Presentation to the Joint Oireachtas Committee on Gender Equality

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Discussion on the Recommendations of the Citizens' Assembly on Care (Recommendations 4-12) and Social Protection (13-19)

Thank you very much for inviting me to speak at this Joint Oireacthtas Committee meeting. In this short presentation, I will draw on my own research and that of others on care[1]. I am happy to comment on the various recommendations during the discussion but will focus my opening statement on more general issues, especially exploring the issues arising from the increased commercialisation of the care of vulnerable persons.

I will make five opening observations:

1. The Universal Need for Care
2. Care Takes Different Forms
3. Commercialisation of Care
4. Need for a National Care Planning Unit
5. Measuring Care – Census data

Appendix – comments on specific recommendations

UNIVERAL NEED FOR CARE

As so many people learned during COVID, people cannot enjoy life or flourish without the recognition, appreciation and company of others. What we learned most of all is that **human beings are primarily *relational* rather than autonomous**[2]. The need for care is universal

[1] I have undertaken two major empirical research-based books on care (with UCD colleagues) Affective Equality: Love, Care and Injustice (2009) and *New Managerialism in Education: Commercialisation, Carelessness and Gender* (2012, 2015). My most recent book, *Care and Capitalism: Why Affective Equality Matters for Social Justice* (2022) analyses the major changes that need to take place in policy-making if we are to have a socially just and caring society. My presentation is also informed by wide knowledge of international research empirical and theoretical research on care, and of course on reports on care in Ireland: The IHREC and ESRI Report on *Caring and Unpaid Work in Ireland* (2019) the UL Report for Early Childhood Ireland *Pathways to Better Prospects* (2020) and Family Carers Ireland report (2020) *The State of Caring,* TASC report on *The Gender Economy* (2020), Pobal *Early Years Sector Report* 2021.

[2] Fineman, Martha 2004. *The Autonomy Myth.* New York: Free Press; Herring, Jonathan. 2020. *Law and the Relational Self*. Cambridge: Cambridge University Press.

because **vulnerability, dependency and interdependency** are endemic to the human condition. No one can live long and well without love and care. It is nurturing that makes us up as emotionally healthy and happy human beings. **Nurturing others**, be they young, very old or any age in between, **takes time, a lot of time**. Because love and care take time, and our market (economic) relationships take time, **care relations and the market relations are always in competition with each other**

Given the primacy of love and care for mental and emotional health especially, Ireland needs to develop a political and cultural appreciation of care as a political principle. Moreover, the principle of care is vital not only for in terms of maintaining all forms of life human, non-human and environmental[3]. We should aim to create a caring and social justice-led democracy, recognising the experience 'of being needy is shared equally by all humans'[4] (Tronto 2013: 29)[i].

It is not only the very young, very old, the sick or those who are vulnerable due to a disability who have a need for care. Everyone needs care. **There can be no social or political justice without imbuing public policy-making with an ethic of care.**

1. CARE TAKES DIFFERENT FORMS ACROSS DIFFERENT CONTEXTS

Caring is about nurturing, and it takes different forms. **Primary care relations** are close intimate **love relations** especially those between parents and children, partners, close friends; **secondary care relations** are lower order care relations, such as those with neighbours and colleagues, and also other professional and other non-intimate care relations; **tertiary care relations** are those **solidarity relations** which involve care for the unknown other. They are expressed through political actions including redistributive taxes, social justice campaigns etc[5].

Two points are relevant here, **First it is important to distinguish general secondary care (such as that provided in professional care services for children and adults) from love** as **love in non-substitutable** (no one else can visit your father or mother for you and claim they are you). There is a mutuality at the heart of intimate relationships which is non-substitutable. While **a** loving relationship cannot be transferred to another person without changing the relationship into something else, secondary care can be undertaken well by different people. **This is an important matter when thinking of childcare or care of older persons. All people need time for intimate love relations including older people who may also be receiving secondary care.** But that is not to say that good paid cannot have deep commitment (and may become loving) over time, but it takes time.

Secondl**y, professional care always has a voluntary and personal dimension** to it. In much of the talk of regulating carers, this is often forgotten. You cannot force someone by regulation

[3] *The neediness of the human condition leads to interdependencies, not only on other human beings but on other species and on the environment... It is only when we acknowledge our shared dependence, … that we can fully appreciate what a new politics of care might involve.* (Lynch, *Care and Capitalism*, 2022: 17).

