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Institutional Business Power: The Case of Ireland's Private Home Care Providers

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Abstract

The marketisation of European home care has given rise to significant private for-profit providers growth. However, little research has focused directly on commercial companies to examine the mechanisms through which they emerge, grow and shape long-term care policy – this is this paper's task. Drawing on the literature on business power, the recent concept of "institutional business power" is introduced, defined as the power flowing from the entrenched position of business actors in the provision of public social services. The paper identifies the mechanisms through which private providers have grown and assesses the extent of their institutional power by examining their influence on policy and the support they obtain from relevant home care stakeholders. The limits of providers' institutional power are also discussed. The paper relies on semi-structured interviews with representatives of public, private and non-profit home care providers.

Keywords: business power; marketisation; private providers; home care; outsourcing

1. Introduction

During the last several decades, older people services have been subjected to a range of marketisation and cost containment measures (Glasby et al., 2021). Initiatives that could help to reduce social care costs like "active ageing" programmes across the life course are sometimes diluted by vested commercial and political interests (Walker, 2018). Instead, governments often choose to marketise older people care in the name of efficiency (Fine and Davidson, 2018; Meagher and Szebehely, 2013; Ranci and Pavolini, 2013; Zhang, 2021). A range of reforms have been implemented, including cash-for-care schemes (Da Roit and Gori, 2019), "personal budgets" (Ismail et al., 2017) and benefits restriction (Ranci and Pavolini, 2015), while ideologies foregrounding consumer "free choice" and provider competition have become more dominant.

As a result, in Europe, long-term care has morphed into a system that may be labelled "restricted universalism" (Moberg, 2017; Ranci and Pavolini, 2015). A key related development is the growth of private home care providers. The

term "private providers" refers to commercial, for-profit companies that deliver domiciliary care services and that operate in parallel to non-profit and public providers. However, existing work on home care mentions private providers cursorily. Little research has focused directly on commercial entities with the objective of analysing and theorising their growth, power and influence over long-term care policy, prompting calls to address this knowledge gap (Meagher and Szebehely, 2013; Mercille and O'Neill, 2021). The home care sector is highly relevant to study the dynamics of business power. European population ageing and the Covid-19 pandemic have put long-term care at the centre of social policy agendas for years to come. The business sector is expected to attempt to meet substantial portions of future needs. Therefore, home care and long-term care should provide illuminating case studies of the growth and evolution of business power, as well as public-private interactions.

Private providers have also been neglected in the literature on the Irish welfare state, even if they increasingly supply significant welfare services. Scholars have examined the retrenchment and activation policies of the post-2008 austerity years (Daly, 2019) and the neoliberal character of the welfare state (Dukelow and Considine, 2017; Kirby, 2010; Murphy and Dukelow, 2016; Powell, 2017). However, despite some discussion of groups like the construction industry on the welfare state (Norris, 2016), the nature of the business sector and its connections to the Irish welfare state remain under-studied. This paper addresses this gap and builds on studies of the neoliberalisation of the Irish welfare state by documenting and theorising the important role of business in it. It is argued that while the Irish state historically relied on religious orders to deliver home care through a process of delegation, over the last several decades, it is a process of deregulation that has enabled commercial companies to displace both religious orders and the state in home care. The private providers that now occupy a significant space in the home care sector owe their influence mostly to their privileged institutional position, and only secondarily to their lobbying activities and size (which is relatively small) in the national economy.

2. Structural and instrumental business power

Theories of business power can help to conceptualise the growth of private providers, the processes through which they displace and/or co-exist with public providers, and their influence on long-term care policy. This paper conceives of business power as the capacity of business actors to influence political and policy decisions (Farnsworth and Holden, 2006; Paster, 2015).

Business power research has gathered renewed interest in recent years due to the increasing levels of inequality and the outsized role of the financial sector in Western economies. Radical political economists laid its foundations by describing the significant influence of the corporate sector on policy (Block,

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1980; Miliband, 1969). Two sources of business power are commonly identified: instrumental and structural power. Instrumental power refers to mechanisms used by business groups to influence policy, such as lobbying and campaign donations (Hacker and Pierson, 2017). Structural power refers to the central position that the business sector occupies in capitalist democracies, which makes governments highly dependent on business for investment and employment (Lindblom, 1977). Structural power gives business decisive leverage to orientate policy because governments' capacity to operate and remain popular with the electorate is closely linked to the business sector's performance. In other words, structural power is rooted in the structure of a political economy whereas instrumental power refers to firms' attempts to influence particular policy decisions through targeted lobbying.

