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Co-operative Care: The Case for Worker Co-operative Elder Care in Ireland

ABSTRACT

Ireland's population age profile is forecasted to increase over the coming decades which will have implications for the care responsibilities of families and the state. However, there is a paucity of quality elder care in Ireland. Elder care worker co-operatives could contribute to meeting this shortfall in supply. This study examines the impact of co-owned elder care provision in Ireland. A case study approach is employed with the Great Care Co-op (GCC) being the case selected. The findings emphasise that the GCC provides a quality service to its care recipients. The care-worker members and family members of care recipients both believe that the standard of care provided is superior to that of a conventional investor-owned care provider. The findings also indicate that the governance structure of the GCC facilitates the delivery of a more responsive service. Both family members of care recipients and care-worker members believe that this is attributed to the Great Care Co-op being a co-operative. This research is innovative in that most of the key stakeholders are interviewed, including: care-worker members, a care recipient, family members of care recipients and representatives of the Health Services Executive (HSE) who liaise with the GCC regarding the provision of care for older people.

KEY-WORDS

CO-OPERATIVE, COLLECTIVE CONTROL, ELDER CARE, MEMBER

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1. Introduction

Ireland's population is ageing and both the number and the proportion of people aged 65 years and over is projected to increase steadily over the coming decades. This demographic trend will place growing pressure on families and the state in terms of care provision and support for older persons.

Access to quality long-term care is already a significant concern across Europe. While national contexts differ, it is estimated that 30% of older adults lack adequate access to care services (Scheil-Adlung, 2015). In Ireland, the challenge is particularly acute with only 1.8 formal long-term care workers per 100 persons over the age of 65, compared to 17.1 per 100 in Norway (ILO, 2015).

Moreover, data derived from high income EU countries, including Ireland, reveal that between 56.6% and 90.4% of the population are unable to access quality long term care services, largely due to the shortage of formal care workers (ILO, 2015). Although, the need to expand the care workforce is widely acknowledged, research highlights that many long-term care workers, especially those employed in conventional investor-owned care businesses, are increasingly part of the precariat, experiencing insecure, low-paid, and undervalued employment (Berry and Bell, 2018).

Conventional investor-owned care providers, whose primary objective is to maximise shareholder returns, often view care staff as a cost to be minimised, rather than as key contributors to quality care (Berge and Bokoumba, 2023). In this context, worker co-operatives may offer a viable alternative model. As organisations owned and operated by their workers, they have the potential to improve both working conditions and care outcomes.

Deploying a case study approach, this paper investigates the potential of a worker co-owned healthcare co-operative in Ireland—the Great Care Co-op (GCC)—to address some of the systemic challenges facing the long-term care sector. The paper's core question is: What is the impact of worker co-owned health care co-operatives in Ireland?

1.1 Worker co-operatives

A worker co-operative is a co-operative owned and controlled by the people who work in it, (United States Federation of Worker Co-operatives[1]). GCC is the first worker co-operative in the home care sector in Ireland, as no other worker co-operative in this sector has been identified. With the support of the Migrant Rights Centre Ireland, the co-operative was established as a response to the exploitation that migrant women experienced when providing care to older people living in their homes. However, a number of the members are from a non-migrant background. The mission

[1] https://www.usworker.coop/what-is-a-worker-cooperative/ [Accessed: 27 May 2025]

of GCC is "to provide great care and great jobs"[2]. GCC's vision is "to create a trusted home care community based on respecting the human rights of all involved in care"[3].

GCC is incorporated as a company limited by guarantee (CLG) with co-operative principles enshrined in its constitution. This specifies that the board must have a minimum of three and a maximum of seven directors. There are three categories of directors:

- Ordinary directors (up to two) who are worker members and are elected at the Annual General Meeting by the membership.
- Representative directors (up to two) who are worker members from a migrant background, and are elected at the Annual General Meeting by membership.
- Independent directors (up to three) who are non-members, appointed by the nominations committee (comprised of two members, the CEO, and one director).

The CEO cannot serve as a director. The service is delivered via a number of hubs which provide elder care to care recipients living in a defined catchment area. Each hub comprises of between 10-12 GCC members.

GCC has opted not to become a multi-stakeholder co-operative because it believed that the most effective approach to becoming both financially sustainable and replicating operations in other areas, was through being a worker co-operative.

The Health Service Executive (HSE) manages all of the public health services in Ireland including personal care services within the community, including those that help people remain living in their communities, when they have difficulties doing so because of illness, disability or age. These include: home nursing services, home helps, occupational therapy and social work services. The HSE delivers its services in the community via nine Community Health Organisations (CHOs), although an evolving health services organisation in Ireland will soon incorporate these structures into Integrated Health Areas. Every home care provider seeking to provide services under contract from the HSE must apply through a competitive national procurement process and meet criteria set out in a tender process. Once the tender process is successful, and a contact awarded, the provider (for example, GCC) establishes a relationship with a local service manager in the CHO in which they operate. The GCC care-worker members also liaise with community public health nurses, on a day-to-day basis. The HSE contract has a duration of up to 24 months, after which time the care provider has to re-tender.

The first and second sections of this paper detail the impact of worker co-operatives and worker co-owned care co-operatives. The methodology will be covered in the third section. The penultimate section details the research findings. The final section contains the discussion and conclusion.

[2] https://www.thegreatcarecoop.ie/our-purpose [Accessed: 27 May 2025]

[3] Ibid.

2. Literature review

2.1 Impact of worker co-operatives

The impact of worker co-operatives extends beyond traditional business metrics such as profit margins and productivity, encompassing a broader spectrum of social, economic, and participatory outcomes (Birchall, 2010). Yet, the extent and consistency of these outcomes remain contested in both theoretical and empirical literature.

