National Council for the Elderly

PROCEEDINGS OF CONFERENCE

HOME HELP SERVICES FOR ELDERLY PEOPLE IN IRELAND

ROYAL MARINE HOTEL, DUN LAOGHAIRE

1ST AND 2ND DECEMBER, 1994

PUBLICATION NO. 41
The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on

- measures to promote the health of the elderly,
- the implementation of the recommendations of the Report, *The Years Ahead - A Policy for the Elderly*,
- methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,
- ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,
- meeting the needs of the most vulnerable elderly,
- ways of encouraging positive attitudes to life after 65 years and the process of ageing,
- ways of encouraging greater participation by elderly people in the life of the community,
- models of good practice in the care of the elderly, and
- action, based on research, required to plan and develop services for the elderly.

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The Department of Health's strategy for effective healthcare in the 1990s, *Shaping a Healthier Future*, promised that priority over the next four years will be given to 'strengthening the role of the General Practitioner, the Public Health Nurse, the Home Help and other primary care professionals in supporting older people and their carers who live at home. The target will be to ensure that not less than 90 per cent of those over 75 years of age continue to live at home'.

As one of its contributions towards the realisation of this objective the National Council for the Elderly published a report in November 1994 on *Home Help Services for Elderly People in Ireland*. The report, which was prepared by Dr. Francesca Lundström and Dr. Kieran McKeown, is the first comprehensive national study of home help services for elderly people in Ireland.

A Conference in Dublin on 1st and 2nd December, 1994 provided a platform for discussion of a broad range of home help issues addressed in the report. We are very grateful to Mr. Michael Browne, a former Research Officer with the Council, for preparing this summary of the proceedings. Though not pretending to record in detail everything said by invited speakers or from the floor, we are confident that this resume provides a useful account of the main issues discussed at this first major Conference on the *Home Help Services for Elderly People in Ireland*. We are therefore indebted to Mr. Browne for preparing this report.

On behalf of the Council I would like to express our thanks to the speakers for preparing such excellent papers and to the participants for their contributions and their support of this most important service.

*Michael White*
Chairman
March 1995
INTRODUCTION

Mr. Michael White
Chairman, National Council for the Elderly

The National Council for the Elderly was established in 1981 as the National Council for the Aged. The terms of reference of the Council are: To advise the Minister for Health on all aspects of ageing and the welfare of the elderly either on its own initiative or at the request of the Minister.

Since 1981 the Council has published 35 other studies exploring the life of the older members of our community in all its variety, in addition to investigating our attitudes to ageing and intergenerational solidarity. The Council’s investigation of the caring process and the needs of carers of the frail elderly in the community in 1987 was the first in a series of studies which try to evaluate the successes and failures of our caring process in the community, and to recommend ways of addressing unmet needs where that is necessary. By so doing, the Council has provided an accurate scientific base on which policy development can be built.

It is long established national policy to maintain the elderly in their own homes for as long as possible. The Years Ahead report of 1988 made specific recommendations as to how care in the community for the frail elderly could be organised. The recent strategy document from the Department of Health, Shaping a Healthier Future, has presented a target, that not less than 90 per cent of those over 75 years of age should live at home.

In order to achieve this target the National Council for the Elderly believes that, in addition to strengthening the role of primary care professionals, other services such as home help, meals-on-wheels, day care services and sheltered housing should be designated as core services underpinned by legislation and appropriate statutory funding. Core services, as envisaged by the Council, are support services which are essential for elderly persons to maintain a quality of life and a level of functional autonomy which enables them to live independently in the community and, consequently, to avoid unnecessary hospitalisation or admission to long-stay institutions.

The National Council for the Elderly is pleased to present this study of the home help service today for a number of reasons.

Firstly, the Council considers the home help service to be crucial in supporting the frail elderly living in the community.
Secondly, there has never been any substantial investigation of the working of the service or its response to the changing needs of the community since it was established over twenty years ago.

Thirdly, the study gives an opportunity to examine the relationship between the statutory and voluntary sectors in service delivery. This is an area in which the Council has a particular interest and which it has examined in a different context in other studies.

Finally, it provides an opportunity to recommend development in the service to meet what will be a growing need arising from future demographic change.
OPENING ADDRESS

Dr. Michael Woods T.D.

Minister for Health

I am delighted to be with you this morning at the kind invitation of the National Council for the Elderly at the opening of this important conference. I have noted, on the inside cover of this latest report from the Council, the long list of useful reports and studies published by the Council over the past thirteen years and this gives me immense satisfaction as I was instrumental in setting up the original National Council for the Aged in 1981 when I was Minister for Health. For a modest financial outlay, the Council has been one of the best ever investments by Government.

And of course the subject of this latest report and therefore the subject of your two-day conference, the home help service, is a matter very close to my heart. I am deeply conscious of the contribution of the home help service to the maintenance of a large proportion of our elderly population in their own home surroundings for as long as possible, a policy which is the cornerstone of our overall plan for care for the elderly. I am impressed by the depth and thoroughness of the report and I know that it will be of tremendous help to the Department of Health in looking at the future role of the home help services. I want to complement Francesca Lundström and Kieran McKeown on a job well done.

I do not intend to comment in detail or at length on the report but I will say that while, on the one hand, there is little doubt but that the quality of the present service is well illustrated by the high level of client satisfaction, nevertheless the report clearly highlights a number of problem areas. Earlier this year, my predecessor in office, Brendan Howlin asked the Chief Executive Officers of health boards to consider certain aspects of the home help service, principally concerning conditions of service. I expect to have that report within the next few weeks. The Council's report on the home help service identifies a need to review more fundamentally the organisation of the service and the legal framework within which it operates. I will be discussing with my Department how best such a review can be carried out to ensure that the home help service continues to play a vital role in supporting dependent older people and their carers at home.

The Health Strategy

Although, as you know, I have been handling the Social Welfare portfolio in recent years, I was fully supportive at Cabinet level of the document, Shaping a
Healthier Future - A Strategy for Effective Healthcare in the 1990s, which my colleague Brendan Howlin launched earlier this year.

It is the mark of a truly caring society that it ensures that its dependent elderly persons are well cared for. Improving health services for the elderly is one of the issues addressed in the strategy document. The health strategy recognises that the rapid rise in the number of people in the oldest age groups will pose a special challenge to health services in the coming years. Over the next four years priority will be given to strengthening home, community and hospital services to provide much needed support to elderly people who are ill or dependent and to assist those who care for them.

The Government's health strategy is based upon the twin concepts of health gain and social gain. Health gain is concerned with increases in life expectancy and improvements in the quality of life. Social gain is concerned with broader aspects of the quality of life and the role of the health services in providing support and intervention to ensure greater quality and equity.

I am glad to note that the National Council for the Elderly has been given a role in the strategy document in so far as the planning of future services for the elderly is concerned.

Conclusion

I am impressed by the range of topics and speakers assembled by the National Council for the Elderly for your two-day conference. The Council has a rightly deserved reputation for the meticulous organisation of conferences to bring the message of its research to a wider audience. When the deliberations of this conference are presented to me, I can assure everyone here present that they will not be put on a shelf to gather dust but will be given prominence and the most sympathetic consideration. It only remains for me to wish you well in your deliberations and to officially open this conference.
CONSIDERATION OF REPORT
HOME HELP SERVICES FOR ELDERLY PEOPLE IN
IRELAND

Session I

Policy and the Administration of Home Help Services for Elderly People in Ireland

Chair: Dr. Rosaleen Corcoran,
Director of Community Care, Eastern Health Board
and Chairperson, National Council for the Elderly
Home Helps Consultative Committee
PRESENTATION OF REPORT

Dr. Kieran McKeown

Co-Author of Report

This paper is divided into eight sections: (1) delivery models of the home help service; (2) assessing eligibility for the home help service; (3) charging clients for service; (4) assessing need for the home help service; (5) some facts and figures on the home help service; (6) tasks performed by Home Helps; (7) implementation of recommendations in The Years Ahead; (8) questions about the home help service in Ireland.

1. Delivery Models of the Home Help Service

There is a wide diversity in the organisation and delivery of the home help service in Ireland and six basic models can be identified, four in the statutory sector and two in the voluntary sector.

Model One, where overall responsibility for the home help service rests with the Superintendent Public Health Nurse and her staff, is used in the North Eastern Health Board, in parts of the Southern Health Board and in Tipperary South (South Eastern Health Board). None of these areas have a Home Help Organiser.

Model Two, where overall responsibility for the service rests with both the Superintendent Public Health Nurse and the Superintendent Community Welfare Officer, operates in Kildare and parts of Wicklow (Eastern Health Board) and in Waterford (South Eastern Health Board).

Model Three, where a Home Help Organiser is employed by the health board to recruit and place Home Helps with clients, is the most frequently used model in Ireland and is to be found in the Midland Health Board, the Western Health Board and in parts of four other health boards (South Eastern, North Western, Mid-Western and Southern).

Model Four, where overall responsibility lies with the Superintendent Public Health Nurse but with Home Help Organisers being deployed to organise the day-to-day running of the service, operates in parts of Donegal and Leitrim (North Western Health Board) and on a pilot basis in parts of Kildare (Eastern Health Board).
Model Five refers to the situation where voluntary bodies have responsibilities for delivering the home help service and operates in most of the Eastern Health Board and in parts of the Mid-Western Health Board (North Tipperary and Clare).

Model Six, where the responsibility of the service rests with the Superintendent Public Health Nurse but where the Home Helps are employed by a voluntary organisation rather than by the health board, operates in parts of Donegal (North Western Health Board).

2. Assessing Eligibility for the Home Help Service

There are three different methods of assessing eligibility. In some health boards - North Eastern Health Board, parts of the South Eastern Health Board (Wexford, Carlow/Kilkenny and South Tipperary) and the Southern Health Board - the medical card is taken as determining eligibility for the home help service, where need has already been established; persons without the medical card are means tested by the Community Welfare Officer. In the Western and Mid-Western Health Boards, the medical card plus other family means are taken into account. In the Midland, North Western, part of the Eastern (i.e. Kildare and parts of Wicklow), and part of the South Eastern Health Boards (Waterford), eligibility is determined by the Community Welfare Officer or Community Care Administrator who completes an overall means test.

3. Charging Clients for Service

There are four different arrangements for charging clients. In four of the health board regions (North Eastern, Western, Southern and part of the Eastern) clients are encouraged but not obliged to make a contribution. In the Midland and Mid-Western Health Boards, the contribution by clients is used to reduce pro rata the payment by the health board to the Home Help. In the Waterford Community Care Area of the South Eastern Health Board, the client is obliged to make a contribution directly to the Home Help. The amount of the contribution is determined by the Community Welfare Officer. In the North Western Health Board region contributions are collected for the Board through the Home Helps employed by the voluntary organisations. The Board's Section 55 grants paid to voluntary organisations in respect of the home help service are abated by the amount of the contributions collected.