A number of studies examine the role of structural and instrumental business power in relation to social policy and the welfare state (Farnsworth and Holden, 2006; Hacker and Pierson, 2002, 2010; Paster, 2013, 2018). For example, Farnsworth and Holden (2006) outline a typology of business inputs into social policy, including corporate provision and production of services, institutional participation and political engagement (see also Holden and Lee (2009)). Pieper (2018) presents an index measuring the power of private providers that incorporates both structural and instrumental sources of power. Still, the study of social policy and business power can be improved by examining a third form of business power: institutional power (Busemeyer and Thelen, 2020; see also Farnsworth and Holden, 2006).

3. Institutional business power

Institutional business power is defined as "power flowing from the entrenched position of business actors in the provision of essential public functions or services" (Busemeyer and Thelen, 2020, p. 454). When private actors deliver goods and services that could be delivered by the state instead, they become essential to society's functioning, which lays the foundations for business power and influence to grow.

The paper examines two key aspects of institutional power: (1) the mechanisms through which it grows, and (2) the extent of private providers' institutional power. Theoretically, three growth mechanisms may be outlined: delegation, deregulation, and accretion (Busemeyer and Thelen, 2020). Accretion happens when private actors expand their power by taking the initiative to move into an area previously dominated by the state, or into a new area with limited state involvement. Deregulation, on the contrary, happens when the state retreats (or fails to expand) in its role as service provider, leaving private actors free to meet demand for services. Delegation refers to a conscious political decision on the part of the state to set up or support a coordinated and stable

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arrangement between the state and private actors in a given sector. The three mechanisms are not always clearly delineated. For example, a process of deregulation may be driven primarily by a withdrawing state, but may also result from active lobbying by private firms. Also, under deregulation, there is usually an element of formal/legal coordination between the state and private actors to divide responsibilities in service delivery and regulation.

The extent of institutional power may be assessed through several criteria. First, business grows its leverage over the state when it holds a strong and credible "exit threat" and when the state's capacity to replace firms through public delivery is minimal (Farnsworth and Holden, 2006). In other words, when private firms are the sole entities capable of delivering a service, and when those same firms have a number of potential alternative avenues or locations to conduct their activities, the threat of exit is felt particularly acutely by the state: firms could easily leave existing arrangements with the state if these are not satisfactory to them.

Second, institutional power increases when state capacity to deliver services is deficient. A "small" state is poorly equipped to deliver services by itself and is thus inherently dependent on private actors to do so. For example, if firms are responsible for the financing of a service, this increases the state's dependence on them because a key aspect of social policy is under the responsibility of private actors. Conversely, if firms are dependent on public funding, as they often are when social services are outsourced, their power is reduced.

Third, feedback effects foster the growth of institutional power and operate at several levels. State reliance on private actors to deliver goods, services or administrative functions can lead to the erosion of state capacity over time to carry out those functions itself; the state will find it increasingly difficult to step in if firms exit. In recent years, austerity policies have compounded this feedback mechanism because expenditure cuts have led to a decay of state functions. Policy feedback also occurs when relevant actors become more supportive of private firms out of necessity or ideological realignment. This is because service provision by private actors entails institutional realignments as other actors (including the state bureaucracy, trade unions, patients groups, political parties) adjust to the evolving reality of increased provision by private firms. Those actors may even accept and support private firms to deliver those services instead of the state because they establish relationships with private providers. Finally, popular opinion and norms may shift in favour of private providers as people get accustomed to them and rationalise them as central actors in goods/service delivery (Culpepper and Thelen, 2020).