In terms of longevity and business viability, early theoretical perspectives, such as Vanek's (1977), suggested that labour-managed firms were more prone to failure than their investor-owned counterparts. This claim, however, has been largely discredited by subsequent empirical analyses. More recent studies (Deller et al., 2009; Pérotin, 2016) offer a counter-narrative, highlighting the resilience and longevity of worker co-operatives. Pérotin's (2016) meta-analysis is particularly compelling, synthesising evidence to argue that worker co-operatives are not only more sustainable but also better equipped to weather economic downturns. This is attributed in part to their financial practices, such as retaining and reinvesting surpluses rather than distributing profits to external shareholders (Alzola et al., 2010; Pencavel, 2013). Moreover, these retained earnings are often directed toward training, innovation, and reserve funds—strategic investments that reinforce organisational resilience and enhance members' capabilities (Pencavel, Pistaferri and Schivardi, 2006; Smith, 2015).

Critically, while conventional firms may prioritise short-term shareholder value, worker co-operatives demonstrate a longer-term orientation, often evident in their operational efficiency and productivity (Birchall, 2010). Research shows that worker co-operatives outperform traditional firms in productivity within the same economic sectors (Fakhfakh, Pérotin and Gago, 2011). This can be explained by the intrinsic motivation of worker-owners, who have a direct stake in the enterprise's success (Conte and Svejnar, 1990). Furthermore, enhanced peer monitoring and reduced management-labour conflict contribute to a more harmonious and goal-aligned workforce (Bowles and Gintis, 1993; Pérotin, 2016).

The emphasis on democratic participation in worker co-operatives also yields tangible benefits in work quality and stability (Restakis, 2010). These organisations often prioritise job security over profitability, leading to employment practices that are less volatile during economic shocks. Rather than resorting to layoffs, worker co-operatives typically reduce wages to preserve jobs (Burdin and Dean, 2012). While this might limit hiring during growth phases, it ensures greater employment continuity in recessions, raising critical questions about how "success" is defined in business performance (Burdin and Andres, 2009).

Another distinguishing feature is the more equitable wage structures found in worker co-operatives (Pérotin, 2016). Research indicates significantly narrower pay differentials and greater perceptions of fairness, which in turn contribute to higher levels of job satisfaction and organisational commitment (Frohlich et al., 1998; Clemente et al., 2012). The participatory and collegial culture

found in these environments promotes not only engagement but also well-being which remains a stark contrast to the often hierarchical and segmented structures of investor-owned firms (Frohlich and Oppenheimer, 2015).

However, while the economic outcomes of worker co-operatives are well-documented, their social impacts remain under-researched (Brown et al., 2015). Preliminary findings suggest that the health and psychological benefits of greater autonomy and social support in the workplace are significant (Baruch-Feldman et al., 2002; Kuper and Marmot, 2003). Job satisfaction is consistently higher among co-operative workers, driven by autonomy, participation in decision-making, and enhanced control over work tasks (Sell and Cleal, 2011; Kaswan, 2019). Grund and Schmidt's (2013) findings on the transformative effect of workplace councils further underscore this point.

Pérotin (2013) links these qualitative dimensions to measurable outcomes, such as lower staff turnover—an indicator of job satisfaction and organisational stability. She argues that participatory governance not only fosters a sense of ownership but also allows workers' potential and creativity to flourish. Yet, these advantages are not confined to co-operative members alone.

The broader community impact of worker co-operatives is another important yet often overlooked aspect. Erdal's (2011) comparative research across three Italian towns reveals that higher concentrations of worker co-operatives correlate with healthier, more vibrant communities. These enterprises play a pivotal role in local economic democracy by anchoring capital and redistributing wealth within communities (Guinan and O'Neill, 2020). Evidence from Argentina and the UK also suggests that worker co-operatives stimulate civic engagement and generate spill-over benefits for local voluntary organisations (Smith, 2015; Vieta, 2020).

Nevertheless, the literature is not uncritical. Several structural barriers constrain the growth of worker co-operatives, including limited access to capital and public procurement opportunities (Mellor, Hannah and Stirling, 1988; Cheney et al., 2014). There is a growing consensus that state intervention, particularly through more inclusive procurement policies, could significantly enhance the replicability of this model (Guinan and O'Neill, 2020).

2.2 Impact of worker co-owned care co-operatives

The strengths of the co-operative model are particularly salient in the care sector, where the tension between the provision of quality care and cost minimisation is most acute (Power and Crowley, 2024). While conventional investor-owned care companies often assert their commitment to service quality, their structural imperative to maximise shareholder returns frequently undermines this goal (Bird et al., 2022). In contrast, worker-owned care co-operatives embed care ethics into their organisational culture, prioritising stable employment conditions, adequate training, and worker participation in governance (Austin, 2014; Berge and Bokoumbo, 2023).

Berry (2013) finds that carers in worker co-operatives provide superior care due to their enhanced autonomy and job satisfaction. Unlike conventional investor-owned businesses, which often struggle with under-staffing and high turnover, co-operatives foster stability through supportive work

environments and professional development opportunities (Bird et al., 2022; Berge and Bokoumbo, 2023). Pollock (2021) further critiques the commodification of care, warning that market-driven logic expels skilled carers from the sector in favour of cheaper, less qualified labour—a trend largely absent in worker co-operatives.

Ultimately, the evidence suggests that worker co-operatives offer a more ethical and effective model for elder care provision (Berge and Bokoumbo, 2023). However, their expansion remains limited by a policy environment shaped by neoliberal ideologies that devalue the very principles—collectivism, democracy, and care—that co-operatives uphold (Lynch, 2022). This misalignment calls for a re-evaluation of how care is conceptualised and supported within national policies.

3. Methodology

3.1 Research question and case selection

The core question being addressed is: What is the impact of worker co-owned health care co-operatives in Ireland?

The research employed a case study approach. Case study is an effective approach when asking "how", and "what" questions (Yin, 2018). These categories of questions form the basis of the interviews conducted. The Great Care Co-op is the only worker co-operative engaged in home care in the Republic of Ireland.

3.2 Conceptual framework

A conceptual framework is employed that incorporates the input factors and internal dynamics crucial to the formation and operation of worker co-operatives. These factors and dynamics give rise to three outcomes: economic, organisational and social (Vieta, 2014; Cheney et al., 2023).

Input factors are those that are essential for establishing worker co-operatives, and include: access to appropriate capital, a supportive legal and policy environment, education and training, and sector-specific characteristics.