There is a strong case for standardising procedures for assessing eligibility and the amount of charges. A more uniform approach to contributions, which would ensure equity between clients and their families in different parts of the country, is required.
4. Assessing Need for the Home Help Service

There are no specific guidelines for assessing need or the number of home help hours that a client may receive. The assessment of need typically takes into account a range of factors including:

- degree of mental and physical incapacity/dependence
- mobility
- living conditions
- family/carer support
- physical and social isolation

In practice, it is the configuration of factors rather than any one taken in isolation that is important in determining need. A basic assumption underlying the assessment of need in most health boards is that home help services should not, in general, either substitute or supplement existing informal arrangements whereby care is already provided by relatives or neighbours to the elderly person. Typically the Home Help is a neighbour and this is informed by the belief that neighbours have a role to play in looking after elderly persons in the community. At a more practical level, the use of neighbours is also designed to minimise the cost of travelling to the client. The majority of health boards are in favour of nationally agreed guidelines for determining need although all emphasised that these would need to be broad and flexible given that need varies substantially between areas along a number of dimensions such as rural-urban, availability of other support services for the elderly (e.g. day centres, meals-on-wheels, laundry), geographical isolation and level of affluence.

5. Some Facts and Figures on the Home Help Service

- The number of Home Helps in Ireland in 1993 was 10,559. This is similar to the number of employees in An Post. Home Helps are typically women who are employed part-time.

- The number of home help clients in 1993 was 17,337. This is equivalent to 3.5 per cent of the elderly population, compared to 14 per cent in Northern Ireland and 19 per cent in Sweden.

- Almost 90 per cent of Home Helps have between one and two clients.

- On average, each client receives 9.7 home help hours per week, equivalent to about two hours per day. The weekly average in Northern Ireland and Sweden is four hours. There is huge variation between health boards in the number of hours per client per week: from 14.8 in the Midland Health Board to 5.8 in the North Western Health Board.
The majority of clients (65 per cent) receive their home help service directly from the health board. Voluntary organisations deliver the service in parts of the Eastern Health Board, North Western Health Board and Mid-Western Health Board.

Expenditure on the home help service in 1993 was IR£13.9 million, i.e. less than one per cent of the total non-capital health budget.

The average cost per client per week of the home help service is £15.48.

Expenditure is not a reliable indicator of quantity of service, mainly because of variations in the rate of pay for Home Helps. Hourly rates vary within and between health boards for both part-time and full-time Home Helps. For part-time Home Helps, the lowest rate is IR£1.00 per hour and the highest rate is IR£3.50.

6. Tasks Performed by Home Helps

The tasks of Home Helps can be divided into five basic categories:

- personal care
- home care
- tasks outside the home
- companionship
- monitoring

The area of personal care is a growing need among elderly persons living at home and all health boards are considering ways of responding to it. Five health boards (Eastern, North Eastern, South Eastern and Midland) have introduced a new position to provide for this, called Home Care Assistant/Attendant. Typically, Home Care Assistants/Attendants do not perform domestic tasks and are paid a higher rate of pay than Home Helps.

The introduction of Home Care Assistants/Attendants has raised issues about the linkage of this service to the home help service which have not been resolved. Home Care Assistants/Attendants have been introduced as an extension of the public health nursing service rather than of the home help service; as such, it seems to be informed by a medical model of need rather than by the more holistic model which informs the home help service. In addition, the organisation and delivery of the service provided by Home Care Assistants/Attendants seems to be parallel to, rather than a continuum of, the home help service. In general, Home Helps and Home Help Organisers have not welcomed the introduction of Home Care Assistants/Attendants which many of them see as an unnecessary partitioning of clients' needs into personal care and other types of care. Home Helps, where necessary, have traditionally
provided both types of care and their partitioning in some health board regions has given rise to practical demarcation difficulties as to the duties to be performed by Home Helps for certain clients. It seems clear that these issues can only be resolved in the context of a more clearly articulated understanding of the home help service and the categories of need which it is designed to meet.

7. Implementation of Recommendations in *The Years Ahead*

In October 1988, a Department of Health Working Party on Services for the Elderly produced a report - *The Years Ahead* - which made detailed recommendations on, *inter alia*, the home help service. This report constitutes official policy on care of the elderly in Ireland in the 1990s. A number of recommendations refer to the home help service.

*Comprehensiveness of Home Help Service*

*The Years Ahead* recommended that the home help service should be comprehensive enough to assist elderly people with all the tasks of daily living (p.97).

A crucial question in this context is what constitutes all the tasks of daily living? Home Helps in all health boards perform a very similar set of core functions in the areas of home duties, tasks outside the home, companionship and monitoring. However Home Helps in four of the health board regions also perform a substantial amount of personal care tasks. The emergence of Home Care Assistants/Attendants in some health boards might be seen as reducing the ‘comprehensiveness’ of the home help service by introducing a new grade to assist with the personal care tasks of daily living.

*Emergency Home Help Service*

*The Years Ahead* recommended that an emergency home help service should be available within a day of request (p.97).

An emergency service is available in six health board regions, namely, the North Eastern, the South Eastern, the Midland, the Western, the North Western and the Southern. The number requiring this service are quite small however.
**Home Help Service Outside Normal Working Hours and Weekends**

*The Years Ahead* recommended that a home help service should be 'available outside normal working hours and at weekends' (p.97).

A home help service outside normal working hours and at weekends is available in most health board regions for a minority of cases. Some health boards seem to be less responsive than others in providing this service.

**Home Help Respite for Carers**

*The Years Ahead* recommended that the home help service should be expanded in scope to provide an evening and weekend relief service for persons caring for elderly relatives at home (p.97).

This is essentially a respite service for carers and is provided, to varying though modest degrees, in four health boards.

**Ratio of Home Help to Elderly Population**

*The Years Ahead* recommended that the immediate aim should be to develop the service to the extent of the whole time equivalent of 4.5 Home Helps per 1,000 elderly people (p.97).

All but one health board - the South Eastern - have exceeded the norm of 4.5 full-time equivalent Home Helps per 1,000 elderly persons. However, it may be worth questioning the norm since all but one health board exceeded the norm in 1988. The use of this indicator is not a very sensitive measure of the adequacy of home help provision in a particular health board region since it takes no account of the complex array of demand and supply factors involved.

**8. Questions About the Home Help Service in Ireland**

i. Health boards are empowered but not obliged to provide a home help service. In practice, each health board provides a home help service but the question still arises: Why is the home help service optional - and therefore vulnerable to underfunding - when other health and social services are core and mandatory?

ii. The home help service has painstakingly avoided substituting - or in many cases even supplementing - the role of families in the care of elderly persons. In practice, this has meant that carers of elderly persons - many of whom may themselves be elderly - have tended to be excluded.
from the service. This raises questions: Should the home help service not support carers in the community? Is it not possible to support families in the care of elderly persons without undermining the role and responsibility of the family in looking after their elderly members?

iii. There is some overlap between the role of Home Helps and Home Care Assistants/Attendants. Home Helps carry out personal care tasks as the need arises as part of their other duties while Home Care Assistants/Attendants perform personal care tasks only. Are these two services adequately integrated in practice? Are they informed by the same model of community care? Does the introduction of Home Care Assistants/Attendants not reduce the comprehensiveness of the home help service?

iv. Health board personnel are divided on the idea of whether there should be a national in-service training programme for Home Helps with a nationally recognised certificate or diploma. This raises the broader question of whether the home help service is - or at least should aspire to be - a professional service or simply a good neighbour service. What model informs the home help service: 'volunteerism' or 'professionalism'?

v. The methods for assessing need and eligibility vary between and within health boards. Under existing arrangements, there is no guarantee that a person entitled to receive a home help service free of charge in one health board region would have the same entitlement in another region. Is it reasonable or fair that such anomalies should exist in the administration of a national service? Should there not be consistency in determining need, entitlements and charging arrangements?

vi. The recommendations in *The Years Ahead* have not been implemented in any widespread manner throughout the various health board regions. Why is this? Is it indicative of an administrative culture which treats the home help service as optional and marginal?
RESPONSE I

Mr. John Brady

Assistant Principal, Department of Health

The Department of Health welcomes this report on the home help service. I would like to thank the National Council for the Elderly for commissioning the report and to congratulate its authors.

It would be hard to over-estimate the extent to which the growth in the number of people reaching advanced old age will affect the health services of tomorrow. In the decade between 1981 and 1991, the death rate amongst older people fell at a faster rate than in any other decade this century. The result is that more people than ever before are reaching advanced old age. It appears that we are only at the beginning of a trend that will see increasing numbers of very old people. We have, at present, one of the lowest life expectancies of any OECD country. A Japanese woman can, for example, expect to live 12 years longer than an Irish woman. It is likely that this gap will narrow and that there will be many more people in their 80s than ever before. Giving Irish people more healthy years of life is a major aim of the health strategy to which the Minister has already referred.

The Irish have a reputation for being depressed about their problems. Let me counteract any depression in relation to our home help services by focusing on the strength of the services which are highlighted in the research. Let me begin with a quote from the report:

When it comes to looking after elderly people’s needs, the Republic of Ireland compares well with other jurisdictions (p. 73).

Despite the many shortcomings in our services, I think this statement is true and it has been borne out by other research work. Let us put our problems in context. All of the findings of the research point to the strength and value of the home help services. For example, between 1978 and 1993 there was an increase of 252 per cent in the number of clients benefiting from the home help service. Between 1980 and 1993, real expenditure on home help services almost doubled. The increase between 1989 and 1993 was particularly significant. The number of Home Helps has increased from just over 5,000 in 1978 to more than 10,500 in 1993. The number of home help hours per client per week at almost 10 hours is twice the level of service provided to clients in Northern Ireland and Sweden. The report records that the satisfaction of clients with the home help service is overwhelming. Let me quote the report once more:
The overall amount of client satisfaction with the service is high and clients have a palpable degree of love or liking for their Home Helps.

Clients report that Home Helps have a very high level of commitment and concern for them (p. 314).

A further strength of the service is the speed and flexibility with which a person in need can be supplied with a Home Help. The involvement of the voluntary sector, which organises about one-third of the Home Helps, is a further aspect of the service which contributes to its strength and vitality. The report draws attention to problems with the home help service and there is no doubt that problems exist. However, let us not underplay the very real strengths and benefits of the service.

The report is critical of what it describes as the lack of interest in the home help service at national level. While the home help service may not have received the attention it deserves at national level, there is other evidence that shows that the service has received considerable attention in the past decade. In The Years Ahead the importance of the home help service was underlined and a number of recommendations were made to strengthen the service which have since been implemented. Secondly, the expansion of funding for the service since 1989 and the increase in the number of Home Helps employed since that date demonstrate that additional resources have been put into the service to strengthen support for dependent people, particularly the elderly, at home.

The report is also critical of what it describes as the lack of implementation of the recommendations of The Years Ahead report. I would suggest that the authors of the report have used narrow criteria in judging the extent to which the recommendations of The Year Ahead report have been implemented. In relation to co-ordination of services, the report was firm in principle but flexible in detail. Provided a health board has made arrangements to co-ordinate services for older people, the Department will not quibble with the way in which it is done. Nor, I suspect, will the members of the Working Party which prepared The Years Ahead report.