A related issue is whether institutional power may be expected to increase over time once private firms have entrenched themselves as actors in welfare provision. Some maintain that business power is expected to increase because once profitable opportunities become available, firms are expected to utilise

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"all the means of political engagement and institutional involvement [available to them] to defend and extend their interests" (Farnsworth and Holden, 2006, p. 479). Moreover, as mentioned above, feedback and lock in mechanisms are expected to reinforce business power (Busemeyer and Thelen, 2020). However, it is also possible that business power could fail to grow or even recede, due to institutional constraints, a changing economic environment, organised labour opposition, or changing societal or ideological norms (Hacker and Pierson, 2002; Paster, 2018; Pieper, 2018).

The remainder of this paper examines the above theoretical issues empirically. It first discusses the mechanisms by which private for-profit actors have established their institutional power in Irish home care. Second, it assesses private providers' institutional power by reference to their capacity (and its limits) to influence home care policy and gain acceptance by other stakeholders in the sector.

4. Methods and data

The paper draws on interviews conducted with officials working for the public provider (Health Service Executive, HSE), private and non-profit providers. Interviews were semi-structured and lasted between 25 and 60 minutes and were conducted face-to-face or by Skype/Zoom, recorded and transcribed. Interviewees worked in all nine Community Health Organisations (CHO) in Ireland, the geographical areas in which the HSE divides Ireland's territory. Interviews probed the reasons for private providers' growth; the nature of the interactions between the three types of providers and the state/HSE; the obstacles to private providers' growth; and the nature of service delivery in rural and urban areas. Participants came from both public and private providers (which allows for an examination of state-business interactions) and from all regions, including rural and urban areas (which is important because processes of private provider growth vary geographically). The project received ethics clearance from University College Dublin's Human Research Ethics Committee. Participants' informed consent was obtained prior to the interviews, including approval of data usage while preserving confidentiality and anonymity.

Moreover, to describe the growth of private providers by region, data on annual public expenditure on private home care providers by geographical area since 2006 were used (Health Service Executive, 2021). The dataset was compiled by the HSE and supplied to the authors. There are metrics other than financial data that could in principle allow one to describe the growth of private providers (e.g. clients served, hours of service provided). However, in an Irish context, those data are not as systematic (e.g. they do not go as far back in time,

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or do not differentiate between private and non-profit providers) as the financial data that were used.

5. Deregulation: the engine of private providers' growth

This section argues that private providers have established themselves through a process of deregulation. However, deregulation has not yet reached rural areas significantly, which remain dominated by the public provider. Moreover, historically, religious and voluntary organisations have delivered much of the home care services in Dublin through a process of delegation. A brief review of the historical development of Irish home care supports these interpretations.

The state began its involvement in home care provision after World War II. While it provided some services directly, it preferred to fund religious and voluntary organisations to deliver the services (Inter-Departmental Committee on the Care of the Aged, 1968; Timonen and Doyle, 2008). Eventually, the state took more responsibility for home care: between 1980 and 1993, real expenditure on home help almost doubled (Brady, 1994, p. 16). However, a geographical cleavage emerged between Dublin and the rest of the country: in Dublin, home care was delegated to religious organisations, whereas in the rest of the country, direct state provision was the norm. For example, in 1993, voluntary/religious organisations delivered 92% of home care in Dublin; but everywhere else, services were nearly all delivered by the state (Lundstrom and McKeown, 1994, p. 133).

The presence (in Dublin) and relative absence (outside Dublin) of voluntary/religious organisations delivering home care is partly due to cultural reasons. Simply put, home care was traditionally provided by the family and neighbours in rural areas, whereas this was less the case in large cities. As an interviewee explained:

> "There's a longer history in the city of alms giving, a Christian type of thing to do, which was the genesis of some of those voluntary [religious] groups . . . Down here [in rural areas] it was kind of your helpful neighbour that we put them in touch with the other neighbour . . . Also in rural areas there might be more culturally, there might be tighter community around them, and there would be more family around them" (Interviewee 28).

Therefore, before the emergence of private providers, Dublin was characterised by state delegation to religious organisations. The state made a conscious decision to outsource care to religious orders, which delivered it on a consensual, voluntary basis. This conforms to a common pattern in other welfare sectors in Ireland given the historically prominent role of the Catholic Church in education, health and social care (Dukelow and Considine, 2017).