[4] Tronto, J. C. 2013. *Caring Democracy: Markets, Equality, and Justice*. New York: New York University Press.

[5] Lynch, K. 2007. Love labour as a distinct and non-commodifiable form of care labour. *The Sociological Review,* 54 (3): 550-70.

to feel for someone else; feelings for other people such as **empathy and understanding are not simply supplied on contract.** They only develop over time, and if paid care relations are too hurried, if people are working under time pressures, **care turns into a form of supervision.** Furthermore if staff are constantly changing with different carers coming all the time, there cannot be any satisfying personal care as the latter takes time and knowledge of the person[6]. Defining personal care as bodily care shows a profound lack of respect for the feelings and needs of those who are living alone and/or lonely.

2. COMMERCIALISATION OF CARE IN IRELAND

One of the debates that has not occurred much publicly in Ireland is the slow but gradual commercialisation of care, not just for children, but especially for older people, be it in the community setting or in nursing homes.

Children: For-profit corporations are now the major players in residential childcare**. More than half of the homes for children in residential care are for-profits run private companies** and these are the only expanding sector for children in need of residential care[7].

Most providers of day care for children are also private operators; they are businesses, albeit small ones. Some are big businesses however and are controlled by pension funds and other investors[8].

Older people: 70% of nursing home beds are now owned by for-profit companies. Older people in need of care are defined by commercial care operators as a product for profit-making. Home care is not defined as a profitable 'market' . In Ireland it is currently valued at €718 million annually and there are 599 'businesses' listed https://www.ibisworld.com/ireland/market-research-reports/residential-nursing-care-industry/

Nursing Homes

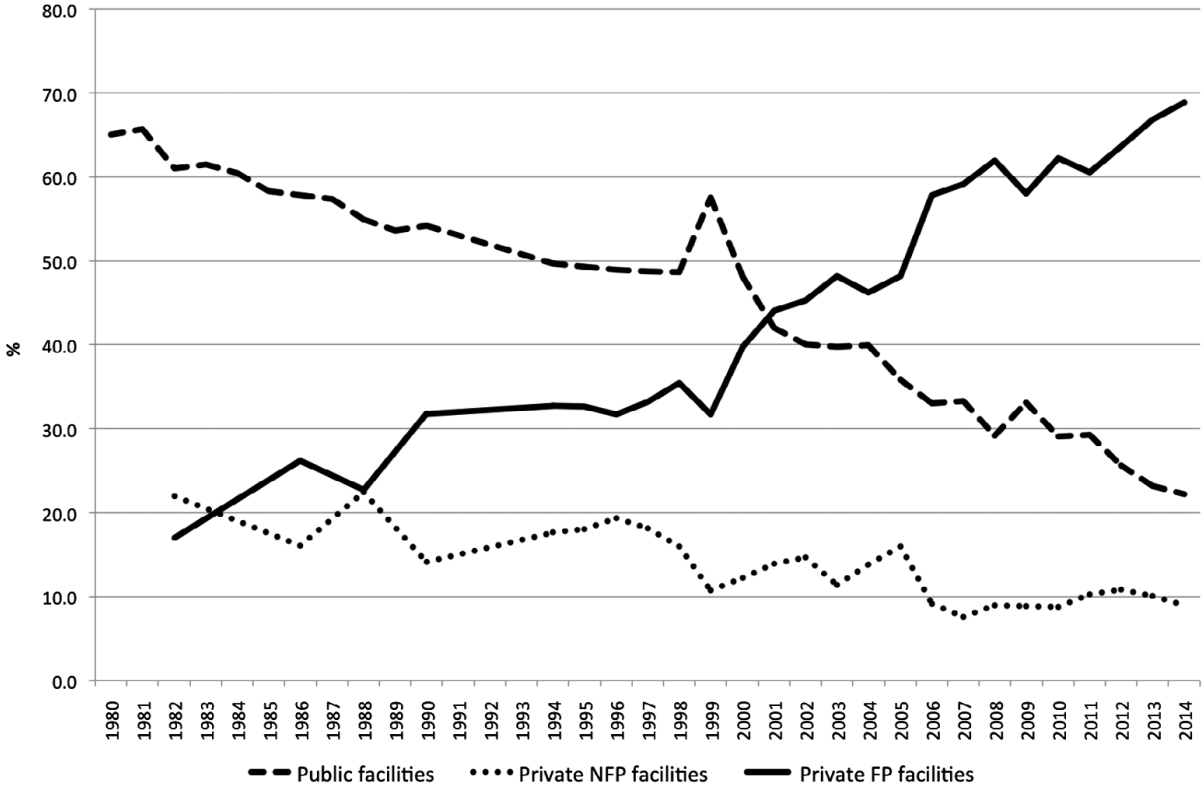
Figure 1 below demonstrates how the **care of older vulnerable people in nursing homes** has been transferred to the for-profit sector since the 1980s.