The great value of the Council's report on the home help service is its systematic appraisal of the way in which it operates. It highlights the need to review the principles on which the service is based which date from the early 1970s. It highlights the issue of the discretionary nature of the service. As a core service, which the Council defines as a service essential to the basic welfare and survival needs of the frail elderly in the community, enabling them to remain at home, there is a need to strengthen the legal framework surrounding the service. The health strategy refers to the services for which no eligibility criteria, or rules governing charges, are set down in legislation. In many cases, these services have developed since the last major overhaul of
health legislation in 1970. These include services which play an important role in providing appropriate care in the community to people who might otherwise need residential care: for example, community paramedical services, home help services, meals-on-wheels services and day care centres. The health strategy recognises that because these services have developed in the absence of legislative guidelines, there are considerable differences from area to area in relation to the extent to which services are provided, who is entitled to receive them and what charges, if any, can be made. The strategy document accepts that it is inequitable that a person's entitlement to a service should depend on the area in which he or she happens to live. It gives a commitment that national guidelines on eligibility and charges which would be applied in a uniform manner in all areas, will be introduced in respect of all services where legislative provisions are at present absent. This development is to form part of the reform of the basic framework of the health services which will be underpinned by new legislation.

One of the fascinating aspects of the Council's report is the classification of the organisation of the home help service into six different models. In principle, there need be no difficulty about the number of ways in which home help services are organised. Flexibility of organisation permits flexibility of response and adaptation to local needs. On the other hand, the report argues the benefits of standardisation for entitlements, assessment, service provision and client contributions as a pressing need. The Department accepts the need to review the organisation of the service to see if one way is more effective than another. The Department would, however, attach great importance to maintaining and fostering the current level of voluntary input to the service. The involvement of voluntary organisations, the varying needs of different parts of the country and the demands of geography and density of population mean that there may be no one model of organisation which is the best for the whole service.

As I mentioned above, the Department is aware of a need to review the principles and organisation of the home help service to ensure that it develops in the most effective way to support dependent elderly people and their carers at home. As mentioned in the Minister's speech, he will shortly receive the report of the Chief Executive Officers on certain aspects of the service. The Department will be looking at ways of reviewing the broad issues raised by the Council's report and will be recommending to the Minister how such a review can best be carried out. This report will provide a vital source of information and opinion on the purpose and organisation of the service at present, as well as proposals for improvements.
RESPONSE II

Mr. M. J. Duffy

Assistant Chief Executive Officer, Mid-Western Health Board

It gives me great pleasure to congratulate the authors of this report. The report will add greatly to our knowledge and understanding of the home help service. I would like to concentrate on what I consider to be the positive aspects of the report from a health board perspective.

1. Having considered this valuable document I find that two sentences in this report are, for me, the most important. I would like to paraphrase them:

   We can now say with assurance that home help clients perceive they are getting a valuable service from people who love them and whom they love and rely on for companionship as much as practical help.

   The home help service is not only relevant in the lives of elderly people. It is an essential element in keeping them where they want to be - in their homes and in their community.

These two sentences capture the essence and the spirit of the home help service in Ireland and these conclusions should not be forgotten.

2. The report states that the percentage of elderly people over 65 in receipt of a home help service is less in Ireland than in other jurisdictions. However, I think it is important to note that the cover does exceed the norms recommended by The Years Ahead. In addition to this, where an elderly person in Ireland is granted a home help service the number of home help hours per week is much greater than in other jurisdictions and this increase in intensity has occurred since 1991 from 7.5 hours to 9.7 hours of home help per week in 1993. It is important that the density of the service increases in tandem with the decline in 'kin networks'.

3. Another feature of the service which has to be taken into consideration here is that the number of Home Helps in Ireland is low by comparison with other jurisdictions. It appears that the comparatively low number of Home Helps can be explained by the fact that the present generation of elderly people in Ireland have uniquely dense and extensive 'kin networks', a feature not as common in other Western societies. As this
feature disappears, and it appears that this is slowly happening, there is no doubt that the level of resources for the service will have to be increased to a corresponding degree.

4. One very important feature of the service is its linkage with the other health board services through the public health nursing service.

5. The report highlights the fact that in assessing need the procedures used are flexible. While I would agree that there should be broad guidelines for the provision of the service I would advocate the continuing use of flexibility\(^1\). I also welcome the conclusion that the basic assumption underlying the assessment of need in all health boards is that the home help service should not in general substitute for informal care arrangements. I consider that these arrangements should be encouraged and supported.

6. I welcome the findings in the report which indicate that clients were remarkably appreciative of the service they received and also the regard expressed for their Home Helps.

7. The Mid-Western Health Board carried out its own review of the home help service in its area in 1991 and in line with the findings of this report we found that 85 per cent of the clientele availing of the service were aged 65 and over. We also found that 60 per cent of the elderly clientele were between the ages of 70 and 85. Two other features of the home help service are that 64 per cent of the clientele live alone and 65 per cent of the clientele are female. With the projected increase in the numbers of elderly and in particular with the increase in the numbers between the ages of 70 and 85 it is quite obvious that the demand for the home help service will inevitably increase in the future. Therefore, more resources will have to be allocated to meet the increasing needs.

8. The home help service is seen as one of the community services for the elderly. There is a special ethos attaching to its delivery. The maintenance of the 'voluntary' character of the service should, if at all possible, continue. Home Helps see their role as providing a personal service by helping people less fortunate than themselves. They benefit personally from providing the service, from being needed, and by sharing with others in the community. This is demonstrated by their flexibility to cope with whatever situations arise.

9. While this report has quite naturally focused on the home help service which is given to the elderly and recognises that 85 per cent of the clientele who receive the home help service are in fact elderly there is another group which receives this service and which is not dealt with in
this report. In the main this other group represents families who are under some degree of stress or crisis.

10. The health strategy, *Shaping a Healthier Future*, introduced the concepts of health gain and social gain to services. I quote from the document:

   *Both health gain and social gain are concerned with focusing on the value that can be added to a person's life, whether in the form of a short-term treatment or an intervention required for a longer period.*

I consider that when the home help service is examined against the concepts of health gain and social gain there will be very positive outcomes. I further consider that the strengths of the home help service can be increased in the future and the negative aspects which have been highlighted in this report can be dealt with under a planned programme over the next four years.
Mrs. Val Tuthill
Chairperson, National Association of Home Care Organisers

Integrity...everybody is talking about integrity...everybody is talking about abuse...I would like to ask you to consider the integrity which you as individuals bring to the very worthwhile jobs that you all have. I would like to ask you to think about the potential abuse of the elderly and infirm that can occur if we do not act with integrity and determination in delivering the needs that these people have and we are entrusted to deliver without question. Everybody here today has the integrity to deliver a quality service to prevent potential abuse.

Unfortunately what might sometimes be seen as bureaucratic inactivity sometimes prevents us from delivering the much needed services to our people. Every week elderly and infirm people die alone. Home Helps regularly call to find the person with whom they have been sharing their lives dead. yet. some health boards disagree with the idea that these Home Helps should be supported in their work by bereavement counselling training. Their argument against training are referred to in the report as follows:

The consequences of over-professionalising the service could be detrimental to its good neighbour and semi-voluntary dimensions and could result in an escalation of costs, via wage claims (p. 158).

I think we will all have to question the assertion that training in some way prevents people from being good neighbours or indeed that it would affect the semi-voluntary dimensions of the service. Furthermore, the suggestion that if a Home Help was trained to deal with bereavement it would lead to wage demands is absurd. The fact is that the small amount of training that has been received by Home Helps in certain of the more caring health board regions has led to Home Helps having a higher sense of esteem and a deeper commitment to their work.

The five health boards which have objected to training need not worry themselves that training will lead to increased wage costs, since in the three health board regions that have given positive support to training there have been no linked wage increases. It might be better for the people in the health boards who opposed training, to consider if it is justifiable to send people out to provide a home help service, which is a ‘primary care service’, without the support of training. If the people who have the power to initiate a proper
training programme fail to do so, they must take responsibility for the consequences.

Training, as I have said, increases the commitment of the Home Help to the service and can be seen to be a method of stopping the flow of Home Helps away from the home help service in tourist regions, where there is an increasing difficulty in finding suitable Home Helps. If we continue to deny this basic support system to the people who deliver the service on a daily basis we will be responsible for the inevitable deterioration of the quality of the service.

Coupled with the lack of training support, the introduction of Care Attendants, who all received training, to perform some of the same duties which Home Helps were and still are providing, is perceived within the home help service as a further indication of the lack of proper recognition and respect which the service has received to date.

We have all heard of the idea of accountability, particularly of late in connection with children who, along with the elderly and infirm, are the most vulnerable within society. Everybody involved in the provision of services to the elderly and infirm should ask themselves whether the arbitrary partitioning of a person's needs into personal care and other types of care, respectively, shows a fundamental lack of respect for the dignity of the client or at best displays indifference to the potential negative impact of such partitioning upon the client, in cases where existing relationships and arrangements had been working well. Some of the difficulties arise from the fact that the home care attendant service is based on a medical model which is not as comprehensively informed about the needs of clients as the existing home help service.

The home help service has always provided the care required and the unnecessary duplication and disruption caused by having parallel services has nothing to recommend it.

These two problems of training and the introduction of parallel services are but two examples, of which there are many, that show the great need for a more co-ordinated and co-operative approach as was recognised in The Years Ahead policy document in 1988. Unfortunately the policy has proven to be too many years ahead of any real co-ordinated action.

Since the passing of the Health Act 1970, which empowered the health boards to employ Home Helps, much has changed. Families have dispersed beyond the neighbourhoods of their ageing parents. The increasing tendency for two adults to be working to sustain households means that daughters of ageing parents who were the traditional providers of care are no longer available. With the constant migration of people, neighbourhoods no longer have the same sense of community which traditionally cared for those in need.
The provision of a quality, sustainable service to elderly and infirm human beings is not a sentimental gesture but a human right. The fact is that provision of care in the community is a more economical method of care than residential care and more importantly can maintain a higher quality of life for those in need.

I began by referring to integrity and the need that we feel for it in our society in these difficult times. All of us have a responsibility to come together to resolve the problems that exist. I believe that we will not resolve any of our problems until the home help service gets proper recognition and support as the deliverer of a core primary care service.

I call on all of you here today to lend support to the development of a well co-ordinated and more harmonious home help service.
CONSIDERATION OF REPORT
HOME HELP SERVICES FOR ELDERLY PEOPLE IN
IRELAND

Session 2

Clients', Home Helps' and Home Help Organisers' Views on the Home Help Services in Ireland

Chair: Mr. Eamonn Hannan,
Chief Executive Officer, Western Health Board and Member, National Council for the Elderly
Ireland, in line with all other European Union countries, has opted for the social policy of community care especially in relation to keeping elderly people in their own homes and communities for as long as possible. In addition, research has shown that elderly people prefer to stay at home. In our study 85 per cent of respondents said they did not want to move house or change their living arrangements.

This paper contains six sections: (1) the study population; (2) who gets home help?; (3) clients views on the home help service; (4) Home Helps' views on the service; (5) Home Help Organisers' views on the service; (6) comparisons with other countries.

1. The Study Population

Initially a qualitative study was conducted by talking to 16 rural and 16 urban home help clients receiving the service from voluntary organisations. From the qualitative study a questionnaire was constructed and a survey of 195 home help clients conducted - 100 from a rural service supplied by a statutory organisation and 95 from an urban service supplied by a voluntary organisation. In addition, 38 part-time Home Helps - 18 from a rural service and 20 from one based in an urban setting - were interviewed, all employed by voluntary organisations. Finally, 38 Home Help Organisers, 16 employed by statutory bodies and 22 employed by voluntary organisations, were interviewed.

2. Who Gets Home Help?

In Ireland in 1993 14,073 elderly people were in receipt of home help services. This is an increase of 384 per cent over the 1978 figure of 5,653 home help clients. Single men, widowed men and widowed women are the groups most likely to get home help. It is striking that married men are the group least likely to get home help. It may be that we all fall into the trap of believing that wives can care for elderly spouses better than the other way around.