In the late 1980s, private providers emerged and grew moderately until the mid-2000s, mostly in the Dublin region (Doyle and Timonen, 2008). Since 2006,

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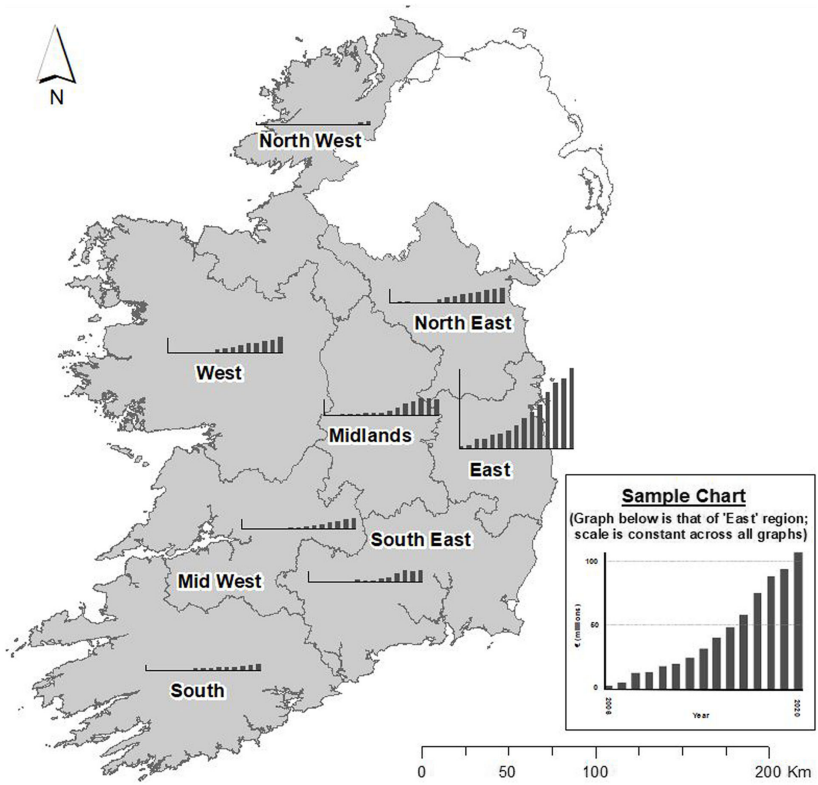

FIGURE 1. Growth of private providers by region, 2006-2020.
Note: Each bar represents the amount of public funding received by private providers for a given year.
Source: Health Service Executive (2021).

they have expanded drastically in Dublin and throughout Ireland's towns and cities (Figure 1) (Mercille and O'Neill, 2021). This happened within a context of significant increases in public expenditure on home care in 2000-2010, made possible by the "Celtic Tiger" economic boom (Timonen et al., 2012). Nevertheless, the state did not expand enough to meet all home care needs directly and instead chose to outsource substantial amounts of care (Health Service Executive, 2014). A tendering process was established whereby public funds are allocated to private and non-profit providers to deliver home care services operating in parallel to direct state provision.

In Dublin, commercially-minded private providers captured the bulk of outsourcing contracts, displacing voluntary organisations, which were unable or unwilling to compete (Health Service Executive, 2014). The state never had a base in Dublin, nor did it ever try to develop one. In other words, home

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care transitioned from state reliance on voluntary organisations through delegation, to reliance on for-profit companies through deregulation (Timonen and Doyle, 2008).

To be sure, it could be argued that the growth of private providers in Dublin is characterised by a delegation mechanism to commercial companies due to the political decision of the state not to build a public infrastructure and instead to rely on private companies. However, on balance, deregulation better describes the process because the delivery of services in Dublin is based on market competition, meaning that both commercial companies and non-profit organisations can compete to be on the tender giving them access to home care funding from the state. In other words, there is no explicit political decision to devolve care specifically to private companies, only to open it to whoever is awarded the contracts based on market competition. Moreover, private providers began to grow because of a decision by government officials to restrain state involvement in home care in the mid-2000s. Minister for Health and Children (2004-2011) Mary Harney of the right-wing party, the Progressive Democrats, implemented outsourcing reforms through "home care packages" in 2006, which led to significant private providers' growth. The rationale was that the government did not want to increase the head count in the public sector as this results in costly pensions and other benefits to be paid by the public purse (Mercille and O'Neill, 2021). This state restraint fits the process of deregulation.