[6] McDonald, A., Lolich, L., Timonen, V. and Warters, A. 2019. 'Time is more important than anything else': Tensions of time in home care of older adults in Ireland. *International Journal of Care and Caring,* Vol. 3, No. 4: 501-515.

[7] Mulkeen, M. 2016. Going to market! An exploration of markets in social care. *Administration,* 64 (2): 33–59.

[8] On October 21st, 2019, the *Irish Independent* reported that Giraffe Childcare group (21 creches in Dublin), was acquired by a UK firm controlled by the Ontario Teachers' Pension Plan, for £26.3m (€30.4m)

Figure 1 Percentage of Total Beds in Different Types of Nursing Home Ownership 1980-2014



Notes: **NFP = not-for-profit, FP = for-profit**.

Source: HSE data Published by Julien Mercille (2018) Neoliberalism and health care: the case of the Irish nursing home sector, *Critical Public Health*, Vol. 28, No. 5, 546–559

Home Care Services

Home care services are also being increasingly provided by for-profit operators especially in the Eastern region and in larger towns and cities, many of which are multinational companies.

The proportion of public expenditure on home care allocated to the private (for-profit) sector rose steeply from less than 5% in 2006 to 40% in 2019. Public expenditure allocated to HSE-delivered home care declined from about 85% in 2006 to 50% in 2019[9] See Table 1 below

[9] Mercille, J. and O'Neill, N. 2021. The growth of private home care providers in Europe: The case of Ireland. *Social Policy & Administration*. Vol. 55, No. 4: 606-621

TABLE 1 Annual home care expenditure (current € millions) by type of provider, 2006–2019

Source:

Mercille, J. and O'Neill, N. 2021. The growth of private home care providers in Europe: The case of Ireland. *Social Policy & Administration.* Vol. 55, No. 4: 606-621.

Year	Private	Non-profit	HSE	Total
2006	3	28	209	240
2007	5	39	272	316
2008	15	46	270	331
2009	17	45	269	331
2010	20	46	275	341
2011	23	46	280	349
2012	41	46	228	315
2013	51	42	222	315
2014	67	41	207	315
2015	89	44	187	320
2016	113	46	185	344
2017	141	48	184	373
2018	169	50	189	408
2019	176	40	230	446

Source: Total expenditure: Table 1. Expenditure on private and non-profit providers: Health Service Executive (2019b) and for 2019, Health Service Executive (2020). Expenditure on HSE provision: total expenditure minus spending on private and non-profit

When the for-profit sector begins to dominate residential and home care, it sets the terms and conditions for other care providers in the field[10]. Commercialisation changes the terms on which care is given. The focus is on minimising costs and making profit, often by reducing pay, casualising labour, short-staffing, charging hidden fees, or only taking wealthier clients[11]. **The financialisaton of care is part of what is involved in commercialisation**. Financialisation results in money being extracted by private investors from the care sector. See evidence from England (the Barchester Group which has 12,000 beds in the UK), Lesotho and Australia[12].

Commercialisation also alters the **terms of the debate about care, defining it as a 'product'**, ignoring ethical and relational dilemmas endemic to caring and the fact that it is about 'the maintenance of life for itself'[13]

[10] Farris, S. and Marchetti, S. 2017. From the commodification to the corporatization of care: European perspectives and debates. *Social Politics,* 24 (2): 109-31.

[11] Public Services International 2022 *The Crisis in Long-Term Care: Effects of private provision*, https://pop-umbrella.s3.amazonaws.com/uploads/3cb663f8-0078-4617-95b8-e1686b052b1a_2022-_THE_CRISIS_IN_LONG-TERM_CARE_EN.pdf

[12] Public Services International 2021 *Care Givers and Takers: How finance extracts wealth from the care sector and harms us all*. https://pop-umbrella.s3.amazonaws.com/uploads/bcac9e47-b0a2-4036-a415-ce65ef0dc36d_Care_Givers_and_Takers__EN_.pdf

[13] See Dowling, E. 2021. *The Care Crisis: What Caused It and How Can We End It?* New York: Verso.