It is evident that those who are ill are more likely to get home help. What is interesting is the considerable percentage of people who are ill and not in
receipt of home help. One can only surmise that they are the group who are being taken care of by informal carers or are in nursing homes.

3. **Clients' Views on the Home Help Service**

The first question respondents were asked was how they found out about the service. There were differences here between the rural and the urban areas. In the rural area 67 per cent of respondents found out about it from their Public Health Nurse. In the urban area respondents found out about it from a variety of people, the most mentioned source was the doctor; mentioned by 30 per cent of respondents. In general, people applied for home help because of illness or injury.

Recipients were also asked how long did they have to wait before the service was provided. In the rural area 51 per cent of respondents got the service immediately by comparison to 12 per cent in the urban setting. A further five per cent of rural and 56 per cent of urban respondents got the service within one month of applying. This, however, leaves one per cent of rural and 12 per cent of urban respondents who had to wait for between two to six months for the service to be implemented. Forty three per cent of rural respondents and 20 per cent of urban respondents could not remember how long they had to wait.

The average length of time people had been receiving the service was three years and the range was from two months to 14 years. The average number of days of home help per week was four, ranging from one to seven. The average number of hours of home help per week was seven in the rural area (range 1 - 21); six in the urban area (range 1 - 56). Urban clients were more likely to have to pay for the service. However, rural clients who paid for the service paid more.

In the survey respondents' levels of physical and instrumental dependency were measured. By physical dependency is meant difficulty or inability to bath, dress and maintain mobility; instrumental dependency is difficulty or inability to shop, prepare meals, do housework, etc. There were no area or gender differences in our survey sample's dependency levels. However, single respondents were significantly less instrumentally and physically dependent than married or widowed respondents. That single people are more self-sufficient is a result that is not unique to this study and has been found in other studies in different countries.

The tasks Home Helps performed were divided into instrumental tasks within the home, outside the home and personal care. For instrumental tasks men and women did not differ but women were more likely than men to get personal care from their Home Help. In the rural area Home Helps were less likely to perform tasks outside the home than Home Helps from the city.
In regard to the social dimension of the home help service respondents were asked how important was their Home Help chatting to them. Over 90 per cent said it was very to somewhat important. One respondent said:

*When my Home Help comes in the morning she's a breath of fresh air, and she brings in what news there is from outside.*

In general home help clients not only like their Home Helps, they *love* them, consider them like an extra daughter or part of the family. One respondent said:

*My Home Help takes over here as if it is her own home and so she looks after it like that. She's just another daughter to me, that's the best way of saying it.*

There is an 'art' which Home Help Organisers practice - matching clients and Home Helps. One old man who used to be a musician was matched with a Home Help who sang in a choir and said his Home Help was just perfect.

Over 90 per cent of respondents are very to somewhat satisfied with the service. One woman said:

*I'm on the pig's back, I never was so lucky in my life, because my Home Help is so good and she 'd do anything for you that you 'd want.*

Another respondent said:

*I really couldn't manage without my Home Help.*

There was one area where clients were dissatisfied with the service. They wanted more home help time. However, many said that their Home Help gave them extra time free.

Around one-third of respondents considered that each one of the services, twilight, night-sitting and weekend, would be useful. Night-sitting was the service that got a slightly higher response rate.

Finally, clients were asked what they would do if the home help services were discontinued. The alarm and despondency this question generated was not remarkable when one considers how important home help is to elderly people.

4. **Home Helps' Views on the Home Help Service**
There were 10,559 Home Helps employed in Ireland in 1993. Of these 98 were full-time and the rest - 10,461 - were employed part-time. Permanent Home Helps are only employed by health boards. There are 57 permanent Home Helps employed by the Western Health Board. 24 employed by the North Western Health Board and 13 employed by the Midland Health Board.

In this study the opinions of 38 Home Helps were sought. All were part-time and all were employed by voluntary organisations. There were 18 from a rural area and 20 from an urban area. Thirty-six respondents were women and two were men. They ranged in age from their mid 20s to mid 60s. All but three were married, many had children and some had grandchildren. Sixty per cent of the Home Helps interviewed for this research care or have cared in an informal capacity for parents, spouses or children with disabilities. This was most striking in view of the fact that only 11 per cent of the population of similar age are informal caregivers. Urban Home Helps had more clients than rural ones. This makes sense because of differences in population density. Home Helps loved their jobs and clients but 87 per cent of them were dissatisfied with their rates of pay (for part-time Home Helps the range is from £1.00 in the Western Health Board to £3.50 in the Midland Health Board. One Home Help said:

You would get more people doing it, not just for the money, I mean people are doing it anyway and I think it deserves to be classed as a job not a voluntary thing.

There were no formal procedures for giving Home Helps time off even for minor illnesses or the flu. Many say they would soldier on. Geography plays a part in this because many rural Home Helps live in isolated parts of the country and there literally is no one else to take over from them when ill. Nearly one-third of rural Home Helps didn't know what would happen should they have to go into hospital. It seems that for voluntary agencies who do not have the benefit of full-time staff there is little backup for time off, for whatever reason, for their staff.

Many Home Helps explained that if they had to be replaced for any reason that it was very important that the client have somebody familiar or someone they can trust. Some suggested that a second Home Help be introduced to the client and get to know their ways 'just in case'.

Respondents were asked to make suggestions about improving the service. These are their suggestions in rank order - the first is the most important:

1. More pay for Home Helps
2. More substitute Home Helps
3. More status and recognition for them and for the service
4. Service should be free to clients
5. Home Help Organisers' Views on the Service

There were 73 Home Help Organisers employed in Ireland in 1993. Of those, 23 were employed by health boards and 50 were employed by voluntary organisations. Thirty-eight Home Help Organisers were interviewed for the study, 16 employed by health boards and 22 employed by voluntary organisations. These comprised of 10 individual interviews and the rest were interviewed in groups comprising between eight and 12 members.

Respondents perceived that the service in general lacks status. Some referred to the home help service as the 'Cinderella Service'. Lack of status for Home Help Organisers is demonstrated by their exclusion from hospital discharge committees. Many reported friction with other professionals. However, all organisers reported high levels of job satisfaction because of positive feedback from satisfied clients and work which they consider worthwhile.

Many spoke of the 'art' of matching client with Home Help. This is something they should be rightly proud of given the positive regard clients expressed for their Home Helps. But matching client and Home Help is just one of the many jobs performed by Home Help Organisers. There were differences in the jobs of those employed by health boards and those employed by voluntary organisations. Health board Home Help Organisers have fixed predictable budgets but have to cope with mountains of bureaucracy, little flexibility and some instability when there are changes in management. Home Help Organisers employed by voluntary organisations never know from year to year how much their budget will be for the following year. They also experience unexpected cuts in budget. However, they have more autonomy and flexibility, though they also have to pay wages and compute PRSI payments - many without the luxury of a computer. Home Help Organisers in rural areas have very large territories to cover. Those working in urban areas have, by comparison, much smaller but more densely populated territories.

Five areas of strain between different philosophies and practices were identified through the analysis of the data:

i. Some believe service provision should be flexible while others claim there should be criteria for who gets home help, how much clients should pay and how much home help they should receive.

ii. Personal care evolves between a Home Help and client and therefore it is appropriate that they should engage in this type of service. This is
countered by the philosophy that Home Helps should only engage in instrumental tasks.

iii. Home Helps should be allowed to engage in minor nursing tasks like cutting toenails or ensuring the client takes their prescribed medicine. This philosophy is countered by the belief that Home Helps should only take care of their clients' non-medical needs.

iv. Some believe that Home Helps should receive training. Others say Home Helps know enough already to perform the tasks they do and therefore training is not necessary and is over professionalising the job.

v. Some believe that there should be checklists of criteria for assessing clients for home help; others think that there should be a multidimensional approach to providing the service, including catering for social needs (loneliness).

6. Comparisons With Other Countries

The home help service in the Republic of Ireland was compared with Northern Ireland, Britain and Sweden. The biggest difference is that in Ireland health boards are not legally obliged to provide home help. In all other jurisdictions there is statutory provision of home help. This means that in Ireland home help could be discontinued or funding withdrawn or cut if the health boards so decided. In addition, unlike other countries, clients cannot take the health boards to court to get redress for their refusal to provide the service.

Less is spent on the home help service in the Republic of Ireland than in the three other jurisdictions. In addition, Republic of Ireland Home Help Organisers and Home Helps are paid less. Home Help Organisers supervise more Home Helps - their average is 197 - whereas in Northern Ireland they supervise 43, in Britain 15, and in Sweden 30. All other jurisdictions have formal mechanisms for training their staff. In the Republic of Ireland Home Helps perform more designated tasks than those in the other jurisdictions.

The percentage of the elderly population in receipt of Home Help is less in the Republic of Ireland, where it is 3.3 per cent, than in Northern Ireland (14.3 per cent) and Sweden (19.0 per cent). However, the number of hours of home help received per week is highest in the Republic of Ireland at 9.7 hours. In both Northern Ireland and Sweden it is four hours.

In Sweden Home Helps have very low status and are usually young school dropouts. Some clients have had as many as 25 different Home Helps over the course of a year. Another difference is that in Sweden the practice of matching client with Home Help is not practised. To illustrate the point an elderly
Swedish woman needing assistance with bathing was assigned a male Home Help. She was outraged and refused to allow him to bath her.

The reason for the low coverage in the Republic of Ireland is that the service as yet does not provide help to the large number of relatives who care informally for their parents and other elderly family members. This policy is different in the other jurisdictions. Until recently Sweden had a scheme whereby family members could become Home Helps for elderly relatives but this has now been discontinued because of the aversion of home help administration to the scheme.

We can therefore say of the home help service in the Republic of Ireland that it may be difficult to get. but when you get it, you get it good!
RESPONSE I

Mrs. Maura Cunningham

Carer

I am married with five children aged eight to 21 years, all in full-time education and living at home. I look after my father who is 81 years old. He is living with us for the past five and a half years. He has Parkinson's disease, he aspirates all food and drink and has many of the ailments of old age. He fell and broke his hip and now uses a frame and a wheelchair when we go out. He is peg fed. We also care from a distance for my mother-in-law who lives alone in Galway (my husband is the only member of his family living in Ireland).

Caring itself is very demanding and difficult, but with the additional burden of trying to tend to normal family needs, it becomes almost impossible to cope with at times. You realise that in looking after a parent the roles are now reversed, they depend on you as you depended on them as a child and with it comes the ups and downs of that relationship.

Those not directly involved, while being kind, do not understand. Caring can be very rewarding but very difficult if sustained over a long period. As a carer I find myself very isolated and trapped, both physically and psychologically drained with little help or understanding from any agency. Also, despite the fact that I am the principal in the field of caring for my father I am never consulted. As a co-worker I should be in partnership with the professionals in the caring situation.

Following a traumatic series of events - (father's hospitalisation, husband's hip replacement and hospitalisation of mother-in-law) a Home Care Attendant (three days a week) and a Home Help (two afternoons a week) were allocated but the latter only for the duration of my husband's hospitalisation.