Outside Dublin, following the same process of deregulation, state restraint allowed private providers to capture a growing proportion of outsourced home care contracts. However, deregulation has not been significant in rural areas, yet. Indeed, there is a geography to home care provision outside Dublin: private providers operate in areas where there are significant concentrations of older people – namely, in larger towns and cities – but in remote rural areas, public provision remains dominant. Therefore, it could be stated that deregulation outside Dublin has operated mostly in towns and urban areas, whereas in rural areas, it has been less significant and private providers have not gained institutional power from rural areas. The fact that all regions other than Dublin contain significant rural areas explains why they have witnessed less private providers' growth than the Dublin area (Figure 1). The remainder of the paper examines both the extent of private providers' institutional power and its limits.

6. Assessing private providers' power

This section argues that private providers have accumulated significant institutional power, for several reasons. First, the state has become dependent on private providers, which account for over half of home care hours nationally (Health Service Executive, 2019). For example, an HSE interviewee described the relationship between private providers and the HSE as follows: "In some

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areas of the country, the HSE is totally reliant on private agencies" – for example, in Dublin, "the HSE has no alternative, it can't just suddenly overnight develop something else" (Interviewee 14). When asked whether it would be possible for the HSE to reverse course and build up its in-house provision so as to overcome private providers' institutional power, interviewees explained that state capacity had by now been hollowed out to such an extent that this would be difficult. Longstanding under-investment in IT systems, staff and infrastructure pose large obstacles to build, maintain and renew a carer workforce and underline private providers' significant institutional power. As an HSE manager described the situation:

> "It's a massive, massive undertaking for the HSE to take on [including] attracting the right people in to actually manage those services . . . we don't have an IT infrastructure across the country, we don't have one single IT system, we don't have the rostering tools, we don't have any of these things, and that's something that we need to grow and we need to develop" (Interviewee 17).

In particular, during the recent years of austerity, a recruitment embargo for home care in the HSE limited the size of the public carer workforce by prohibiting the hiring of additional staff. The effect was to increase reliance on private providers, a causal relationship noted by a number of interviewees:

> "There was a recruitment embargo a number of years ago and that meant that when our staff resigned and retired, we didn't fill them and therefore we had shortages and when we had shortages we went to the private providers" (Interviewee 23).

Second, the institutional power of private providers is revealed in the shift in stakeholder groups' perceptions of them toward a greater acceptance of commercial companies as key players in home care. Whereas in earlier years, the HSE and Department of Health explicitly favoured non-profit organisations in outsourcing, today they desire a balanced mixed provision system and value private providers. For example, in 2007, interviews with senior HSE home care managers indicated that the majority of them "would prefer to contract all of their care requirements to the not-for-profit organisations, since they were 'linked more closely' to the HSE structures" (Doyle and Timonen, 2008, p. 328). This position is different from that expressed by our interviewees, who stated that private providers are integral and essential actors in delivering home care when the public sector is unable to do so. An internal HSE study stated as such: "the HSE is clearly not averse to working with for profit service providers in the area of home care service delivery and opening up public funding to a range of providers" (Health Service Executive, 2014, p. 9). An interviewee stated the same: "Home care is delivered in partnership with private providers as well as non-profit organisations. This partnership approach brings benefits in service delivery" (Interviewee 24). A government official, when asked if the Department

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of Health had a preference regarding provider type, echoed this perception: "We don't mind who provides the service, as long as it is delivered well", adding that "I don't know that there are any negatives" with private companies compared to other types of providers (Interviewee 4).

Non-profit providers also recognise that private companies can play a positive role in forcing all types of providers to professionalise their operations. One interviewee in the non-profit sector described the positive changes in their own organisation due to the emergence of private providers and the higher professional standards they fostered within the sector:

> "The standard we operate now 10 years on is unrecognisable from the standard we were at 10 years ago . . . we have very powerful IT systems, we have excellent policies and procedures, we have staffing structures, we have professional support" (Interviewee 13).