The corporatisation of care can and has driven out other providers from care provision. Big commercial operators can absorb the costs of regulation, bureaucratisation etc. which can cripple smaller non-profit providers.

WHY DOES IT MATTER IF CARE IS GIVEN ON A FOR-PROFIT BASIS?

The value and practice of care is antithetical to the value of making money. Research comparing private non-profit, public and for-profit elder care in other countries, shows that, *over time,* the quality of care is not as good in the profit-making sector[14].

Care Logic Differs from Market Logic

- Care logic is driven by human needs not by efficiencies; it cannot be measured in quantifiable outcomes; it is an experience not a product and as such it cannot be defined as a commodity, without being undermined
- Care needs are variable, they cannot be codified as being the identical for all.
- Temporal Logic of care differs from market logic. Care cannot be done in measurable time: nurturing needs dictate the time frames not economic or policy logics
- Care labour time is not infinitely condensable; you cannot do it in less and less time. It is not possible to produce 'fast care' like fast food in standardised packages – Time-defined care often leads to pre-packaged units of supervision
- Good caring is about nurturing relationships. And, even when it is paid for, there is a voluntary dimension to doing good care that cannot be supplied by regulation or order. Caring requires a disposition, energy, attentiveness and desire to care that cannot be supplied by 'training' alone.
- Though education can enhance the quality of care provided, loving-led care cannot be supplied to order like a set of new clothes.
- The Rationality of caring is different from, and contradicts, scientific and bureaucratic rationality. It is for this reason bureaucracies can be uncaring as they often cannot make the rules flexible enough to provide individualised care for people who are highly dependent, and who may be non-verbal.
- The concept of 'care package' implies that care is a commodity like a package of groceries that can be bought and sold; this contradicts the meaning of care. **It implicitly changes the definition of a person from a Citizen to a Consumer**. This is a widespread practice across government departments (See final note ** in the appendix below)

[14] Comondore, V. R., Devereaux, P. J., Zhou, Q., Stone, S. B., Busse, J. W., Ravindran, N. C., ... Guyatt, G. H. (2009). Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *British Medical Journal*, 339, 15. doi:10.1136/bmj.b2732
For a list of other research studies showing the problems with for-profit nursing home care, see Julien Mercille (2018) Neoliberalism and health care: the case of the Irish nursing home sector, *Critical Public Health,* 28:5, 546-559

3. DEMOGRAPHIC CHANGES – NATIONAL PLANNING UNIT FOR CARE

While the Citizens' Assembly recommendations for childcare are quite specific, (for example to increase state expenditure on childcare from 0.37 to 1.0% of GDP), the recommendations with respect to adult care are very general. There is no specific expenditure target set for funding the care of adults in their own homes, nor for supporting family carers. Yet, the 2016 Census shows that there is a 5.1% increase in the number of family care hours provided since 2011[ii].

It seems essential to **have a National rolling Ten-year Action plan** for childcare and adult home care supports with projected budgets. This has to be planned beyond the lifetime of any given government.

Advance care planning based on up-to-date demographic data is required. Such planning must then be aligned with policy planning in related government departments.

If we want care to happen, there **will have to be a National Care Planning Unit established** perhaps within the current Department of Children, Equality, Disability, Integration and Youth.

4. DEFINING AND MEASURING CARE WORK IN IRELAND IN THE CENSUS

The question in all recent Censuses, including the 2022 Census, allows only the care of adults to be counted as care work. As it does not include childcare, **the Census fails to measure the full extent of care work in Ireland.**

Q 21. Do you provide regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability?

Q 21 needs to be changed in any future Census. This would allow us to see the full extent to which women are carers, not only of adults, but of children, and of children *and* adults at the one time.

Appendix OTHER COMMENTS

Recommendation 4a and 4b – Improve the terms and conditions of those in paid employment as Carers

Given that many of those who qualify with a degree in social care/childcare do not stay on to work in childcare for reasons of low pay and poor working conditions[15], I particularly welcome the proposal to develop a develop a pay and career structure for paid carers, including both childcare workers and carers of adults.

However, while home care workers employed by the HSE (approximately 50% of home care support assistants) have established wages, contracts and regulated conditions arising from collective agreements with trade unions (HSE full-time wages range from €27,400 to over €33,000),[16] **there is no obligation on other private service providers to align terms and conditions with publicly employed staff so there can be significant variation in terms of employment across providers**. As the Migrant Rights Centre (2015)[17] has documented, there are a large number of migrant workers in this sector with many experiencing poor conditions of employment.