Following a lot of pressure and many enquiries a Home Help was found for my mother-in-law and this Home Help now attends one hour a day, Monday to Friday. The Home Help has made a significant improvement to my mother-in-law's quality of life and has alleviated our concern as carers from a distance.

Returning to my father and our home situation. Some form of home help service should be available to carers especially in the case of emergency. My main concern is that if anything should happen to me, who would look after my father? I have nobody to call on except my immediate family who can attend to him. But they are at school or college and my husband is now back at work part-time.
In an emergency I would have no alternative but to put my father in a nursing home. The move would be very traumatic for him and he would be disorientated in the new surroundings for a period. For example, I find that when he is admitted to hospital it is nearly a week before the professionals manage to organise him to my satisfaction i.e. he cannot lie down in bed because he aspirates his saliva and, also, I have found him drinking a cup of tea. When I contacted an agency to enquire about sending out a Home Help or Attendant, when they heard my father was peg fed they said it would have to be nurse. This to me was not necessary and too expensive.

If an emergency arose after 5 p.m. I cannot even contact my Public Health Nurse or have a Home Help come. It's not that I would be calling on the service all the time but knowing such a service was available would give me much mental relief. Even at the moment, the Home Care Attendant cannot give my father his medication, so I have to ensure that this is done before I go out.

As a family we can't go out to socialise like in past years. My father can't eat or drink and it isn't fair to him to bring him to a pub or restaurant and sit by while we enjoy ourselves. On a few occasions he has become very depressed and cross when I wouldn't give him a sandwich or cup of tea while visiting relatives or friends.

I feel the voluntary organisations could do a lot in arranging people to call and sit with the elderly, talk to them, give them the local news, read the newspaper etc. This would alleviate some of the loneliness and it could be something to look forward to each week. I find that I cannot always give quality time to my father as I am busy about the house, tending to his needs and the family's. There are many retired able people who if their services were harnessed would be helpful in such situations and they would be making a great contribution to the community.

I have made this suggestion on many occasions, but unfortunately I am not able to organise, inform, or muster help from this group in society. I haven't the time to even meet friends for a cup of coffee and chat as I cannot leave my father alone for any length. This type of service would give a carer a break, it wouldn't cost anything except a bit of organisation and no training would be necessary as it wouldn't entail any nursing.

I feel there should be some organisation to provide support services for carers who have to be away overnight or for occasional evenings out. This twilight and weekend service would be very welcome. It would mean that you could plan an outing or accept an invitation and join friends and this would be a tremendous bonus to a carer. You could feel human again and have time to appreciate the more pleasant things in life. Some form of home help has to be put in place and be accessible to carers. Carers cannot be left isolated.
Again, I would like to emphasise the following points regarding the home help service.

1. The service should be available to all who need it not just the elderly living alone.

2. It should be flexible enough to take into account evenings and weekends and should extend where necessary beyond an hour.

3. There should be a known contact number in the case of emergency.

4. It should be available without the worry of cost.

5. There should be a review of the tasks to include the administering of medications.

I hope the service will be reshaped to take into account some of the points I have outlined.
RESPONSE II

Ms. Mary Coyne

Home Help, Western Health Board

My response must be in my capacity as a statutory full-time Home Help working for the Western Health Board in a rural setting of North West Connemara, as part of the community care team.

The role of Home Helps has shifted very much from domestic duties, to social and personal care, and Home Helps in many areas now carry out the duties of the new grade of Home Care Assistant/Attendant who are now working in some health board areas. I feel there is no real need for a new grade of formal carer as domestic and personal care can both be provided by an appropriately trained Home Help.

I feel that whatever position one undertakes, there must be a certain amount of on the job training, or in-service training and this applies to Home Helps especially now given the changes in the service to more social and personal care.

To this end I feel there should be a nationally recognised form of training right across the board for all Home Helps. I would not favour too much training which might lead to over professionalisation of the service. I value the fact that the people I care for see me as one of them, an extended family member.

At present I am one of five full-time Home Helps from the Western Health Board area undertaking a two year part-time Diploma Course in Social Care at the Health Promotion Unit at University College, Galway. The cost of this course is being met by the Western Health Board and European Union funding. We also attend several in-service training days each year on aspects pertaining to our work. All agencies can only reap a rewarding harvest from a well co-ordinated and suitably trained home help service.

I was amazed that there was no nationally recognised training for Home Help Organisers since these are the people we as Home Helps must look to for direction and guidance.

The home help service works closely with the public health nursing service and I am lucky that in my area there is a great team spirit between the General Practitioners, Public Health Nurses, Home Helps, the district hospital and the welfare home for elderly people. This I realise is not the case in many areas where Home Helps are not valued as part of the community care team. The low esteem felt by many Home Helps is a by product of the fact that many of them
appear to work in isolation with no back up service when they are ill or go on holiday. (I am lucky that I am provided with reasonable cover for holidays and illness.) Also, some receive such a low rate of pay for the tasks they are asked to perform, especially part-time Home Helps. There must be proper recognition of the rights of part-time Home Helps and a fair and just wage for a job well done.

The home help service is often described as a core service within community care and the report would appear to bear this out. Surely it is time that this service became mandatory as it is in many other countries.

There is a need for more Government funding to expand this vital and very cost effective service. There is also a need for special consideration for health boards where cover extends to vast rural areas now very dependent on home help services because of the devastation caused by years of out-migration. The good neighbour concept of home help cannot be relied upon in these areas as all the neighbours are themselves elderly relying heavily on outside agencies such as the home help service.

It is heartening to read that the home help service and Home Helps in particular are held in such high esteem and warmth by those elderly people who avail of our care. These are the people who really evaluate the quality of our service.

I feel the home help service is a service of the future which will expand even further to meet the needs of those who require the service, not only elderly people but those with a psychiatric illness, people with a disability, families in distress. Some Home Helps are at present working with these people as I am myself. We as Home Helps must be ready, able and willing to meet the needs of this hopefully expanding service.

We must have a positive attitude to our work, constantly upgrading our skills and knowledge and being aware of changes in structure in the provision of home help services. I am lucky that I work for a very forward thinking health board and have a very fair and approachable Home Help Organiser whom I see and talk with on a regular basis and who really values the care I provide to elderly people. All in all I see a very bright and optimistic future for the home help service and last but not least I am a Home Help and very proud of it. It is a very vital, noble and for me, rewarding job and one I really enjoy.
RESPONSE III

Sr. Carmel Molloy

Home Help Organiser

This study has raised some very important issues regarding the home help service right across the spectrum - from the Department of Health and health boards, through Home Help Organisers, Home Helps and, of course, the recipients of the service.

I would like to make my response to this study under four headings: (1) policy; (2) how the home help service is seen: (3) the challenges arising out of the report; (4) the future.

1. Policy

I welcome this report because it highlights for us, in a way which hasn't been done before, the variations which exist in the understanding and delivery of the home help service, both between health boards and within health boards, and this to my mind goes back to the original policy statement on the service in the 1970 Health Act, which states that health boards may provide a home help service. If, and how this is done is left to each health board, and this has led to the differences in levels of service, in how it is organised and delivered, its availability, the money which is made available to it, and how that money is spent.

In the last few years statements about home help services have been made in *The Years Ahead*, and in documents like the Eastern Health Board Policy Document (1989), and more recently in *Shaping a Healthier Future*. But in my experience these have for the most part been *aspirational* statements, and until these are put on a more firm basis, and put into action, and into legislation, the home help service will always be available only at the discretion of the health boards. At this point in Ireland no elderly dependent person, with a medical card, who wishes to remain in their own home is entitled to the help and support of a Home Help, as, for example, she/he is entitled to hospital services or the public health nursing service, if needed.

The discretionary nature of the service has a knock-on effect on funding also. It is interesting to note that in Northern Ireland, where the service is mandatory to people in need, that the per capita expenditure is 40 per cent higher than it is here, where the service is discretionary. It is also interesting to note that the average weekly cost of the service per client is lower in the voluntary sector (with a few exceptions) than in the statutory sector and yet it is the voluntary...
organisations that have the most difficulty in receiving the money to run the service. Those of us in the voluntary sector all know the experience of having large bank overdrafts, and of having the worry of not knowing if we can pay the Home Helps. This apart from the embarrassment we feel at the small amount of money we can give to a Home Help for the essential job she/he is doing. I think this latter point is true both in the voluntary and the statutory services.

The report also points out the absence of basic office accommodation and equipment, which many Home Help Organisers experience, in both sectors. So, if the Minister for Health in *Shaping a Healthier Future* asks for planning, monitoring, evaluation - how, I ask, can this be done efficiently, or even done at all, if the only equipment available is perhaps a pen and paper, and the only accommodation is the corner of a desk, as the researchers discovered?

2. **How the Home Help Service is Seen**

As has been stated in this study, there are different understandings of the home help service. On the one hand it is seen as an extension of the public health nursing service, and on the other hand as a domestic service. Whichever way it is understood, it is generally regarded by health boards, and by many (but not all) health professionals, as being a secondary or menial service, and this is reflected in the low level of pay, the bad working conditions and the negative attitude of some health boards towards training. It is also reflected in the fact that Home Help Organisers are not automatically included in the various 'teams' (Care Teams etc.) concerned with care of the elderly in the community, proposed in *The Years Ahead*.

I would like to suggest a way of understanding the role of the home help service which gives it its rightful and important place in the total care of the dependent person at home, rather than seeing it as a subordinate service.

The home help service is about making or maintaining the home for the elderly person, as she or he would like it, and in a way that the person can say with dignity and pride 'this is my home'. For dependent or frail elderly people the only service which may make the difference between someone being able to continue living at home or not, is the Home Help Service. So while I agree with what this report says about the home help service being a core service - I would go further and say that perhaps it is the core service!

I disagree with the view that the Home Help's job is less important, or even that some home help jobs are less important than others (and therefore should cost less). If an elderly person needs help with the activities of daily living, who is to say that helping him or her to wash and dress themselves is more important than ensuring that the floor is swept, the meal cooked, or the fire lit? Also, a
high level of trust and responsibility is placed in the Home Help going into someone's home.

The report mentions the absence of an emergency home help service and I accept this in the context of new referrals, but again if there was proper remuneration for Home Helps an emergency service could be available. However, I have to state that in my experience there is another kind of emergency service which is available in most instances. It is when the Home Help goes to her client and finds him or her unwell, and has to spend extra time - time which is unplanned, and is over and above what the Home Help has been asked to give. I don't think that this kind of commitment and availability should be overlooked.

3. The Challenges Arising out of the Report

A number of issues arising out of the report give rise to concern, one issue is money. A related issue is the absence of any standards for the service, or any contractual agreement with voluntary organisations that run the home help service. If there were formal agreements between the funding agencies, i.e. the health boards and the voluntary organisations, each party would benefit and ultimately the elderly client will benefit. On the one hand, the health board would know that the service for which they are providing the money is delivered, and on the other hand, the voluntary organisations wouldn't feel that they are begging when they are asking for money, and they would know that their grants would be paid.

A further issue which makes me feel uneasy is the tension which has arisen in the last few years around the employment by some health boards of Care Assistants, and the difficulty which some Home Help Organisers have with what is perceived as a duplication of the Home Help’s work, and a compartmentalisation of the tasks which need to be done for the elderly client. I would invite all of us, in each discipline to ask ourselves what this is all about, and is one component of it, as I suspect it is, about power and control. I would also suggest that we remember the total care of the elderly dependent person, and that the Home Help, no matter what her particular tasks are, is part of the caring team, and should be recognised as such.

