients, limited training opportunities and protocols against maintaining contact with families in the event of a client's death were all condemned as uncaring and 'about the bottom line not good care' (MRCI 2019). Problem representation of home care then reinforces essentialized constructs of migrants as naturalized carers.

While the consequences of marketization for care recipients are made visible, migrant care workers also embrace a version of the care market in their participation in emerging social enterprise models. In this programme, migrant care workers are 'enterprising carers' who receive entrepreneurship training to establish a social enterprise in home care (MRCI 2019). 'We asked the tough questions about how we could compete with these big industries. The answer is us. Carers are valued because we value care. Staff turnover, which is a major challenge in other care companies, is mitigated in this approach as this model invests in staff' (MRCI 2019). A discourse of the caring migrant entrepreneur (Bassel and Emejulu 2018) is reproduced, eager to provide services that can deliver superior care and working conditions within broader market logics.

## Conclusion

Bureau et al. (2017) identified how ideas were discursively employed to support marketization as a solution to the problem of elder care. They identified broad discursive similarities and distinctions in problem representations across societies. Rescaling their approach I examine a specific country case study with a focus on front line policy actors' discursive engagement with market ideas at the point of policy implementation. This analysis aimed to understand how ground-level experiences of policy implementation influence the discursive construction of care markets. Added to gender and policy scholarship (Bacchi, 2017) are insights from a feminist analysis of policy implementation (Carey et al., 2017) that widens the definition of implementing actors to include less visible interests and draws attention to the gendered and racialized implications of policy discourse. This approach contributes to our understanding of the role of ideas in marketizing processes and how they are discursively embraced or contested in policy implementation. The Irish case is explored as a quasi-market where a traditional familial gender conservative welfare state incrementally embraces marketization of home care policy with implications for the position and power of established and newer implementing actors.

In line with Bureau et al. (2017) demographic crises and cost containment feature in problem representations of all interests, alongside the constructions of the public sector as inefficient and in need of reform. For private interests, care recipients' sense of entitlement to care alongside preferential treatment of non-profit providers are substantial obstacles to solving the problem of home care. Solutions advanced embrace competition as a catalyst of change and invoke underlying assumptions about the power of the market to cater for individual needs, free choice and user empowerment.

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<sup>5</sup>Private care companies also employ gendered and racialised constructions of female carers to advertise their products.



Competition but also increased state resourcing in the form of consumer-directed schemes will enhance care outcomes as consumers 'top up' with additional services available from private providers. Care worker recruitment and retention also figure in problem representations as a side effect of under-resourcing by the state and inflexible social protection rules.

Non-profits affirm state failure to deliver home care at the same time as discursively contesting aspects of marketization. They draw attention to the transaction costs of tendering and compliance as downward pressures on carer wages. Choice and competition, fundamental market ideas, are not disregarded by non-profit providers but rather recast in terms of empowerment and consumer sovereignty, deemed difficult especially for older care recipients. Here the discourse of the market is reproduced without the burden of its attendant risks with the state framed as culpable in mitigating these for care recipients. However, this framing evokes tensions between the construction of citizens with care needs and as consumers of care services. Non-profits assert their superiority in framing profitable care as incompatible with quality care. Carers and care worker non-profits offer the most stringent critique drawing attention to the role that profit plays in reducing workers conditions and the quality of care.

Private interests refer to special VISA status linked to caring occupations, while non-profits refer to migrant integration and regularisation of existing migrant care workers. While all refer to poor working conditions as problems for recruitment and retention, women and migrants are constituted as naturalized 'carers'. If provided with modest increases in pay or cover for travel these assets will solve the crisis of home care. Silences exist around how competition and increased productivity may impact on workers. Private actors operate gender essentialist constructions of care workers. Migrant care workers contrast their care ethic against private sector care logic, yet underline racialized caring subjectivities and subscribe to some market ideas in the form of an entrepreneurial or social market model of home care provision. Overall while non-profit and migrant carers contest marketizing processes, their discourse confirms dominant models of care and risk reinforcing racial and gendered stereotypes.

Marketization is understood to be an important remedy for policy implementation problems. Marketizing care policy requires a gradual but distinctive erosion of the idea of care as a public service. This is achieved through material-discursive shifts that define care as a commodity, the state as an ineffective care provider and the private sector as better at providing autonomous individuals the possibility to choose the kind of care they like (Vaittinen et al., 2018). How front line actors discursively frame state failure alongside choice has consequences for how marketization is accepted as the solution to problems of home care. In Ireland, a small state with a quasi-market, care policy implementation is disordered and remade by market ideas as incumbent and newer implementing actors compete for resources and contest the meaning of care and care work with gendered and racialized effects. A focus on the discourse of front line actors reveals nuances in how marketization is received and contributes to a better understanding of how policy problems are framed and how such framing shapes implementation processes.

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No potential conflict of interest was reported by the author.



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## Appendix

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