Long Term Care Report
Note in relation to publication of the Report of the Long Term Working Group

This report was finalised by the working group at the end of 2005 and submitted to Government in January 2006.

While the report's proposals were not formally endorsed by Government, its analysis and recommendations have informed subsequent decisions, including the Fair Deal policy on Long-Term Nursing Home Care.

The principles underpinning the report formed the basis for discussions about long term care with the Social Partners prior to the new national programme negotiations leading to a clear vision articulated in Towards 2016 on a number of priority actions to support older people to participate in society in a full and meaningful way.

It is important to note that the report was prepared on the basis of the best information available to the working group at the time. In some instances the data used was tentative in nature and in many cases has been superseded by better or more up-to-date data. This should be borne in mind when reading the report.

JANUARY 2008
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1. SUMMARY

Introduction
1.1 The Working Group was established by the Tánaiste and the Minister for Social and Family Affairs in January 2005. It was chaired by the Department of the Taoiseach and comprised senior officials from the Departments of Finance, Health and Children and Social and Family Affairs. The membership of the Group is set out at Appendix 1.

1.2 The terms of reference were:

Taking account of the proposals in the Mercer\(^1\) and O’Shea\(^2\) Reports to:

− identify the policy options for a financially sustainable system of long-term care; and
− rationalise the range of benefits, services and grants (both statutory and non-statutory) currently in place, and address associated issues.

1.3 Its scope was on people over 65 in need of care.

Budget 2006
1.4 This report was prepared in advance of Budget 2006 and the text has not been updated to incorporate announcements in the Budget. However several initiatives in the Budget are consistent with the recommendations of the report, including:

− Expansion of Home Support Packages
− Increased funding for Home Help Service
− Revised Nursing Home Subvention Eligibility Thresholds
− Increased Respite Care Grants
− Increased funding to support sheltered housing
− Improvements in Carer’s Allowance and Carer’s Benefit Schemes

Further details on these measures are included at Appendix 2.

Demographic Trends
1.5 The Group noted the demographic changes relevant to its work. It is estimated that, in 2006, approximately 463,000 people will be aged 65 years and over. Latest population projections suggest that this figure will increase to 1,105,000 by 2036, increasing the number of people over 65 as a percentage of working age population from 18% to 39%. Within this, the number of people aged over 85 is projected to increase from 46,700 to 155,500. This trend is expected to continue out to 2056 when the old age dependency ratio is projected to reach 60%.

1.6 It is clear that these demographic trends alone will increase the need for services and therefore the cost of caring for older people in coming decades. However, the Group noted a number of other relevant factors which make predictions about demand for and supply of long-term care difficult. These include:

− the number of people requiring long-term care is also determined by disability prevalence rates and the recent OECD Report on Care for Older People\(^3\) suggests that there are favourable disability trends with regard to older people internationally;
− social trends, particularly higher female labour force participation, will impact on availability of informal care;
− on the basis of Mercer projections, there is a disparity between estimates of current need (in 2006) and existing level of public service provision; while this may in part be unmet need, it may also reflect needs being met through informal care or otherwise.

\(^1\) Mercer Limited, 2002, Study to Examine the Future Financing of Long-Term Care in Ireland. This study was commissioned in 2000 and published in 2002.
\(^2\) O’Shea, 2002, Review of the Nursing Home Subvention Scheme. This review was commissioned in 1999 and published in 2002.
\(^3\) OECD, 2005, The OECD Health Project, Long-term Care for Older People.
1.7 The Mercer report was based on UK disability prevalence rates, which have not been updated since the mid-1980s. Applying these rates to updated population estimates, it can be projected that the number requiring some form of care will increase from 84,700 in 2002 to 177,200 in 2032 and 309,900 in 2052. However, these projections must be treated with caution in the light of the factors listed above.

1.8 In addition to demographic trends, increasing expectations about the quality and certainty of care provision appropriate to a modern society add pressure for significant reform and investment in the years ahead.

1.9 It is important to note that the cost of long-term care is only one implication of demographic trends. Wider implications, for example in relation to the cost of acute medical care and pensions, have not been considered by this Group. Similarly, there will be continuous pressures for service improvements in other areas of expenditure.

**Principles Underpinning Future Policy**

1.10 Future demographic trends, along with the fragmented and incomplete nature of existing services, pose a significant challenge in terms of building an infrastructure to provide long-term care for older people in Ireland.