The final point which makes me feel uncomfortable is the references in the report to the Home Help being like 'a daughter to her client', as if this were something desirable. While I encourage Home Helps to be caring, flexible, committed and responsible towards their client, I also encourage them to be responsible about themselves and their own lives and families. Many women can fall into the 'compassion trap' and find it difficult to say no, so I remind the Home Helps that they are not their client’s daughter, and that a certain detachment is necessary. Otherwise they will become burnt out.
4. The Future

My final heading in this paper is about the future - how I would like to see the home help service develop in the future, and I will do this by making simple short statements:

I want to be able to think when I do an assessment 'what can we do to help this person so that he/she can live at home with dignity and pride?', instead of thinking 'how can I get out of giving this person a Home Help?', or 'how little can I get away with?'

I want the service to be client led. i.e. that the client can ask for what he/she needs.

I want Home Helps properly recognised for the job they do, with just remuneration and working conditions, and appropriate training.

I want to know that I, as a Home Help Organiser, am recognised as an equal partner in the team of professionals caring for the elderly in the community.

I want to see its potential as a very appropriate support for carers developed.

I want the arrangements between voluntary organisations and the health board put on a firmer and more formal basis.
RESPONSE IV

Miss Anne Boggan

Home Help Recipient, Dublin

I am very grateful to the National Council for the Elderly for asking me to reply to this morning's paper. I would like to thank the authors for their excellent report and findings on home help services for elderly people.

During my working life it never occurred to me that one day I would be in need of care. When I returned home after major surgery the Public Health Nurses and their assistants, with care and kindness, helped me to recover. Then my Home Help took over and I rely on her a great deal.

I look forward to her coming - always bright and cheerful. Apart from her duties, which she performs so well, on her way to and from work she brings messages. She also posts letters for me and brings local news that is not only interesting but often important. Indeed, she may be the only person I have to speak to all day long. And life can be very lonely for people who are confined to their home.

I am fortunate to have good neighbours and a few friends who call for a chat when they have time. You can have television and radio but old people need company, especially if they are unable to get about. I congratulate Home Help Organisers in their difficult task of finding suitable people to do the work. But I can assure them that their help is very much appreciated as is the assistance home help clients receive from their Home Helps.
INTERNATIONAL PERSPECTIVES

Chair: Session I

Professor Davis Coakley
Trinity College and St. James' Hospital, Dublin

Chair: Session 2

Mr. John Sullivan
Programme Manager, Community Care
Western Health Board
HOME HELP SERVICES FOR ELDERLY PEOPLE IN EUROPE
FINDINGS OF A RECENT SURVEY

Dr. Ada Kerkstra
Netherlands Institute of Primary Health Care

Because of the absence of a systematic overview of the similarities and differences between the home care system in the twelve European Union countries, the European Association for Home Care and Help at Home commissioned the Netherlands Institute of Primary Health Care to conduct a study into the organisation and financing of home care in Europe.

This paper is divided into five sections: (1) organisation of home help services; (2) relations between home help services and home nursing; (3) funding of home help organisations; (4) reported problems in home help services; (5) conclusion.

1. Organisation of Home Help Services

Nowadays, all of the twelve Member States of the European Union have organisations for home help services, although in Greece and Italy the organisation of these services is still in a developmental stage. In some parts of those countries there are no home help services available. In some countries (Denmark, Spain, Luxembourg and the United Kingdom) home help services are not a part of the health care system but belong to the social services and are organised by and the responsibility of the local authorities, i.e. the municipalities. Belgium, France, Italy and Portugal have a mixture of home help organisations organised by the municipalities and private organisations. In Italy, however, the Government wants home care as part of the national health service, but this policy has not been implemented yet. Ireland, Germany (partly) and the Netherlands are the only three countries in which home help services are part of the health care system. In Greece home help services are provided by a mixture of private organisations, non-profit organisations like the Hellenic Red Cross and Greek Orthodox Church and voluntary organisations.

In most countries Home Helps do not have a formal education, just a few short courses and a ‘training on the job’. Only Home Helps in Belgium, Germany, Italy and 20 per cent of Home Helps in the Netherlands have had specific education varying from six months to three years in duration. In Denmark a one year education programme for Home Helps has recently been introduced. There are large differences between European countries in the available manpower of Home Helps.
In Italy, Luxembourg, the Netherlands and Spain most of the clients or their families contact the organisations themselves, whereas in France, Ireland and the United Kingdom the majority of the clients are referred by other professional care providers, like General Practitioners, hospitals and Home Nurses. In Belgium, Greece and Portugal about half of the clients contact the organisations themselves.

In all countries the assessment of the need for home help is performed by a professional (Home Care Organiser), who is not involved in direct home help care. In nearly all countries this professional is a Social Worker, but exceptions are made in integrated organisations for home help services and home nursing; in that case the assessment is sometimes made together with a nurse or by a nurse. In most countries the Home Care Organiser also decides about the amount and type of home help care to be provided.

The main tasks of Home Helps can be described as home-making activities (preparing meals, washing dishes, cleaning, doing the laundry etc.), hygienic and other personal care, general and family support (shopping, going for a walk with the client, administrative support), stimulating informal care (i.e. help from family members, neighbours or friends) and moral support with psychosocial problems (counselling and advice). France is the only country in which Home Helps are not allowed to provide personal care. In all countries Home Helps spend most of their time on home-making activities.

2. **Relations between Home Help Services and Home Nursing**

The increasing elderly population induces a greater need for home help services and home nursing. Therefore, in many countries policy makers recognise the advantages not only of co-operation, but also of merging the two services into one organisation and there seems to be a tendency towards integrating home nursing and home help services. In Denmark and Ireland both services are part of the same organisation. In France and Germany both services are often integrated and in the Netherlands, the umbrella organisations for community nursing and for home help services merged in 1990. In Belgium, Greece and Luxembourg there are some organisations providing both services. In addition, in Belgium multi-disciplinary co-operation initiatives are subsidised on the condition that General Practitioners, Community Nurses, Home Helps, Social Workers as well as three other professions take part in them. In the private sector of the United Kingdom there are organisations which provide both home nursing and home help services. Furthermore, one of the major conditions for the new approach in home care in the public health system is an extended co-operation between home nursing and home help services i.e. consultation between social services and health agencies is required. Finally, also in Portugal and Spain developments are taking place towards more intensive co-operation between the two disciplines.
3. Funding of Home Help Organisations

With the exception of Greece, organisations of home help services in all countries are to some extent funded or subsidised by the central Government (sometimes part of public insurance), local authorities, (based on central or local taxation), or by both. Home help services in Belgium, the Netherlands, Ireland, Spain and Portugal are funded mainly by central Government solely. The United Kingdom system largely involves local authorities buying blocks of home help services from independent agencies. In Denmark, Luxembourg, France and Germany funding is through a combination of local taxation, national taxation and in the case of the latter two some insurance companies. In Italy the funding of the service is from local authorities and in Greece the home help services delivered by the Hellenic Red Cross and the Orthodox Church are funded by the resources of these organisations and from voluntary contributions. Contrary to the practice in respect of home nursing, in most countries co-payment for home help services is required, mostly related to the income of the family and sometimes also to the composition of the household. In most countries co-payments contribute 10 to 20 per cent of the budget for home help services, the exception being Luxembourg where this contribution is about 30 per cent.

4. Reported Problems in Home Help Services

There are some problems in home help services that seem to exist in many countries.

Firstly, waiting lists for home help services are quite usual in most countries. Only in Denmark, Germany, Luxembourg and the United Kingdom are there no waiting lists. According to the experts the waiting lists are caused by budget problems, that is the budgets are too low, while the demand for home help services is increasing. The lack of sufficient resources is, according to the experts in many countries, due to the fact that the home help services have a low priority. In some countries it was also reported that it was a problem to target the available resources to the right people, that is to the people who really need home help. In some countries there are also large differences between the regions in the supply of the services.

Related to the first problem, in many countries there is a shortage of Home Helps. According to the experts the profession is considered as not attractive, because it has a low status, it is poorly paid and the training is considered to be insufficient.

Finally, regarding the co-ordination of care, in many countries the Home Helps complain about the level of co-operation with hospitals and General Practitioners. The reason for the unwillingness of the General Practitioners and
the hospitals to co-operate is that Home Helps are perceived as professionals with a low status.

5. Conclusion

On the basis of this overview we have to conclude that the unification of Europe with regard to the organisation and financing of home help services is still far away. However, the problems encountered in home help services seem to ignore the borders of the Member States.
HOME HELP SERVICES FOR ELDERLY PEOPLE AND CASE MANAGEMENT IN COMMUNITY CARE

Professor David Challis
Personal Social Services Research Unit
University of Kent

This paper has three sections: (1) development of community care in the United Kingdom and Australia; (2) case management; (3) studies of case management in the United Kingdom.

1. Development of Community Care in the United Kingdom and Australia

During the late 1980s there was a general move in many countries away from institutional care to community-based care. The shift to community care in the United Kingdom was reflected in a central Government policy document, Caring for People, published in 1989. This document had six key objectives for service delivery:

(i) To promote the development of home care, adult day care, and respite services to enable people to live in their own homes wherever feasible and sensible.

(ii) To ensure that service providers make practical support for caregivers a high priority.

(iii) To make proper assessment of need and good case management the cornerstone of high-quality care.

(iv) To promote the development of a flourishing independent sector alongside good-quality public services.

(v) To clarify the responsibilities of agencies and make it easier to hold them accountable for their performance.

(vi) To secure better value for taxpayers' money by introducing a new funding structure for social care.

In accordance with these objectives a number of changes were to be made in the provision and funding of services:
(i) Local authority social service departments were to be responsible, in collaboration with medical, nursing, and other interests, for assessing individual need, designing care arrangements, and securing their delivery within available resources. Assessment would be undertaken both for people seeking day and home care services and for those seeking admission to publicly funded residential and nursing home care. These activities would include the appointment of case managers for individuals such as the vulnerable elderly when it was appropriate.

(ii) A new funding structure would place responsibility for the financial support of those who enter residential care with the local authority who would have to assess each applicant's need for such a placement.

(iii) Local authorities would be expected to make maximum use of the independent sector.

(iv) Local authorities would produce and publish clear plans for the development of community care services in their area.

In Australia a 1986 policy document identified a number of problems with the existing system: focus on institutional care rather than home care; lack of assessment and rehabilitation; failure to match resources to individual need; lack of co-ordination of agencies and care services; inefficiency of present funding arrangements.

New care policy in Australia had two main thrusts. Firstly, residential care would only be used as a last resort for elderly people. This would reflect both their preferences and the budgetary pressures on the Australian Government. Secondly, enhanced community services would be funded by resources redirected from institutional care. In order to implement this policy additional central Government funds were allocated for enhanced home care services. Admissions to Government funded institutional care were to be by means of assessment. A case management approach to home care was also introduced.

The shift to community care has three key elements:

- enhanced home care;
- co-ordination and case management; and
- alternative and more sensitive forms of residential care.