Further commenting on the ongoing preparations to establish a national statutory scheme for home care:

> "I think the Department [of Health] would be foolish not to listen to them [private providers] . . . they have a lot of expertise, they're doing this all over the country for a long time, the internationals have expertise from other countries as well, so actually they will have insights that would make those bits of legislation better I think. Of course, we should not listen to private providers uncritically, but we should listen to them" (Interviewee 13).

The differences between non-profit and private providers should not be exaggerated as the former are still somewhat uncomfortable with home care delivery driven by the profit motive (Cullen, 2019). Nevertheless, there is an acceptance of private providers as established and dominant players in the sector that must be engaged and who can bring benefits to home care delivery.

Finally, the acceptance of private providers is also demonstrated by a major survey of home care stakeholders including carers, service users and their families, patient advocacy groups and providers (The Institute of Public Health in Ireland, 2018). The survey reported on the views on home care of 2,629 respondents, including 109 home care organisations representatives. To the question, "Do you think that people who receive home care should have a choice in who provides their care?" the survey found that 87.5% (n=1,338) of respondents agreed with the statement, while only 6.1% (n=94) believed that users should not be involved in such decisions (The Institute of Public Health in Ireland, 2018, p. 43). Choice of provider, of course, is inherently tied to a mixed system of provision including private providers. Therefore, the notion of choice of provider has become a norm accepted (albeit perhaps reluctantly at times) among home care stakeholders.

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7. Limits of business power

Nevertheless, there are limits to private providers' institutional power. First, their "exit threat" is relatively weak because they are dependent on state funding to operate. In other words, while the state, in practice, is highly dependent on private providers to deliver home care, it retains a not insignificant amount of leverage over them as the purse holder – industry sources estimate that on average, 75% of private providers' revenue comes from public expenditure and 25% from private sources (clients' out-of-pocket payments) (Mercille and O'Neill, 2021). A private provider expressed the importance of public funding to the sector's operation thus: "In Ireland, it's the HSE that pays, or nothing happens" (Interviewee 6). Similarly, when asked if their business would be viable without state funding, another private provider responded: "No – we would have been a very small home care company... it wouldn't have allowed an adequate income" (Interviewee 9).

Second is the impact of geography. Remote and rural areas are sparsely populated. This means that clients tend to be located at long distances from each other, which requires carers to spend time traveling between clients. The HSE does pay carers for their travel time, but private companies do not. Therefore, it is often impossible for private companies to operate in remote areas because they are unable to hire carers, who prefer to work for the HSE given the better pay and conditions (Mercille et al., 2022). The dominance of the HSE in rural areas was explained by an HSE interviewee as follows:

> "If you take, for example, Connemara and up into some parts of Mayo [rural areas], the private companies fail to attract staff up there, because people just don't want to work for companies that pay €10 an hour and not have any security, and that's where the HSE has to fit in" (Interviewee 17).

Private providers confirm that they operate in and around urban areas where there is a large enough concentration of potential clients: "In the very rural areas... with a lot of traveling involved it's very hard to make it pay... the vast majority of my business is coming from the core of the city" (Interviewee 6).

If remuneration increased for carers working for private providers, the latter could recruit more staff and operate in rural areas and boost their institutional power. However, this would raise their operating costs and until public funding rates increase or profits are reduced, it is not a foreseeable development. Better working conditions could also be obtained by raising the low unionisation rates (about 10%) among private providers' workforce toward the rate in the public sector (about 90%), but this is unlikely for the time being (Mercille et al., 2022).

Third, private providers face opposition from some local HSE teams: in areas where public delivery continues to dominate, those teams make significant

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efforts to recruit carers and invest in the tools required to train and manage their workforce, in addition to creating a rewarding work environment. One HSE manager explained that in the west and south of the country, for example, significant efforts were made to increase staff numbers and maintain a public carer workforce instead of outsourcing:

> "The view was taken, well, look, let's increase the staff numbers that we have and let's do some training with them . . . and therefore then the level of funding that was to be put out was invested internally and not to the private providers, and therefore the private providers didn't get the same level of foothold that happened on the east coast [Dublin]" (Interviewee 28).