Internal dynamics govern how worker co-operatives function, particularly in relation to collective ownership, control, job security, and participation in decision-making.

The impacts of worker co-operatives can be categorised into economic, organisational and social outcomes. Economic impacts include wage equality and wage stability. Worker co-operatives typically exhibit lower wage disparities compared to conventional investor-owned businesses, as income distribution is more equitable. This is due to the fact that workers collectively decide on compensation. Regarding organisational impact, this relates to how worker co-operatives, innovate, retain membership and respond to market changes (Vieta, 2014; Cheney et al., 2023).

Social impacts focus on worker empowerment, self-determination, the reduction of workplace

hierarchies, improved work-life balance, job satisfaction, social cohesion, and community development. In worker co-operatives, owner-members are actively involved in shaping the policies and strategies of the business. This engagement fosters a sense of ownership, responsibility, transparency, and trust, as members have a direct role in determining the direction of their workplace (Vieta, 2014; Cheney et al., 2023).

3.3 Methods

A combination of semi-structured interviews and documentary research was employed. 15 semi-structured interviews were held with care-worker members of the Great Care Co-op; a care recipient; family members of care recipients; and Health Services Executive (HSE) officials with responsibility for elder care services in Ireland. All of the care workers employed in the GCC are members (following a six- months' probation as an employee). It is important to state that there are no non-members employed in the GCC. The interviews were held, in the main, using Microsoft Teams and they lasted between 40 minutes and one hour (resulting in 11 hours of data). The background of each of the interviewees is detailed in Table 1.

Table 1. Background of interviewees

Identifier	Background of interviewee
GCC-1	Care-worker member
GCC-2	Care-worker member
GCC-3	Care-worker member
GCC-4	Care-worker member
GCC-5	Care-worker member
GCC-6	Chief executive officer
GCC-7	Care-worker member
FAM-1	Family member of care recipient
FAM-2	Family member of care recipient
FAM-3	Family member of care recipient
FAM-4	Family member of care recipient
FAM-5	Family member of care recipient
CAREREC-1	Care recipient
HSE-1	HSE employee
HSE-2	HSE employee

Source: author's own elaboration.

3.3.1 A note on employment and membership in GCC

Following induction, each staff member must successfully complete a six-month probationary period before being offered membership in the GCC. During this probation, individuals are classified as employees only (and not members). To date, all employees have chosen to become members of the GCC upon completing their probation.

The GCC board holds the sole authority to appoint a chief executive officer (CEO). Currently, this role is fulfilled by the role identified as GCC-6 in Table 1, above, who is responsible for the day-to-day operations of the business[4]. GCC-6 reports to the board during monthly meetings and maintains regular communication with the chairperson between meetings.

3.4 Data collection and coding

Qualitative methods of enquiry were employed to facilitate informants to share their knowledge in a flexible manner during the data collection phase (Bryman, 2004). Semi-structured interviews were utilised as they allow this flexibility (Creswell, 2014). A list of trigger questions was used to guide the semi-structured interviews. The trigger questions emanated from the author's core question.

3.5 Analysis

Qualitative thematic analysis was employed to analyse the data gathered. This process occurred inductively and deductively. It entailed reading each of the transcripts a number of times to become familiar with the data. The text of each of the transcripts was then coded, and sub-themes developed from groups of related codes (Braun and Clarke, 2006). In turn, these sub-themes were then assigned to the five themes derived from the conceptual framework.

3.6 Limitations of research

The researcher had intended to conduct focus groups with both care-worker members and family members of care recipients, alongside the semi-structured interviews. However, unfortunately, this became impossible to organise due to time constraints. This was potentially a shortcoming as focus groups provide researchers with the opportunity to gain the views of individuals collectively on phenomena. Moreover, this method provides individuals with a greater level of "ownership" of the process, compared with individual interviews.

[4] The author obtained explicit consent from the interviewee for the use of their statements in this publication, with full awareness that their organizational affiliation and role may allow for identification.

4. Findings

The research findings pertain to interviews with, a care recipient, care-worker members, family members of care recipients and HSE staff. The five themes to categorise the research findings are based on the conceptual framework outlined in section 3, namely input factors, internal dynamics, organisational impact, social impact and economic impact.

4.1 Input factors

4.1.1 Start-up capital

One interviewee highlighted the difficulty of securing start-up capital for the GCC. Initially, funding could not be obtained within Ireland. However, the GCC was fortunate in securing finance from the European Social Fund under a Women's Equality Measure, and this resourced a capacity-building programme before GCC began trading. While invaluable, this EU funding was considered difficult to administer.

In its efforts to secure additional start-up capital, GCC received advice that funding organisations in Ireland would not support an entity incorporated as an industrial and provident society[5]. Based on this guidance, GCC incorporated as a company limited by guarantee[6], while continuing to operate in line with co-operative principles.

> *"And the worker co-operative model, because there were dividends involved in it, they wouldn't fund us. So that was part of the reason why we went for a company limited by guarantee because that's the traditional charity and not-for-profit structure. That's changing now, but all the advice that we got at that time when we approached funders, was that they would say no, they wouldn't be able to fund us in that state. So that was one of the reasons we made the decision to apply that company limited by guarantee status. But, again, that was a huge amount of work as well."* (GCC-6)

Subsequently, GCC launched operations with 30,000 EUR in seed funding.

4.1.2 Training and support

Interviewees highlighted the extensive training and support provided in GCC, noting how these are more comprehensive and provided on a longer-term than in investor-owned care companies.

[5] There is no specific legislation dealing with co-operatives in Ireland (other than credit unions). Entities who wish to follow the co-operative model often register as industrial and provident societies, and operate under the Industrial and Provident Societies (IPS) Acts 1893-2021.

[6] Co-operatives have the option of incorporating as a company (and the "company limited by guarantee" has no shareholding).

For example, three care-worker members refer to the practice in GCC of new staff shadowing experienced care-worker members and that this was provided for longer periods of time than in a conventional investor-owned care company. In addition, team meetings have set up a forum for care-worker members to gain advice and information. Three care-worker members assert that GCC supports staff to develop existing skills and acquire new ones, such as care-worker members receiving administration and governance training. The point is made how local teams are empowered to solve issues, and care-worker members are supported to take on responsibility and learn from mistakes.