As most of those who work in early years care are young women, *childcare workers need to have maternity leave, parental and adoptive leave, and care leave, similar to other workers*, as well as sick pay and other basic entitlements. **This is not mentioned in the recommendations.**

Recommendation 9 (d) Paid leave for Parents – Comments

Maternity Leave – 26 weeks leave on maternity benefit €250 per week

Paternity Leave – 2 weeks on paternity benefit €250 per week

Paid Parental Leave – 5 weeks (both parents) during first year €250 per week

Unpaid Parental Leave – 26 weeks up to age 12

Increasing the paid leave for parents is very welcome and essential if more parents are to paid leave.

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[15] An Early Childhood Ireland survey of 3,200 childcare workers, in 2019, found that 65 per cent of 3,200 surveyed do not expect to be working in the sector in five years' time 'if things stay the same'. During the Covid-19 crisis, a survey of over 1,000 childcare professionals found that 32 per cent intend to leave the sector within the next 12 months. https://www.earlychildhoodireland.ie/wp-content/uploads/2021/05/Pathways-To-Better-Prospects-2020.pdf

[16] https://www.earlychildhoodireland.ie/wp-content/uploads/2021/05/Pathways-To-Better-Prospects-2020.pdf

[17] https://www.mrci.ie/app/uploads/2020/01/Migrant-Workers-in-the-Home-Care-Sector-Preparing-for-the-Elder-Boom-in-Ireland.pdf

The rate of maternity and paternity (and paid parental) leave €250 per week **is only one third of the gross average weekly earnings** of a worker in Ireland. This makes taking leave very costly. **Unpaid parental leave** is only available to better off workers can avail of this option

It is not financially possible for most people paying high rent or with a substantial mortgage (and pre-existing childcare costs) to take maternity/parental/paternity leave beyond what is absolutely essential unless their employer tops up the payment. **The fact that 46% of women on maternity benefit did not receive a top up from employers (in 2019) shows that many women have to return to work as soon as possible.**

The CSO data show that those in the public sectors and education were the most likely to get a top up and those in the financial and real estate; the least likely were those in retail, wholesale and the hospitality sectors, namely lowly-paid women[18]**.**

The reason for the low take up of parental leave and paternity leave (55% of men took paternity leave in 2019) is undoubtedly related to the unsustainability of a family living on maternity/paternity benefits alone.

Recommendation 10 Actively supporting older people and people with disabilities to live independently

While the recommendations here are welcome unlike the proposals in Recommendations **8 and 9,** about childcare, which are specific (the recommendation to increase state expenditure on childcare from 0.37 to 1.0% of GDP), **there is no specific expenditure target set for funding the care of adults in their own homes nor for independent living for those with disabilities, or infirmities due to age.** Yet, the 2016 Census showed that there is a 5.1% increase in the number of family care hours provided since 2011. Carers provided over six million (6,608,515) hours of care per week, an average of 38.7 hours per carer; caring hours amounted to over **343 million hours (343,642,780) of unpaid care a year[19], most of which were done by women.**

Children as Carers

There is also no reference in the recommendations to **children who were carers** yet the 2016 Census showed that there were 3,800 children under the age of 15 who were carers, making up 1.9 per cent of the carers in the State at that time. I am not sure if this committee is addressing this matter, but it is serious.

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18 https://www.cso.ie/en/releasesandpublications/er/eampb/employmentanalysisofmaternityandpaternitybenefits2016-2019/

19 https://www.cso.ie/en/releasesandpublications/ep/p-cp9hdc/p8hdc/p9cr/

**Citizens with Rights and Needs are being redefined as Customers by State Agencies

- **Revenue Commissioners** – There were 2262 references to 'customers' on its website (November 2021)
- **Department of Further and Higher Education Research, Innovation and Science** has a Customer Charter (Nov. 2021) https://www.gov.ie/en/organisation-information/0d96a-our-customer-service-promise/
- Department of Education, Department of the Environment, Department of Agriculture etc. all have customer charters
- **Parole Board** has a Customer Charter
- **Health Service Executive (HSE) has multiple sites and 100s of references to customers**

One cannot be a customer to a human right as it is not something you purchase off a shelf – it is a non-negotiable entitlement