1.11 The Group proposes the adoption of the following principles as the basis for future policy:

- All relevant public services should be designed and delivered in an integrated manner around the needs of the care recipient, based on a national standardised needs assessment
- The use of community-based care should be maximised
- The important role of family carers should be recognised and supported
- Where community-based care is not appropriate, quality residential care should be available on an equitable basis in accordance with financial circumstances and as between public and private provision
- There should be appropriate levels of co-payment by care recipients based on an assessment of financial resources
- Policy must evolve effectively in response to demographic, labour market and social changes in Ireland
- Any model adopted must be financially sustainable over the long-term.

**Existing Services**

1.12 A considerable range of benefits and services are currently provided by Departments and Agencies and these are summarised in the report.

1.13 A range of Departments and Agencies are involved in the provision of services to older people (see table 4). The Group strongly believes that there should be a more integrated approach to service planning in order to guarantee the most efficient use of resources and to deliver the optimum level of service to each care recipient, and carer where appropriate. This requires a single policy framework on long-term care for older people, developed by the Department of Health and Children in consultation with other relevant Departments at national level, while the lead role in service delivery should lie with the Health Service Executive (HSE).

**Community-Based Services**

1.14 The Group believes that a central principle of policy going forward should be to support older people to remain in the community. It is generally accepted that older people and their families have a preference for home care. International evidence suggests that provision of home support packages will complement, rather than substitute for, informal care by family members and others, which will remain a cornerstone of long-term care policy.

1.15 Improved home care support will also help to minimise requirements for residential care services and, in most cases, it can be provided at a lower cost than residential care. However, it is
important to note that the OECD have warned against overly optimistic assumptions about savings arising from people availing of community rather than residential care.

**Home Help Services**

1.16 At present, home help services are the core services in place to support people to remain in their homes. Home helps usually assist people with household tasks, although they may also help with personal care. According to the HSE Service Plan for 2005, approximately 29,000 people over 65 are in receipt of the home help service. An average of 5 hours per week is provided at an approximate cost of €120m. Current provision of home help services is described in more detail in Chapter 5.

1.17 The home help service is an essential foundation for any expansion of home support packages, by enabling many older people with lower levels of dependency to remain at home. Home help services will also normally form part of a home support package, possibly with additional hours beyond the standard level of provision. The Group considers that flexible and good quality home help services will continue to be at the centre of community-based care over the long-term, requiring continued prioritisation within the HSE.

**Home Support Packages**

1.18 The Group believes that there should be a move towards the provision of home support packages on the basis of a national standard approach, with clear criteria in terms of access, quality standards and availability. Further details on home support packages are set out below.

1.19 While the Group supports the principle of community-based care, the decision in each individual case will depend on the needs assessment. Where high intensity care is required, this decision must also take account of the relative cost of community-based and residential care.

1.20 The Group recommends an initial, targeted approach in order to allow further work take place before decisions can be made on a longer-term programme of services. Therefore, as a first step, the Group proposes the provision of an additional increment of home support packages in 2006 and 2007. These packages should comprise services such as public health nurse, day care, occupational therapy, physiotherapy, home help services and respite care, whether drawn from the existing pool of services or any additional resources which might be put in place. If appropriate, they should also take account of requirements for specialist equipment or adaptations to the house, and the availability of sheltered housing options.

1.21 Each package will be tailored to the needs of the recipient, taking account of his or her particular circumstances and the presence or otherwise of a carer. It could involve the provision of services by public and/or private providers, voluntary groups and individuals. In most cases, this should be through direct reimbursement of the service provider by the HSE. However, in order to maximise flexibility it may be appropriate, in certain circumstances, to make a cash payment to the care recipient on the basis of receipted and approved expenses.

1.22 These additional packages should be focused, by the HSE, on older people currently in residential or hospital care, who have the capacity to return to their homes, and at people in the community who are considered to be at risk of requiring residential care in the absence of such intervention.

1.23 In accordance with current practice, a co-payment should be required in the case of these packages depending on the result of an assessment of the individual's financial resources. For the purposes of this initial increment of home support packages the Group believes that the assessment should not take the value of the person’s primary residence into account. However, the position of the primary residence in the longer-term co-payment arrangements will need to be considered in the context of the long-term financing of community-based care following the completion of the evaluation referred to below.