Care-worker members compare this experience with conventional investor-owned care companies in which they were employed, noting how they were provided with both an inadequate level of training and a lower amount of time shadowing experienced care workers.

4.2 Internal dynamics

The findings of this research indicate three dimensions of internal dynamics: collective ownership, collective control, and a lateral structure.

4.2.1 Collective ownership

A staff member underscored the importance of having a majority of the GCC board comprised of care-worker members, noting that the day-to-day realities of providing care informs the GCC's strategic decision-making. One care-worker member expresses astonishment upon applying for a position, stating their disbelief that a home care business could be co-owned by the carers delivering the care:

> *"When I looked at the job advert, it sounds great but it's too good to be true. This can't be right."* (GCC-2)

Three interviewees emphasised how GCC addresses exploitation and powerlessness.

Three care-worker members mention how the GCC governance structure is responsive to the needs of the care-worker members.

> *"It was because of something that was noticed on the team, felt by the team. The board said yes as it would be great for the team."* (GCC-3)

4.2.2 Collective control

One interviewee highlighted that care-worker members within the GCC possess collective decision-making authority. Both operational and strategic decision-making are made collaboratively, reflecting a participatory governance model. This structure fosters economic democracy, enabling workers to exercise greater agency and control over their working conditions and broader lives.

> *"It is breaking new ground. Its approach is to create a whole new paradigm shift away from the status quo that puts workers at the heart of it. And that really gives them autonomy and freedom and responsibility to make decisions about their own lives."* (GCC-6)

According to two care-worker members, this fosters a positive and supportive work environment, and an enjoyable experience of work. The ability to participate in decision-making processes allows them to directly influence the terms and conditions of their employment. This stands in stark contrast to their experience working in conventional investor-owned care companies, where workers report feelings of isolation, disempowerment, and a lack of agency—particularly in situations where they were unable to address clients-related concerns or issues directly with family members.

Three care-worker members assert that while working with conventional investor-owned care providers, they did not have any influence over the delivery of care. In addition, if they were not in a position to work certain hours or locations then this could result in negative repercussions:

> *"And what they do is they give you less hours or they give you more difficult clients and they give you more difficult areas to get to".* (GCC-3)

In addition to fostering a more positive and supportive work environment, three interviewees emphasised that worker control over the operation contributes to delivery of higher-quality services. Several GCC members attributed this effectiveness to training they received in collective decision-making, conflict resolution and to the decision-making and governance structures established within the GCC. Two interviewees further linked quality service delivery to the co-operative practice of collectively and collaboratively working to address shared issues and challenges faced by care recipients.

> *"Every week we discuss changes that we want to make and support one another and the kind of camaraderie and the team and the collectivization of it has been hugely beneficial for us, because it's a stressful job, taking care of people who can have health issues."* (GCC-6)

GCC care-worker members are reported to be very proud of their organisation and their role within it.

> *"She was really proud of the company, like she did reference the company several times and she was proud of it and proud of what they were doing and proud of her role."* (HSE-1)

4.2.3 Lateral structure

Communication within the Great Care Co-op is widely regarded by interviewees as constructive and integral to the co-operative's functioning. Three interviewees specifically emphasise the role of constructive communication in facilitating effective decision-making. Furthermore, high levels of formal dialogue between care-worker members contribute to team work, by fostering familiarity, solidarity, and mutual trust. Team meetings, in particular, are identified as essential forums for collective problem-solving and peer-learning.

"We have meetings every week to discuss important issues clients are experiencing. We aim to find the best way to solve clients' problems." (GCC-5)

"We meet every week to ensure that we're supported and listened to and heard. We give each other the experience and benefits of each other's experience, so it's great." (GCC-3)

The lateral decision-making structure within the GCC fosters collective control and shared ownership of workplace practices. In contrast, this experience is not reflected in interviewees' employment experience in conventional investor-owned care providers, and one interviewee describes the impact of a hierarchical environment and lack of decision-making input in a former employment (a conventional investor-owned care company).

"Lack of input into decisions affecting job leads to stress as [you] do not know what to expect." (GCC-2)

The Great Care Co-op is deemed as less bureaucratic, as issues are usually addressed locally rather than being escalated to management, thereby enhancing responsiveness and autonomy:

"We don't have, for example, to go to the office and then explain to the manager about an issue, as we have this situation normally solved." (GCC-5)

4.3 Organisational impact

The findings reveal several dimensions to the theme of organisational impact within GCC, which are examined in the sections below.

4.3.1 Adaptability

Three care-worker members emphasise the GCC's commitment to delivering a customised service, tailored to each care recipient's needs. Two interviewees noted that care-worker members have acquired new skills to enhance the quality of the service for care recipients. One care-worker member emphasised how GCC has embraced technology to achieve a more efficient operation, which not only contributes to cost savings, but allows care-worker members to spend more time providing direct care, rather than undertaking administrative duties.

"You have to be innovative in a whole lot of ways. You want to be greener and reduce paper, you want to be innovative and how you're being more efficient in terms of how the carers are working and letting them focus more on care, rather than being bogged down by administrative work. This requires software and that requires money." (GCC-6)

A HSE employee remarks on care workers' ability to exercise sound judgement when dealing with complex and challenging situations. The same interviewee observed care-worker members reacting confidently and calmly when dealing with challenging circumstances associated with care recipients.

> *"When somebody gets ill or if there's panic going on because you know somebody might have a temperature or somebody might be sleepy or somebody might have had a fall, the carer can come in kind of confidently and deal with the situation effectively."* (HSE-1)

The HSE employee recalls a specific incident in which a care-worker member dealt effectively with a medical emergency involving a GCC care recipient. The care worker's calm demeanour and effective response were seen as indicative of their skill and preparedness.

> *"I remember one day and the carer came in and there was a medical emergency and, they managed it well in terms of keeping everybody calm so that they could do what had to be done. I would say they were obviously skilled."* (HSE-1)

4.2.3 Solidarity

Three care-worker members describe the strong sense of support they experience within the GCC team. They make the point that if care-worker members experience challenges or problems in their work, they gain support from other colleagues.