Enhanced home care to be effective needs to be intensive, co-ordinated and focused. The core tasks of case management - case finding and screening, assessment, case planning, and monitoring and reviewing - all contribute to more effective and efficient long-term care.
2. Case Management

A case manager is a designated person who has responsibility for organising all the care inputs for a particular person. The case manager co-ordinates the inputs and ensures that gaps in the system are filled. One particular model of case management operating in the United Kingdom has the following operational features:

- clear and continuing case responsibility;
- targeted caseload - elderly people on margin of institutional care;
- smaller caseloads;
- trained and experienced fieldworkers;
- decentralised budget, with clear expenditure limits;
- knowledge of unit costs of services;
- service packages costed;
- systematic records for assessment and monitoring;
- closer health care linkages, either formal or informal.

3. Studies of Case Management in the United Kingdom

Studies of case management in Kent, Gateshead and Darlington examined a particular model of case management where case managers worked with relatively small caseloads of the most vulnerable elderly and with decentralised budgets. The findings of this series of studies are remarkably consistent. In all settings there was a reduction in the use of institutional care facilities. Furthermore, all the available data indicate that the quality of life of elderly people and their caregivers receiving these case management services improved significantly more than that of clients receiving the usual services. In all the studies these gains were achieved at no greater cost than for providing existing services over the same time period, and in one case at lower cost, reflecting the relatively high cost of long-stay hospital care and indicating greater efficiency in care provision.

It is clear that the case management arrangements can be seen to differ within the projects by such factors as setting and degree to which case managers are also service providers. It is likely that the most effective form of case management arrangements will vary with the circumstances of different groups of clients, local area characteristics, and the nature of local health and social care systems. Nonetheless, there are several areas of debate concerning the development of case management that are of general application. Particular concerns include targeting, control over resources, the style of case management, the role of case manager as service developer as well as co-ordinator, linkages with the health care system, and the organisational infrastructure within which case management takes place.
The Kent, Gateshead, and Darlington studies were carefully targeted services focused on those for whom there was considerable potential for substituting home-based for institutional care. This is clear from the results and yet, although indicating greater efficiency (improvements in welfare at similar cost), on the whole there was only limited evidence of significant cost savings. Hence it is probable that, if the same case management approach were applied to those with a slightly lower level of need where the opportunity for substitution by community care is less, there is a possibility of rising costs. This is because individuals whose needs fall just below that of present institutional care currently receive relatively low levels of service, and case management with more detailed assessments could well lead to increased expenditure beyond that currently incurred. It would therefore seem that careful targeting is one of the factors associated with the studies' positive effect on admissions to institutional care.

The evidence would indicate that control over resources is an important factor in enabling case managers to respond more effectively to the varied individual needs of elderly people.

The delegation of budgets to individual case managers would seem to be a crucial element of the development of more responsive care patterns. It remains to be seen whether organisations can achieve effective decentralisation of decision-making and balance this with effective accountability. The challenge of making such changes should not be underestimated, particularly in view of organisational traditions, and the bureaucratic hierarchies of public sector organisations.

Case management is not a wonderful give-all but requires careful targeting and imagination and clarity in its implementation.
REPORTS OF PARALLEL SESSIONS
The speaker referred to Section 61 of the *Health Act 1970* which provides a statutory basis for a home help service. The wording of the Act empowers, but does not require, health boards to provide a home help service. A Department of Health Circular (11/72) set out broad principles for the home help service which have guided its operation over the past two decades. The Circular referred to the role of the home help service in preventing institutional care and stated the importance of ensuring from the start that the service was of a high quality. It also referred to the provision in the Act for charges to be made for the service.

Reference was made in the Circular to placing an emphasis initially on meeting the needs of those who at present cannot have satisfactory support made available to them by their family and neighbours and prioritised elderly people who are infirm and housebound. The 1972 Circular placed considerable emphasis on voluntary sector provision and implied that health boards should only become involved where the voluntary sector was unable to provide the service. The need for careful selection of Home Helps and for appropriate training was also referred to.

**DISCUSSION**

The Chairman mentioned, *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s*, and the commitment contained therein to support the elderly and their carers. He suggested that Circular 11/72 contradicted the aims of the strategy by prioritising the elderly living alone as a client group and not providing support for carers. He noted that most Home Helps had one or two clients to whom they provided care over a period of several years. Therefore, it was likely that Home Helps would find themselves supplying ever increasing amounts of personal care. In this scenario training would need to be ongoing.

There was a discussion on rates of pay for Home Helps. The discrepancy between rates of pay for Home Helps in the public and private sectors was
pointed out. It was claimed that the low rates paid to Home Helps were an example of exploitation of women and that such rates of pay would never be tolerated in a male dominated profession. It was suggested that the low rates of pay served to devalue the home help profession and lower Home Helps’ self esteem.

There was agreement that the role of both the Home Help and the Home Help Organiser needed to be defined. There were problems with the Home Helps’ function being seen in terms of domestic rather than personal care and with the Home Help Organiser being seen as supporting the Public Health Nurse rather than having a defined role of her own. There was agreement that it was a waste of a nurse’s time to be involved in organisation of home help services.

Training was another issue of central concern. From the discussion it was obvious that training structures and the volume of training varied widely across the country.

It was noted that due to changing demographic and social structures, families would increasingly become less able to provide informal care without support from the statutory services. Caring for dependants in these situations would demand considerably more personal care from the home help service than does caring for the mildly dependent living alone.

The three conclusions reached by the workshop were:

1. The home help service should be a statutory core service which health boards must provide and it should have a recognised training and pay structure.

2. A Home Help Organiser is essential to the running and training of a home help service. The Home Help Organiser should be an equal member of any community care team.

3. The home help service should have standard eligibility and charges criteria set down at national level.
WORKSHOP 2

Voluntary Home Help Services: Partnership, Funding and Other Issues

Chair: Ms. Janet Convery
Social Worker, Eastern Health Board and Member, National Council for the Elderly

Speaker: Mr. Ciaran Roche
Eastern Health Board and Ad Hoc Committee of Voluntary Home Help Organisations

The speaker referred to the uneasy relationship that often exists between the voluntary and statutory sectors. He suggested that a complementary relationship was appropriate and that the statutory sector needed to be more flexible while the voluntary sector needed to be more accountable. The strengths and weaknesses of both statutory bodies and voluntary organisations were listed. Integrated community-based work, based on partnership, requires a pro-active approach from statutory bodies and changes in some bureaucratic procedures. For example, much more evening work is required if voluntary organisations are to have the opportunity to be fully involved in planning, decision-making and case studies. Also, voluntary organisations need to adopt and develop the necessary structures to allow partnership to evolve.

A system for improved information flows developed by the Committee of Voluntary Home Help Organisations was identified by the speaker as one area of focused change in the voluntary-statutory relationship.

DISCUSSION

The main issues that emerged were:

1. Information

There is a need for a better information base to more accurately reflect the actual level of service provision by the voluntary sector and demand for services. This would present a more professional image of the service, would facilitate better planning and also allow for more effective monitoring and evaluation of the service.

2. Co-ordination

There is a need for the appointment of a co-ordinator or a co-ordinating committee to include participation by voluntary providers. This would enable all home help providers:
• to standardise record keeping and develop an information base;
• to standardise service provision procedures for eligibility, charges etc.;
• to monitor the quality of service.

3. Funding Issues

Budgets are too small and often do not reflect increases in demand experienced by many home help organisations.

There are *no contracts* drawn up and often no written commitment to funding at a particular level from year to year (i.e. no clear budget allocations specified).

In many areas, there are delays in payment of funds by the health boards to voluntary providers.

Current wage levels do not acknowledge the critical importance of the home help service to recipients.

There are questions of equity involved where providers are treated differently (in terms of levels of funding and other support) *between* and even *within* health boards.

4. Training

There was general agreement that training is important in improving the quality of service and as an acknowledgement of the value of the individual Home Help's contribution.

5. Gender Issue

It was suggested that the home help services suffer (in terms of having low status, low budgets etc.) because the work undertaken is 'women's work' and is performed mainly by women.

6. Differential Rates of Pay

There was dissatisfaction about the differential treatment of Care Attendants *vis a vis* Home Helps who, it was thought, do much the same work but get paid much less.

It was acknowledged that the proposals in respect of information and co-ordination would add to the huge administrative workload of many voluntary home help organisations and would require an allocation of additional resources.
WORKSHOP 3

Service Development Priorities: Carers' Support, Night-Sitting, Weekend Services, Information and Private Home Care Services

Chair: Dr. Margo Wrigley
Consultant Psychiatrist in Psychiatry of Old Age,
Eastern Health Board and Member,
National Council for the Elderly

Speaker: Mrs. Angela Gurnett
Home Help Organiser, ClareCare

The speaker suggested a number of service development priorities to take account of both the current level of provision by the home help service and also the potential of the service to provide more comprehensive support for families and neighbours caring for elderly persons. These developments should include: (i) training; (ii) publication of guidelines for eligibility and client contributions; (iii) appeals and complaints procedures; (iv) home help support for carers; and (v) weekend, twilight and night-sitting services. The home help service should be available to those who need it, including carers. The home help service should also be an integral part of community care services and should be consulted and informed about decisions in respect of home help recipients. The key to further development of community care is based on the principle of complementing informal care with formal support. This in effect means providing a support structure to enable caring families and relatives to get regular breaks. There should also be formal procedures for complaints and appeals by home help recipients and their carers.

DISCUSSION

The main issues that emerged were:

1. Focus of Home Help Service

Service provision should be tailored towards the actual needs of people and should specifically provide support services for carers. Provision should be made for weekend, twilight and night-sitting services.

2. Training

Selective procedures were important and should be followed by appropriate induction courses. Such courses should cover not only the practical aspects of the work but also issues such as confidentiality, communication/assertiveness,
nutrition and sensitivity to people's physical and medical condition. Appropriate training should also be provided for Home Help Organisers to improve their skills in selecting/assessing/supporting Home Helps and, also, in the administration of the system.

3. Eligibility

Clear guidelines on eligibility need to be laid down and published and should include guidelines on client contributions. Such guidelines should focus on the actual needs of people as well as their financial position.

4. Mandatory Home Help Service

The home help service should be mandatory rather than discretionary for people who need it.
The speaker stated that the basis of good case management is assessment - the functional assessment of individual elderly persons, taking into account their specific social support networks. Assessment is most effectively targeted at people deemed to be in the 'at risk' category who can then be offered packages of care appropriate to their needs and circumstances. It often takes the skills of more than one professional to assess the requirements for an individual person. However, there should be one person who has local responsibility for accessing the team members required to do assessments and, also, the various agencies required to implement an appropriate package of care.

The Eastern Health Board's experience of developing community-based packages of care through District Care Units were set out. The general consensus emerging, thought not statistically confirmed, was that the team approach with individual packages of care does improve the level of care received by the individual. This approach, however, also uncovers needs that cannot be met from existing resources.

The speaker felt that packages of care should be underpinned by the principles of equity, accountability and quality of care and that the effectiveness of such care must be monitored.

DISCUSSION

The main issues that emerged were:

1. Liaison/Communication

Effective liaison and communication between disciplines and agencies is paramount in the development and implementation of individual packages of care. Specifically, areas of contention between Home Care Attendants and
Home Helps and between the home help service and the public health nursing service need to be resolved.

2. **Social Workers**

Social Worker support for the elderly should be provided and the appointment of Social Workers for the elderly should be considered.

3. **Models of Care**

A range of models of care for the elderly should operate depending on local needs and resources. In particular, we should avoid blindly following models that have been developed in the United Kingdom.