1.24 This initial, targeted approach is recommended in order to allow further work take place before decisions can be made on a more wide-ranging programme of services. In particular, the Group recommends:

(i) that a formal evaluation of these packages be completed by mid 2007; this should include an evaluation of costs and benefits, delivery model, outcomes for care recipients, availability of family or other informal care, impact on care recipients and family carers, implications of possible mainstreaming and impact on acute hospital services.
(ii) that to inform this evaluation, the HSE should record detailed information on these packages, the profile of recipients and accompanying informal care provision.

(iii) that a standardised care needs assessment framework for application on a national basis be developed immediately by the HSE, possibly based on an existing model; this should be sufficiently robust to determine the need for and appropriate type of long-term care package taking account of the needs of the care recipient and the carer as appropriate.

(iv) that a national standard financial assessment framework be developed to apply for both home support and residential care; final decisions on the level of co-payment required for home support to be taken following the evaluation in 2007.

(v) that formal protocols for case management and delivery of home support packages for application on a national basis be developed by the HSE.

(vi) the development of an appropriate approach to ensure quality standards in respect of home support packages.

1.25 This interim approach will also provide an opportunity, in the context of the establishment of the HSE, to develop greater clarity around existing levels and types of community and home support service provision. Importantly it will also facilitate further work on assessing the availability of sufficient skilled staff.

1.26 The Group believes that further progress on all these issues is essential before informed decisions can be taken on longer-term policy in this area and approaches to financing it.

Costings of Home Support Packages

1.27 The potential gross cost of home support packages will depend on:

(i) the level of demand/need

(ii) the average cost of a home support package

(iii) the supporting infrastructure of community services, and

(iv) the administrative costs involved

The net cost to the Exchequer will also depend on the level of co-payment from care recipients.

1.28 At present, there is no comprehensive assessment of need for community care services in Ireland. The Group considered different estimates which have been produced examining the need for long-term care services among the older population. These include estimates contained in the Study to Examine the Future Financing of Long-Term Care in Ireland (Mercer 2002), the recent report on Long-Term Care for Older People (OECD 2005) and figures produced by the National Council on Ageing and Older People\(^4\). There is a considerable variation in the figures produced and the actual demand will also depend on the nature of the needs assessment, the level of co-payment decided on and other factors.

1.29 While a costing will only be possible following evaluation of the initial packages proposed and subsequent decision on nature and availability of a mainstreamed package, it is clear that there are potentially very substantial financial implications. Potential responses to meeting these are discussed in paragraphs 1.86-1.96 below.

1.30 The Group believes that the provision of home support packages can only be fully successful when combined with enhancement of the wider infrastructure of community services. The Group has identified in particular housing for older people, home helps and respite care. Identifying the medium and long-term cost of home support packages will need to take account of these wider community services.

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\(^4\) NCAOP, 2005, Submission to the Department of Health and Children on The Long-Term Care Needs of Older People.
1.31 After the evaluation of the initial roll-out of the home support packages, the HSE should be in a position to provide figures for the range, distribution and average cost of caring for older persons in the community.

**Importance of Respite Care**

1.32 Respite is provided by a number of bodies (statutory, private and voluntary), and in different ways, in cash and in kind (public and private). Respite itself can take many different forms and can be respite for the carer, the care recipient or a combination of both. The carer might, for example, go on a holiday and arrange for someone else (on a paid or unpaid basis) to provide care in the care recipient’s home. Alternatives would include the care recipient moving to a respite bed for a certain period in a public or private respite arrangement. This could be on a regular or an ad-hoc basis and would, of course, depend on the availability of respite beds in the local area.

1.33 In addition to this, actual arrangements will depend on the individual preferences of the care recipient and the carer.

1.34 The Group believes that respite care needs to be provided in a more planned and systematic manner. Future provision should also build on the flexibility of the variety of the existing arrangements but ensure delivery to the carer and the care recipient in an efficient and cost effective way. In this regard, the Group noted the positive response to the Respite Care Grant, introduced by the Department of Social and Family Affairs in 1999, and considers that its potential to contribute in a cost-effective way to the achievement of the Government's policy goals in the care area should be examined.