> *"If there is an issue or any problem, I feel supported. I feel protected as a carer."* (GCC-1)

A strong sense of solidarity exists within the Great Care Co-op team, according to those interviewed, and one interviewee likening the experience to being part of a family.

> *"It is like you are part of a family. We support and listen to one another."* (GCC-2)

The Great Care Co-op is characterised by an absence of elites and individuals of higher status within the organisation, according to a care-worker member. They also highlight that the absence of elitism and hierarchy fosters an egalitarian working environment, where all members are treated with equal respect and dignity.

> *"We have a team meeting every week and we've contact with our colleagues and there's no hierarchy. There's nobody looking down their nose at you. Everybody's the same."* (GCC-2)

In contrast, two interviewees who previously worked in conventional investor-owned care companies referred to a practice in conventional investor-owned companies of not encouraging collaboration between care staff. Furthermore, one of the interviewees observed that conventional investor-owned care companies discouraged communication between employees, and endeavoured to foster a sense of isolation among care workers.

> *"I wouldn't have had contact with any of the other carers. We were not allowed share phone numbers or share addresses."* (GCC-2)

4.3.3 Openness

Two care-worker members highlight the importance of openness in communication among colleagues as being a key enabler of ongoing learning and professional development.

> *"By speaking to each other, we have the opportunity to learn."* (GCC-1)

The same interviewee elaborated how open and candid dialogue is ingrained in the organisational culture of GCC. The environment of open communication encourages the free exchange of ideas and experiences without fear of negative repercussions, thereby fostering continuous learning and reflective practice. HSE staff and several care-worker members commended the quality of communication, considering it as very effective. HSE representatives, in particular, commended the quality of communication from GCC care-worker members, to them as funders, noting its high quality.

4.3.4 Respect

A culture of respect was consistently highlighted by interviewees as a key characteristic of the organisational culture, referring to how it underpins interactions between colleagues in the GCC. According to two care-worker members, respectful interactions among colleagues are not only foundational to the work environment but also contribute to overall job satisfaction and organisational cohesion.

> *"A really important point is how we are treated. Manners are so important. If I go to another work place where there is no manners and there is no respect, I would not like to work there."* (GCC-1)

Respect was also a key theme arising in the interviews with family members of care recipients. Two family members of care recipients described how they are shown respect by care workers. For example, they spoke about the workers being scrupulous about making contact, via text message, if the care-worker members are even marginally late for their scheduled appointment. This attention to detail was appreciated.

> *"The Great Care Co-op are usually bang on time and if they're not, and were five minutes late, they'd send me a text. So, I mean, that's a big difference."* (FAM-1)

The same interviewee further commended the reliability and punctuality of GCC care-worker members, a point echoed by an HSE employee who also praised the respectful way in which care workers engage with families and their individual circumstances.

In contrast, two care-worker members with previous experience working in private, conventional investor-owned care companies, reported a starkly different organisational culture—one in which respect is lacking for both carers and clients. They note inadequate training for care staff provided by these conventional investor-owned care companies to deal with clients with complex health issues, as well as a lack of acknowledgement or appreciation for staff. One care-worker member recounted her experience when leaving a conventional investor-owned care provider.

> *"Nothing like we're sorry to lose you or anything like that. No, we want your ID badge. We want your uniform and any PPE that you have. Please return it to the office as soon as possible. Don't discuss the fact that you're leaving with any of your clients because they'll be upset. Don't discuss anything with your colleagues."* (GCC-2)

Another care-worker member contrasted her experience working at a private nursing care home with her experiences with GCC.

> *"It really was like chalk and cheese compared to my experience of care in the nursing home. I immediately felt valued. I was listened to."* (GCC-3)

The same interviewee also highlights the lack of support provided to clients in her former workplace, a conventional investor-owned care company, particularly for those with complex needs. She makes the point that this is indicative of a lack of respect for the client.

> *"Where is the respect and dignity for the elderly people? They have somebody, who doesn't know what they're doing, but the carer wants to help. Getting thrown in the deep end, doing things that they don't know how to do, like it's shocking."* (GCC-3)

4.3.5 Proximity

Three care-worker members attribute the punctuality of the GCC care-worker members to them typically living in close proximity to the homes of care recipients. In contrast, conventional investor-owned care companies operate across broader, regional, catchment areas, often requiring staff having to travel considerable distances between client appointments.

In addition to improved punctuality, three care-worker members and one of the HSE staff interviewed identified the following further benefits arising from the GCC localised service:

- Decentralised and autonomous decision-making: local teams have the authority to make operational decisions.
- Increased efficiency and enhanced productivity resulting from reduced travel time enabling care workers/members to allocate more time to direct care.
- Community engagement: care workers' familiarity with their local area enables them to keep care recipients informed of what is happening in their locality, enabling them to maintain community connectivity.

These findings highlight the operational advantages of a geographically localised, worker-owned care model in delivering responsive, community-integrated elder care.

4.4 Social impact

The findings of this research indicate eight dimensions of social impact: client centred, autonomy, trust, continuity and consistency, quality of care, growth and personal development, shared responsibility and enthusiasm.

4.4.1 Client centred

Interviewees consistently emphasised the GCC's aim to meet the needs of care recipients and commitment to a person-centred model of care. Several care-worker members described how this ethos is operationalised in practice:

- The time of care delivery is determined by the care recipients, ensuring flexibility and respect for care recipients' routines.
- Care plans are shaped from direct consultations with care recipients and their families, who inform care-worker members of the type of assistance required.
- Sufficient time is allocated between appointments, enabling care-worker members to travel between appointments so that they are not late.
- Prospective clients are only accepted if there is adequate capacity to provide a high quality service.
- If delays are unavoidable, communication is maintained with the care recipient promptly to inform them that the care-worker members may be delayed.
- Care-worker members engage with relevant organisations to help to resolve broader issues that clients are encountering.
- Dedicated time is allocated to planning the service delivered to care recipients.