4. **Role of Public Health Nurse**

The role of the Public Health Nurse is crucial in identifying need and should not be underestimated.

5. **Non-Medical Card Holders**

Community-based services should cater for non-medical card holders and services should be targeted more to this group of people.

6. **Care Teams**

Home Help Organisers should be members of care teams co-ordinating services and developing packages of care.
WORKSHOP 5

Avoiding Institutional Care: The Home Help Needs of Clients and Informal Carers

Chair:  Mr. Frank Goodwin
Chairman, The Carers Association Ltd.

Speaker:  Mrs. Winifred Bligh
The Alzheimer Society of Ireland

The speaker focused on the need for support for carers from the home help service, particularly carers of people suffering from dementia or Alzheimer's disease and suggested that in this respect home help services at present are piecemeal, fragmented and underfunded. Home Helps need training in all aspects of ageing with particular emphasis on dementia and coping strategies. Trained personnel need to be available to respond to the constant demand for help from carers. In this regard the role of the Home Help needs to be defined. What is needed is a greatly expanded but uniform home help service which is flexible and available seven days a week, offering practical and informed assistance including attendance to personal hygiene. A general upgrading of the whole service is required including improved rates of pay, working conditions, and status for Home Helps while making the service cheaper or free to clients. Men should also be encouraged to join the home help service to be available to male clients.

Carers require weekend, night relief and twilight-sitting services - relief from constant watching and attendance. Sometimes they need practical help with domestic tasks, including laundry. Many also require someone to listen and offer emotional support.

DISCUSSION

The main issues that emerged were:

1. Resources

Additional finance is urgently required to expand and develop the home help service to support carers.
2. **Training**

Training for Home Helps needs to be expanded and developed to enable Home Helps to carry out their tasks more effectively and sensitively and to complement the role of family or neighbourhood carers.

3. **Flexibility**

There should be flexibility in the provision of the service to allow for variation in the nature and extent of service required.

4. **Recognition of Home Help Service**

The role of the home help service should receive better recognition. For example, the service should be involved in planning and policy making and should be consulted in this regard.
WORKSHOP 6

*Home Helps: Their Role, Tasks, Responsibilities and Problems in Providing Home Care for the Dependent Elderly*

**Chair:** Ms. Ann Kelly  
Superintendent Public Health Nurse  
North Western Health Board

**Speaker:** Ms. Madeline Hudson  
Home Help, Midland Health Board

The speaker explained the role of the Home Help and described the main tasks carried out. These tasks fall into three main categories: personal care, household chores and shopping (including paying bills). The Home Help is also responsible in many instances for monitoring the elderly person's condition and reporting anything unusual to the Home Help Organiser, Public Health Nurse or relative, or for contacting the doctor if deemed necessary. Home Helps frequently supervise the taking of medication. In addition to these roles the Home Help plays an important social support role by listening, comforting, reassuring and by bringing the local news. Reference was made by the speaker to the fact that some elderly persons have great difficulty in giving up their independence and may resent the presence of the Home Help. The responsibility of the Home Help in such instances is to re-assure and set the person at ease.

**DISCUSSION**

The main issues that emerged were:

1. **Safety and Security of Home Helps**

There is a need to place more emphasis on the safety and security of the Home Help - to recognise their vulnerability (both physical and emotional) while working in clients' homes. The Home Help's reputation for honesty and confidentiality must also be protected where the Home Help must deal with cash and property of the client, or is privy to information which is of a confidential nature.

2. **Training, Advice and Support**

The need for adequate training for Home Helps was emphasised (In some areas, an induction course is compulsory before a Home Help is allowed to work in the community). In addition to dealing with normal problems arising,
bereavement counselling and advice on areas such as sexual harassment, and the need for Home Helps to maintain professional detachment and avoid burn out should be included in training.

3. Sharing of Information

Home Helps should have all necessary information regarding clients’ history etc. in order to make informed decisions and to understand clients’ behaviour. They should be seen as part of the community care team and recognised as more than domestic assistants.
The speaker described the role of the Home Help Organiser. The tasks involve:

(i) Visiting clients and assessing their needs:
(ii) Interviewing, selecting and assigning Home Helps:
(iii) Providing basic training for Home Helps:
(iv) Mediating in difficulties between Home Helps and clients;
(v) Keeping records;
(vi) Supporting Home Helps;
(vii) Liaising with Public Health Nurses.

The main problems are:

(i) Finding suitable personnel to work as Home Helps;
(ii) Providing adequate supervision because of ever-increasing numbers of clients;
(iii) Finding Home Helps to work with problem families;
(iv) Lack of resources to cater for all the demands on the service.

DISCUSSION

The main issues that emerged were:

1. **Models of Service Delivery**

The six models of service delivery outlined in the report should be examined to see which is most likely to best benefit the *client.*
2. **Home Help Organisers**

The job descriptions of Home Help Organisers should be reviewed to take account of the extension of their responsibilities in recent years. Also, additional training in management, communication and liaison skills should be provided.

3. **National Criteria**

The home help service should be mandatory. National criteria should be set down in respect of:

(i) Client contributions;
(ii) Payment of Home Helps:
(iii) Eligibility in terms of needs.

It is only then that the future provision of the service can be properly costed and developed.

4. **Role of Voluntary Organisations**

The role of voluntary bodies in service provision needs to be considered and re-stated.
WORKSHOP 8

Home Help Recruitment and Training: Needs and Priorities

Chair: Mr. Len Commins
Community and Family Training Agency, Ballymun

Speaker: Mrs. Pam Towers
Education and Training Officer, National Association of Home Care Organisers

The speaker described the process of recruitment, induction and training formation for Home Helps throughout the country. The most important qualities in Home Helps are a warm, friendly disposition and a mature caring attitude. Induction programmes usually cover health and safety hazards as well as basic duties and responsibilities. Ongoing training equips Home Helps to deal with more complex and difficult situations.

Training courses and seminars for Home Helps have been organised individually throughout the country without reference to any national curriculum or standard because none has existed to date. Also, only a small percentage of Home Helps have participated in such courses.

Specific reference was made to the BTEC Course in Caring available through the City of Dublin Vocational Education Committee (CDVEC), for Home Helps. This is a comprehensive course with a number of modules. Topics covered include communication and interpersonal skills, bereavement, caring for the disabled and information on health and social services. The speaker also referred to a part-time one-year Certificate or two-year Diploma Course in Social Care provided by University College Galway.

DISCUSSION

The main issues that emerged were:

1. Distinction between Care Attendant and Home Help

Profound concern was expressed about the division and acrimony that exist around the issue of Care Attendant vis a vis Home Help. Upgrading the home help service and making it mandatory was seen as a way forward if accompanied by open and honest communication and trust between all involved.
2. **Recruitment**

More younger people should be recruited for the home help service with special emphasis on recruiting the young unemployed.

3. **Training**

(i) The first priority should be more adequate training for Home Help Organisers.

(ii) There is a new urgency for basic training related to health and safety.

(iii) There is a need for an agreed package of training for Home Helps with appropriate accreditation. Such a package could be delivered by a range of agencies/institutions.
SUMMING UP

Chair: Mr. L.J. Tuomey
Former Chairman, National Council for Elderly

Speaker: Dr. Cillian Twomey,
Consultant Physician in Geriatric Medicine
Southern Health Board

People in receipt of home help services are generally very well satisfied with the services. Home Helps tend to be committed and dedicated people who provide a high quality service despite very low pay in some instances.

Historically the home help service was geared towards a very narrow group of elderly people (i.e. those living alone). The financial sum allocated for the service tends to be based on this narrow definition of what the service does and, therefore, does not cater for other important areas of involvement, for example, support for family carers or, perhaps, those above certain income limits. The following are the key points arising out of the conference deliberations:

- There is a need for definite budgetary allocations and programmes of action to implement the aspirational aims of the Government's strategy document, *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s*.

- Voluntary organisations have an important role to play in service delivery and this role should be enhanced by the forthcoming Government charter on voluntary organisations and by appropriate financial support.

- There is merit in flexibility and variety in developing the home help service on the basis of a common sense approach to what works best in a particular area. However, flexibility must be governed by criteria of quality and equity.

- Where *The Years Ahead* report has been implemented it has been very good but a number of its recommendations in respect of the home help service have not been implemented.

- Health care provision should be tailored to individual need from bottom up rather than from the top down.

- Training for Home Helps is an essential part of health care provision but care must be taken to avoid over-institutionalising the home help service.
• Very frequently the Home Help builds up a relationship with the client and this aspect of the service, while not possible to buy with money, must be supported by adequate financial support for the Home Help.

• The home help service in Ireland is a great service if you can get it but far more people (both elderly and carers) need and would benefit from the home help service if it were available to them.

• There are very many family carers providing essential support for elderly relatives in the community. It is unacceptable that such carers do not get the support they need.

• The home help service should be available to all who need it without the issue of cost being a barrier. This point is particularly pertinent in respect of people who do not have a medical card but whose income would not be adequate to pay privately for home help support.

• The confusion between the role of Home Help and that of Home Care Attendant that has arisen in recent years should cease. There is no need to institutionalise differences when both groups of people are substantially doing the same thing. What is required is more common sense in dealing with such issues.

• A key point is that community care must be adequately resourced if it is to be a realistic alternative to institutional care and if home-based care is to be enhanced to the level required in many instances.

• The health board committee structures for service co-ordination proposed in *The Years Ahead* should be implemented. These structures would help to facilitate a case management approach to home-based care.

• The home help service needs to have more formal recognition, equal partnership with other professionals and disciplines and resources commensurate with its responsibilities and role.

• The home help service should be mandatory. It should be expanded to provide support for carers and funded accordingly. The voluntary aspect of the home help service should be retained where appropriate but we cannot rely on goodwill and good neighbourliness forever. Training for Home Helps should be an integral part of the service.

• The recommendations of *The Years Ahead* both in respect of the home help service and in respect of co-ordination should be implemented and funded accordingly.
• Since the elderly are not a homogenous group services must be delivered with a degree of flexibility and common sense to cater for each individual situation.

• It may be the case that an effective response to the underfunding of the home help service will only occur through greater awareness of the issue brought about by appropriate lobbying.
NATIONAL COUNCIL FOR THE ELDERLY PUBLICATIONS

1. *Day Hospital Care*, April 1982
4. *Community Services for the Elderly*, September 1983
5. *Retirement Age: Fixed or Flexible (Seminar Proceedings)*, October 1983
7. *Incomes of the Elderly in Ireland: And an Analysis of the State's Contribution*, May 1984
8. *Report on its Three Year Term of Office*, June 1984
10. *Housing of the Elderly in Ireland*, December 1985
11. *Institutional Care of the Elderly in Ireland*, December 1985
12. *This is Our World: Perspectives of Some Elderly People on Life in Suburban Dublin*, September 1986
14. "*Its Our Home": The Quality of Life in Private and Voluntary Nursing Homes in Ireland*, September 1986
17. *Choices in Community Care: Day Centres for the Elderly in the Eastern Health Board*, September 1987
18. *Caring for the Elderly, Part I: A Study of Carers at Home and in the Community*, June 1988

National Council for the Elderly Fact Sheets

Fact Sheet 1  Caring for the Elderly at Home
Fact Sheet 2  Carers You Matter Too!
Fact Sheet 3  Ageing in Ireland: Some Basic Facts
Fact Sheet 4  Voluntary Sector Services in the Community