Fourth, the historical path dependency of certain areas predisposes them to maintain significant levels of public delivery. For example, in some counties, the HSE/Department of Health had historically a lot of home helpers (perhaps because home care was prioritised by past Department of Health officials, or because other community and primary care services were already well provided or less needed, which allowed significant resources to be allocated to home care). Those large pools of public delivery carers are more difficult to erode as they have priority over private providers in the allocation of home care packages, which can only be outsourced once the HSE cannot provide them itself.

8. The relative importance of different types of power

This paper has argued that one key source of private providers' power is institutional. But how important is it relative to other sources of power for Irish home care? Structural power is not as significant as institutional power. Although private providers draw on a certain amount of structural power in that they are part of the Irish political economy, they remain relatively small players compared to commercial entities in, say, Big Tech, finance and real estate. Even if large global chains dominate the home care landscape, their operations in Ireland take the form of small franchises akin to SMEs (small and medium-sized enterprises) that do not exert a significant impact on the national economy.

Instrumental power is arguably more relevant but remains less significant than its institutional counterpart. It manifests itself mainly through the industry's trade association, Home and Community Care Ireland (HCCI), which has 80 members, mostly franchises of US- and UK-based global chains like Home Instead, Bluebird and Caremark. Those large firms dominate the private sector, while smaller domestic companies are in a minority. In the last several years, HCCI has become more systematic in its attempts to influence policy. Its instrumental power is visible in key policies that have benefitted private providers, such as the way in which the tendering process has been gradually modified to favour commercial companies. Indeed, in 2014, private providers launched

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a legal action against the HSE and argued that public subsidies received by non-profit organisations constituted illegal state aid resulting in unfair competition under the tender for home care contracts. Private providers also objected that certain contracts had not been put out to public tender by the HSE, which had instead managed them through traditional grant funding arrangements (Carolan, 2014). In other words, private providers wanted to marketise further the allocation of publicly-funded home care services. The private providers eventually obtained what they wanted and the state acquiesced to their demands. Indeed, subsequent tenders forced all non-profit organisations onto the tender in order to get public funding for home care and two traditional streams of funding were merged and marketised. Previously, the "home help" stream was reserved for non-profit organisations only and excluded private providers, which were only allowed to compete for the second stream, "home care packages". However, since 2018, there is only one stream, called "home support", and all providers must access it through the tender. The tender system has thus been marketised further, to the benefit of private providers.

However, it would be incorrect to argue that instrumental power is more important than its institutional counterpart. Instrumental power, or the effectiveness of lobbying actions, strongly depends on the extent to which private providers dominate home care (their institutional power) and the inclination of government towards marketisation. Both factors have strongly favoured private providers and created a supportive environment for lobbying efforts. Indeed, the growth of private providers has been driven, fundamentally, by successive governments' ideological inclination to marketise public services. As seen above, the right-wing Progressive Democrats initiated a number of significant privatisation and marketisation reforms in health and social care in the mid-2000s. At the time when those reforms were initiated, and for a number of years thereafter, private providers accounted for a very small portion of home care services, were barely starting to organise as a group, and thus were not in a position to shape policy without the state concurrently pursuing those reforms for its own ideological reasons. Indeed, the growth of private providers only took off after the government decided to outsource home care through "home care packages" in 2006 (Mercille and O'Neill, 2021). Also, it is only in 2018 that HCCI established a chief executive position, which made the organisation more systematic in its activities.

Second, it is not conceivable that private providers' lobbying would be as effective if they were not responsible for over half of home care hours delivered nationally. The latter ensures that the state must take them seriously and consider their requests. They would not have the influence that they currently have if they delivered only a small fraction of home care. This is not to say that private providers have not been effective at influencing government, but rather, it is to

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maintain that their instrumental power is contingent on, first, a governmental ideological stance favourable to outsourcing, and second, the accumulated institutional power to which the latter has given rise.