One care-worker member outlines how her practice remains professional when attending to the needs of, and spending time with, each care recipient.

> *"I'll keep it very professional. If I was finished 15 minutes and my client says you can, you know, off you go, which doesn't happen that often, I wouldn't sit down with the family members and have a cup of tea and start shooting the breeze with them. I'd say, you know, my client is always number one, but if they wanted to sit and chat to me about certain things that are related to my client, I would."* (GCC-4)

A family member of a care recipient expresses appreciation for the responsiveness and attentiveness of GCC staff, referring to how their input has been valued and their care wishes met.

> *"They've been really good. So, they took on board our wishes regarding X's care. We started out with maybe two days a week and now it's up to four days a week."* (FAM-2)

The same family member is impressed with how the values of the care-worker members are aligned to those of GCC.

> *"The quality of the people—they really hold the values of the organisation and you know, implement those values on a daily basis."* (FAM-2)

In contrast, two care-worker members, who had experience of working in a conventional investor-owned care company, referred to the practice of adding additional clients to carers' schedule to maximise income, thereby overloading staff with additional clients and reducing clients' allocated time.

> *"So, say for argument sake, missus X was entitled to one hour call between 10:00 and 11:00. That call would be reduced to between 10:00 and half past 10. They'd stick another call in should be an hour, but they're only get the half an hour. Then you go to your next call that would be from 11 till 12."* (GCC-2)

The same workers underscored that such scheduling compromises the quality of care and stands in stark contrast to the GCC's more person-centred and ethically grounded approach.

4.4.2 Autonomy

Three care-worker members emphasised the advantages of having the authority to maintain direct contact with family members of care recipients. This direct engagement not only facilitates timely adjustments to care schedules but also fosters responsiveness to the dynamic needs of clients.

> *"Like the difference with the co-op compared to a private care company, is we have direct access to family members. I think we know who to phone. We know who their next of kin is. We would have all the phone numbers would be available to us. The family members and the clients also have our phone numbers, so if things change, they want a different time call or they've got an appointment, they can ask us if we could, you know, come a little earlier today or a little later today? We can do that if we have time as we do our own schedules."* (GCC-2)

Communication directly with carer's family enables family members to receive updates on the health of their relatives who are receiving care.

> *"For example, if she was considerably worse or she had slowed down a lot today, you know, you can report these things to the family, and otherwise, they may not notice."* (GCC-3)

The same three care-worker members spoke about how their autonomy also enables them to advocate on care recipients' behalf with wider professionals, enabling prompt responses to a wide range of needs from broader services.

> *"I can go back to the public health nurse on their behalf and suggest these things. You can set the ball rolling so that maybe an OT [occupational therapist] can come out to assess the situation. They might have been eligible or they might have been in need of this equipment."* (GCC-2)

The same three care-worker members highlighted that public health nurses place significant value on direct communication with GCC care-worker members. According to the interviewees, public health nurses are reassured in having direct contact with care-workers members, as it enhances oversight and supports timely interventions.

> *"The public health nurse has said to me, 'it's like having another set of eyes out in the area. It's like having another set of eyes on the clients that I can't visit every week'. She looks at it, that I'm helping her. I'm watching one of her clients for her. And if I see something go wrong, I can e-mail her. I can phone her right and report that back then."* (GCC-2)

Care-worker members having the authority to advocate on behalf of care recipients has resulted in them gaining additional resources.

> *"She would have had to pay for me all the time, but I realised what was going on, so I spoke with X [a family member] and we agreed to contact disability services, because, she had a disability. We advocated for her and we got her an hour of care seven days a week."* (GCC-3)

Another interviewee highlights how research shows care workers/members often wish to advocate on behalf of their clients. However, interviewees who were previously employed in conventional investor-owned care companies had not been encouraged to do so.

> *"One of the things that really came out from the research was that workers felt they didn't have a voice. They had a lot to say. They wanted to advocate for their clients, and they wanted to advocate for themselves. But if they did, they were penalised first. So, they either lost their hours or they were put on difficult rotas."* (GCC-6)

The same interviewee emphasises that in their prior roles in conventional investor-owned care companies, they had no input into how the service was delivered to clients. This lack of inclusion contributed to feelings of isolation.

> *"And many, many, many conversations with carers who we work with now, none of them have ever said they've been consulted by the back office or by boards for developments in work. Like if there's, if they were considering a new policy or procedure, it all is coming from top down rather than bottom up. Carers themselves are actually isolated. The companies as the strategy that they don't want the carers to actually meet each other so they don't have team meetings."* (GCC-6)

In contrast, a different interviewee described how, at GCC, care workers are empowered and have the authority to communicate with family members and advocate on behalf of care recipients. This autonomy allows them to use their initiative to resolve issues care recipients encounter.

> *"We don't have to go back to them [managers] for support or to ask to do something. When we have any kind of issues, we can get involved just with the family and the client and altogether we try to resolve and make everything better."* (GCC-5)

Moreover, one care-worker member highlights that direct liaison with care recipients and their families enables the time of care schedules to be altered to suit the individual needs of care recipients.

In addition, two care-worker members mentioned that they can make the decision about whether or not to accept new clients, enabling them to maintain a work-life balance.

Family members of care recipients also recognised the benefits of direct communication. One interviewee appreciates being able to communicate directly with care-worker members.

> *"We can get first hand, how X is getting on when I am working during the week. It puts me at ease and reassures me."* (FAM-2)

Another family member of a care recipient echoes this sentiment, noting that communicating directly with GCC care-worker members means that they very rarely need to speak to the manager, as communication with care-workers members was sufficient and effective.

A HSE staff member also emphasises the benefits of GCC care-worker members communicating directly to public health nurses. In complex cases, real-time and daily updates from care workers ensures timely and accurate information sharing about the progress of care recipients—something not

typically observed in conventional investor-owned care companies. In conventional investor-owned care companies, communication is often filtered through management, which the HSE staff member identified as a shortcoming that can compromise the quality and accuracy of information shared.

To summarise, care-worker members, family members of care recipients and HSE staff agree that care-worker members having the autonomy to communicate directly with them is a benefit, and enhances the quality of care and responsiveness to individual needs.