1.35 The Group was aware that different respite arrangements would be required in different circumstances and that these should be established as part of the needs assessment. This should take account of the Respite Care Grant from the Department of Social and Family Affairs where payable and its practical value in the particular household circumstances together with the preferences of those concerned in so far as possible.

1.36 The Group notes that the proposed future policy on the provision of residential care will also have implications for the provision of respite care, including the balance between public and private bed capacity, the method of funding such respite care, and its link to the Respite Care Grant. It proposes that the Department of Health and Children and the HSE should bring forward proposals following progress on residential care policy including the needs analysis of residential care requirements.

**Carer’s Allowance/Benefit**

1.37 The Group noted that 25,700 informal carers are currently in receipt of Carer’s Allowance and Carer’s Benefit, of which approximately 50% are caring for people aged over 65. It has considered the role of these payments relative to the home support packages. It believes that while these payments are based on defined eligibility criteria and provide income support for informal carers, they are an important part of overall State support of care for older people as they enable people to be cared for at home on a full time basis. The Group believes that they should continue as a separate measure to home support packages, which are based on service provision as opposed to income support.

1.38 The Group was aware of arguments put forward for the abolition of the means test for Carer’s Allowance. The Group is of the view that the Allowance should continue to be means tested as it relates to income support and is not a payment for caring. It considers that the level of expenditure involved in such a proposal would be better allocated to the area of home and community-based care. However, there may be potential to enhance Carer’s Allowance as an income support measure within the existing policy framework.

1.39 In the assessment of need to establish the level of dependency of a person, the Group considers that the presence or otherwise of a carer is obviously relevant. While the levels of payment of Carer’s Allowance/Benefit is not relevant to this assessment (as this is the income of the carer), the presence of a carer, which is facilitated by the social welfare payment, is pertinent.

1.40 The Group believes that enhanced recognition and support for informal carers is an important aspect of community-based care and makes a number of proposals in sections 1.41-1.49 below.
Support for Carers

1.41 Informal, usually family-provided, care will remain a cornerstone of long-term care policy. The expansion of home support packages and other community care measures should be seen as a complement to informal care provision.

1.42 The Group noted the Carers Association report, ‘Towards a Family Carers Strategy’\(^5\). As mentioned in Chapter 4, the Report raises issues in the areas of:

- services and supports for family carers;
- carers’ health and social well-being;
- remuneration for carers;
- education and training for carers;
- return-to-work and work-life balance for carers; and
- access to information.

1.43 The Group noted that informal care is not provided exclusively to older people.

1.44 The Group acknowledges that the Carer’s Allowance, Carer’s Benefit and Respite Care Grant payments from the Department of Social and Family Affairs are part of the infrastructure for supporting informal carers.

1.45 The Group also notes initiatives in the area of training and education which are beneficial to carers who wish to re-enter the workforce when their caring responsibilities have finished.

1.46 FÁS, in recognition of the need to provide flexible and easily accessible training and employment services, particularly to women who wish to return to work after an extended absence, developed the Expanding the Workforce (ETW) process. This process offers a gateway, in particular, for women wishing to return to the labour market, providing interventions suited to the needs of the individual and offers on-the-job training.

1.47 With regard to training in the skills required by informal carers to enhance their ability to provide personal and social care, a number of voluntary groups representing the interests of family and informal carers provide training in caring skills for their members. The HSE funds such voluntary groups to provide training on their behalf but acknowledge that this is done on an ad-hoc basis from area to area.

1.48 In particular, the Group proposes that:

- enhanced support and recognition of the role of carers should form part of the development and implementation of policy for long-term care.

- training for carers, both during their caring role and after their caring responsibilities have ceased, should be supported. In particular, a more unified and co-ordinated approach to training informal carers in the skills required to provide care should be adopted.

- respite services should be provided in a manner to maximise support and certainty for carers.

- the needs of informal carers should be taken into account within the needs assessment process.

1.49 The Group proposes that future policy on these and related issues should be informed by structured consultation, on a cross-departmental basis, with carer representative organisations.

Housing

1.50 A range of grant schemes (Essential Repairs Grant, Scheme for Special Housing Aid for the Elderly, Disabled Persons Grant) assist older people to remain at home through improvements to their dwellings. Support from these programmes should be integrated, as far as possible, with home support packages, through liaison and protocols at local level.

1.51 The Group welcomes the current review of these Schemes being carried out by the Department of the Environment, Heritage and Local Government and believes that this is an opportunity to ensure these supports are effectively channelled to those most in need and that the application and payment process is as streamlined as possible.