Related, can broader ideational shifts in Ireland help explain the growth of private providers? Briefly, one could point to the "Celtic Tiger" period of rapid economic expansion from the 1990s to the collapse of the housing bubble and financial crisis of 2008. This period involved an ideological shift among large segments of the public in favour of capitalism, markets and entrepreneurship, providing the favourable context within which marketisation reforms in health and social care took place. In particular, growing incomes allowed more people to seek private health insurance, a marketised solution to a deficient healthcare system (Allen and O'Boyle, 2013). Although it is difficult to relate precisely those broad cultural and ideological currents to the growth of private providers, it is fair to say that they provided an environment conducive to privatisation.

Finally, the strength of lock in and feedback effects should be considered. The case of Irish home care reveals a privatisation process giving rise to a form of institutional power less rigid or locked in than others have suggested (Busemeyer and Thelen, 2020; Farnsworth and Holden, 2006). Indeed, when significant societal shifts occur, entrenched private actors can be displaced either by the state or by other types of private providers, which diverges from expectations that lock in effects grow private actors' power consistently. For example, in the 1990s-2000s, private providers displaced voluntary organisations (private non-profit) in Dublin. This shift was driven by the secular decline of the Catholic Church in Irish society, which lost a lot of its prominence in delivering social and health care services.

Also, commercial providers have recently grown significantly throughout the country and thus currently occupy a comfortable position in the home care sector. But it remains an open question whether their growth will continue, and it may even be partially reversed. First, rural areas may constitute a permanent obstacle to private providers' growth, unless public funding levels increase substantially and providers can afford paying higher wages to carers. Second, it is possible that what some observers (Krugman, 2021) have identified recently as the end of neoliberal trickle-down economics and the return of more interventionist governments in Western economies may constitute a shift significant enough to overturn private providers' growing power and eventually lead to a revitalised role for public provision in home care. Related, home care workers could strengthen their position through collective bargaining and unionisation (although this seems unlikely at present), which could cause profit margins to drop and private providers to exit the sector. The public provider could then regain some space within the home care sector and reverse deregulation. Another possible scenario is that private providers' growth could stabilise

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and the home care system could reach a state of equilibrium whereby the state and commercial companies deliver services in more or less equal proportion. This is likely if, in particular, private providers resist venturing in rural areas. This mixed provision system is in fact the government's and private providers' declared objective, although the exact proportions remain to be determined.

9. Conclusion

This paper has argued that the concept of institutional power helps explain the growth and influence of home care private providers in Ireland. The concept is particularly pertinent to the study of social policy because it refers to the provision of services by private actors in interaction with the state. Because public funding is often integral to the delivery of such services, in principle, institutional power may not have the potential power of its structural counterpart due to the leverage accruing to the state by virtue of its funding of private providers' operations. Secondly, because social services delivery tends to rely on providers being grounded in a specific national or local territory, it is difficult for those providers to exit their local or national market to go elsewhere if government policy does not follow their interests; in other words, exit threats are weakened. In contrast, structural power refers to the strength of the business sector in a political economy and includes large segments of the corporate sector that do not depend on state funding and which are relatively mobile. In that way, structural power is not limited as institutional power is.

However, for companies involved in social services provision, institutional power may often be the most important source of power. Indeed, they may have limited structural power to draw on because they are usually not industrial, financial or technological leaders in the national political economy. Moreover, as argued above, their instrumental power often derives in the first place from their large institutional footprint in delivering services for the state; therefore, instrumental power can hardly be interpreted as a fundamental source of power for such companies.

Nevertheless, when larger commercial entities supply public services, structural power becomes more relevant. This would be the case in social policy sectors like housing, where global real estate companies are key players, as well as with certain hospital, primary care centres and nursing home chains (Mercille, 2018a, 2018b, 2019). Moreover, markets larger than Ireland tend to attract more global corporate entities, which could translate into a more important role for structural power in social policy. In short, further work is needed on the conditions that increase or decrease institutional and other forms of power. Moreover, the relationships between structural, institutional and instrumental power should be explored in more depth. Every business entity draws some power from all three sources, but they should not be seen as separate. It would

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be fruitful to identify which sources are fundamental and play a role in facilitating the others, or which dominate in which social policy sector and for what types of businesses.

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Competing interests

The authors declare none.

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