4.4.3 Trust

Care-worker members, family members of care recipients, and HSE staff all emphasise how trust between care workers and care recipients is critically important to the delivery of home care. All family members of care recipients trust the care-worker members, who provide home care to their family members. One family member of a care recipient attributed this trust to the ethos underpinning the GCC, noting that it not driven by financial motives, but by a commitment to providing an optimal service for the care recipient.

> *"It's really good to have someone that's fully engaged. It is important to know that and that she will be helpful and open and let you know, have her well-being at, the forefront. We can trust them. This is kind of part of the dynamics that we have with them. And I value that very highly. It'll always be on their mind because they're coming from an ethos of creating something for the greater good as opposed to something for a bottom line, you know."* (FAM-2)

This interviewee maintains that she gains peace of mind knowing that the GCC is providing care to her relative. Another family member emphasises the importance of a trusting relationship with GCC care-worker members, which has enabled him to discuss sensitive issues regarding his partner's health in confidence.

> *"They all have good personality. The level of care I guess is very good. And I'll tell you now if she wasn't feeling well or something like that, I'd be far more confident to confide with them, and have confided in the carers in the past."* (FAM-1)

The interviewee attributes the high level of trust to having the same carers since he engaged the services of GCC combined with their care experience, professionalism and empathy. Four care-worker members echoed this assertion that there is a high level of trust between GCC carers and care recipients. However, trust between care recipients and carers needs time to be strengthened. One care-worker member is of the opinion that trust is very important, particularly when the carer provides personal hygiene care.

> *"They know that the service will be of a high standard which means that the client is not going to be afraid to know who's coming and have concerns about what is she going to do and how is she going to take care of me. So, I felt that with the clients who were not my main client—so I had the opportunity to provide cover for the client and she felt good."* (GCC-1)

4.4.4 Continuity and consistency

Five GCC members of staff emphasise the importance of continuity in building strong relationships between the care-workers members and care recipients. Two interviewees highlighted that receiving care from the same carer over time fosters trust not only between the client and the care worker, but also with the client's family. A family member of a care recipient notes that this continuity and consistency of care gave him more confidence in the GCC service compared to that of a conventional investor-owned business.

Four family members emphasise that GCC care-worker members always attend their care appointments at the scheduled time. The same four interviewees experience the GCC service as being reliable, and are confident of the service's reliability.

> *"This problem of no shows has never happened with the Great Care Co-op. If our carer cannot make it then somebody else shows up. I have never been let down by the Great Care Co-operative. It is a really reliable service. Overall, the experience is really good with the Great Care."* (FAM-3)

Two family members of care recipients report having more confidence in the GCC service than in a conventional investor-owned company they had previously used. One family member attributes the high turnover of care workers in conventional investor-owned care companies to them using care provision as a temporary profession, contrasting this with the more committed and consistent approach of GCC carers.

4.4.5 Quality of care

All five family members of care recipients that were interviewed rate the quality of care provided by GCC as being of a high standard.

> *"The service is extremely good. My husband had the same two carers for nearly 18 months. My husband got to know them. The care initially entailed going out to walk with X for an hour. The walk would usually take one hour, three times a week. This increased to five days a week. We got to know the carers. One of the carers noticed that he was unsteady while using a stick and recommended the use of a rollator. They provided great support. The carers provided great emotional support to me as we could talk to Y [the carer] about how he was doing. We were very fond of Y and she was to my husband. Indeed, she became a close friend, visiting him in hospital and attending his funeral."* (FAM-5)

Three family members of care recipients view the care provided by GCC as being very empathetic.

In addition, the two HSE staff members interviewed, regarded the GCC quality of service as being of a high standard. Care-worker members and HSE staff both emphasise the critical importance of emotional and psychological support in providing care. Moreover, one care-worker member and a HSE employee both highlighted the holistic nature of the service and assert that this is a fundamental aspect of the GCC service, by meeting the emotional, physical, and psychological needs of care recipients, while also advocating on their behalf. A HSE employee further noted that care-worker members provide emotional support to family members of care recipients.

4.4.6 Growth and personal development

Two care-worker members comment that their confidence has increased as a result of working in the Great Care Co-op. In particular, the participation in governance structures gives care-worker members the confidence to liaise with public health nurses and other state agency employees.

> *"I'm not afraid to go out there and talk to people now, whereas before I would have been. I've being talking to the public health nurse and social workers and other state agency staff, I talk to anybody now."* (GCC-2)

Some care-worker members take on leadership roles within the co-operative. There are numerous examples of this, including: some members undertaking the role of chair of co-operative internal committees (often their first experience of such roles); existing board members mentoring new board members; participating in external training in group facilitation; and undertaking the role of minute-taker which is rotated every second meeting (which enables members to develop secretarial skills). In addition, each hub holds weekly planning meetings, and the role of chairperson, minute taker and work scheduler at these meetings is rotated (with each role held by a member for between six to nine months). This prevents hierarchies from emerging within the hubs, while also supporting skills development: members receive training to enable them to effectively perform these roles.

4.4.7 Shared responsibility

Two care-worker members are of the opinion that there is an equal distribution of administration tasks with the GCC care team. According to one of these interviewees, every care-worker member is responsible for carrying out care needs assessments. The same interviewee notes the absence of both a hierarchy and elites within the GCC. The absence of elites is facilitated by the rotation of roles. Another care-worker member asserts that every member of the care team has to fulfil their administration responsibilities. She also noted that responsibilities go hand-in-hand with autonomy.

4.4.8 Enthusiasm

One family member of a care recipient speaks about how the care-worker member's personality enlivens the care recipient and family members. Another family member of a care recipient believes that care-worker members are committed to their profession and role as a care worker, which has impacted on how they carry out their role.

> *"The staff of the GCC have a real interest. They responded to my initial query within a day. They were very creative in how they dealt with my husband's health condition."* (FAM-3)

A HSE staff member values working with the GCC care-worker members, given their high level of engagement in their work.

> *"I found it really positive, actually working with them, because they were so engaged and enthusiastic towards their work."* (HSE-1)

The same HSE staff member was impressed with the attitude of a care-worker member.

> *"But this lady really loved her job and wanted to do it well and was kind of proud that she could do it well, but also that she had an ownership in it."* (HSE-2)

4.5 Economic impact

The findings under the theme of economic impact focus on three components, namely, conditions, financial sustainability and working environment.

4.5.1 Conditions

Three care-worker members assert that the conditions in GCC are superior to those in a conventional investor-owned care company. Two care-worker members highlighted the consistency of work schedules at GCC, which enable them to plan their lives outside of work. This contrasts with their experience in conventional investor-owned care companies, where they did not have any influence over the number of hours assigned to them nor their schedule.

> *"I felt I was being pulled and stretched. I was starting work in the morning and I wouldn't be finished work at 10 o'clock at night."* (GCC-2)

In the experience of three interviewees, pay is better in GCC than in conventional investor-owned care companies located in the South Dublin area. Two interviewees noted how the conventional investor-owned care companies that they worked for failed to honour a pay increase, awarded to them. A HSE employee refers to another practice of conventional owned investor-owned care companies, where care workers are expected to travel long distances between clients' homes without being compensated through a mileage allowance.

4.5.2 Financial sustainability

Establishing a foothold in the home care sector has been challenging for GCC, and is attributed to the presence of international franchises which dominate the market in Ireland. These organisations have significant financial resources to advertise their services widely. In contrast, GCC had limited funding to engage in conventional marketing and promotional activities, and instead, promote their services through presentations at parish council meetings and through social media channels. However, being a small care provider, GCC did not encounter any hostility from conventional investor-owned care businesses.

GCC has not yet reached break-even point. A major milestone for GCC's financial sustainability was securing a HSE tender in August 2023. This has provided a sustainable source to public clients

which marked an important turning point for GCC. Following the award of the HSE tender, GCC increased its traded income by 70% in 2024. GCC aims to break even by the end of 2026 as detailed in the strategic plan.

4.5.3 Working environment

Five care-worker members describe the positive work environment in the GCC, and consider it to be superior to their prior experience of the work environment in conventional investor-owned businesses. They report feeling supported working in the GCC, in contrast with the isolation they previously felt, when working in a conventional investor-owned care provider. One interviewee even noted a significant improvement in her health since joining GCC.

"My health has improved. I've been told I look better. And I have a life outside work now as well." (GCC-2)

Three care-worker members are committed to working in the GCC due to a combination of the work environment and the culture.

5. Discussion and conclusions

The findings associated with the core question "*what is the impact of worker co-owned health care co-operatives in Ireland?"* indicate that the GCC has an overwhelmingly positive impact on the lives of the care-worker members, care recipients, and family members of care recipients. These results align with existing literature that highlights the potential of worker-owned care models to transform both employment and care outcomes (Berge and Bokoumbo, 2023).

Moreover, the findings indicate that HSE staff in the home care sector, as well as the families of care recipients, recognise and value the high standard of care provided by the GCC. Family members frequently described the care delivered by the GCC as superior to that offered by conventional investor-owned providers they had previously engaged.

The quality of care can be attributed to several interrelated factors. First, the GCC's status as a worker co-operative—with a mission to provide quality employment for its members and a governance model based on collective ownership and control—fundamentally shapes the delivery of care. This is consistent with previous research, which finds that co-operative structures enhance both service quality and worker well-being (Austin, 2014; Berry and Bell, 2018.). Second, the co-operative's approach to care delivery positively impacts care-worker members, care recipients and their families and this is again consistent with the literature. Third, the commitment of GCC care-worker members to providing high-quality care reinforces the organisation's capacity to fulfil its mission and realise its vision, as outlined in the introduction.

While the literature affirms many of these findings, several operational aspects of the GCC have received limited academic attention. First, the lateral decision-making structures empower

care-worker members to retain control of the business. Second, the localised service coupled with the continuity of the carers contributes to care being delivered punctually and reliably. This enables the development of trusting relationships between care-worker members and the family members of care recipients. Third, care-worker members have the autonomy to organise their work schedules to suit the care recipients, to liaise with the family members of care recipients, and advocate on care recipients' behalf. This further contributes to the quality of service and reinforces the trust family members of care recipients and HSE staff have in the GCC. Fourth, the culture of the organisation contributes to care-worker members supporting each other on a day-to-day basis which promotes peer solidarity. Finally, the work conditions of the GCC are deemed to be far superior to a conventional investor-owned care business. This contributes to GCC care-worker members having a better quality of life. For example, they have the opportunity to engage in educational and social activities because they have a set work schedule.

The positive impact of the GCC on the lives of care recipients would indicate that the HSE should prioritise contracting services to be provided by a worker co-operative. Indeed, including social considerations in the public procurement process would provide an opportunity for the HSE to include these impacts in a tender assessment and award process, to the benefit of both the GCC and its care recipients.

However, the research also highlights several challenges faced by the GCC. These include difficulties in securing start-up capital, gaining market access in a landscape dominated by investor-owned providers, securing HSE tenders, and attaining financial sustainability.

The above challenges will need to be addressed if the GCC intends to replicate its operation. In a broader context, worker co-operatives in Ireland face systemic barriers, such as low public awareness, a prevailing culture of individualism that does not favour co-operative enterprise, and insufficient state support (Doyle, 2019).

With regard to supports for the GCC, research could explore the potential for local development companies, local authorities, the credit union movement and producer co-operatives to support the GCC to develop hubs in new locations. This research could adopt the methodology of participatory action research. Another two pieces of research could compare the contribution of the GCC to conventional investor-owned care companies and also compare conditions of employment of care workers employed in conventional investor-owned care companies and the GCC.

Finally, research also needs to be undertaken with the aim to change policy towards worker co-operatives in Ireland (Birchall, 2010). Ireland has a particularly under-developed support eco-system for worker co-operatives compared to other countries, including Canada, Italy, and Spain (Gavin et al., 2014). The potential of worker-owned care co-operatives to make a tangible and clear difference in Irish society cannot be understated. This economic model is collaborative, non-exploitative and, at its core, is designed to benefit the community most.

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