1.52 The Group believes that the provision of sheltered housing can play a significant role in allowing older people to remain in the community. The voluntary sector, supported through the Capital Assistance Scheme, already plays an important role, and has the potential to do even more in the future. However, it is essential to ensure that the ongoing care element of such provision is addressed at the same time as the construction element. This will require a structured approach by the HSE to deciding on and providing ongoing support for care services in sheltered housing settings.

1.53 The Group also notes that the increase in house values should provide scope for innovative solutions to funding community/voluntary accommodation for older people, with potential roles also for private and State provision. Likewise, the potential to facilitate older people who wish to “downsize” into more suitable private accommodation should be explored.

1.54 The Group believes that the key to accelerating progress in this area is improved institutional structures at national and local level. It therefore proposes:

- the establishment of a cross-departmental team comprising the Department of the Environment, Heritage and Local Government, the Department of Health and Children and the Health Service Executive. This team should liaise directly with voluntary housing representatives to develop and oversee detailed policy in this area.

- that the cross-departmental team should, as a priority, agree on local structures and protocols for integrated management and delivery of housing requirements and the provision of care. This should include appropriate links with assessments of need carried out by the HSE.

Residential Care

1.55 The most recent data available from the HSE indicates that in 2004, there are almost 19,500 people were in residential long-term care in Ireland representing 4.3% of the over 65 population. Of these, approximately 30% are classified as low or medium dependency suggesting significant scope to reduce the current level of residential care with enhanced community-based services.

1.56 Mercer estimated that the rate of occupancy of residential beds for over 65s could increase to 5.4% by 2051, in line with the increasing share of over 80s.

1.57 However, having reviewed the most up-to-date data available and recent OECD research, and pending the outcome of the bed needs analysis referred to in paragraph 1.59 below, the Group considers that a target residential occupancy rate of 4% may be achievable in the medium term, if the correct policy mix is implemented, particularly in regard to significant community-based supports, including respite care.

1.58 As the OECD itself points out, however, international data are not always wholly comparable. This estimate must, therefore, be treated with caution in advance of the proposed assessment by the HSE set out below.

1.59 An up-to-date needs analysis of residential care requirements, including respite care beds, should be carried out by the HSE in conjunction with the Department of Health and Children. An assessment was carried out 5 years ago by the Health Boards and an up-to-date review should take account of recent developments such as home support packages which may form a significant alternative to residential care, the growth in private sector capacity and the geographic spread of needs and supply. It should also be informed by the 4% medium-term target suggested by the Group. This exercise should be completed within 6 months and cover residential needs of the older people only.

1.60 A related issue is the need for, and availability of, high or maximum dependency beds within overall levels. While the Group’s analysis suggests there should be an adequate supply of nursing home beds to meet current need, there is some evidence of a shortage of high-dependency beds. It is essential that the analysis above cover this aspect.
1.61 Even a 4% residential occupancy rate has very significant cost implications and an initial assessment of these based on certain assumptions is outlined in Chapter 7. In summary, if 4% of people over 65 require residential care the total estimated cost would increase from €0.9 billion (0.6% GNP) in 2005 to €6.8 billion (1.8% GNP) in 2051. Alternatively, at a 4.6% figure, the cost would be €7.9 billion (2.0% GNP) in 2051, while the Mercer estimate of 5.4% implies a cost of €9.2 billion (2.4% GNP) in 2051. The Exchequer commitment arising from this would depend on the size of the co-payment contributed by individual recipients, as discussed below.

1.62 Residential care is currently provided by a combination of private and public facilities, with a range of factors determining the level of financial contribution required by the older person or their family.

1.63 The Group proposes that the following principles should inform a new policy approach to residential long-term care:

- a national standardised needs assessment should determine whether a person has a sufficiently high level of dependency to require residential care (i.e. that community-based care is not appropriate)

- a financial assessment would be carried out according to a national standard to determine the level of co-payment appropriate

- the co-payment assessment should be indifferent as to whether that care is provided in a public or private facility

- the co-payment assessment would take account of assets, including housing owned by the person.

1.64 Significant legislative change will be required to implement these reforms and this should be prioritised with a target of publication in 2006. These reforms will need to be consistent with the outcome of the wider review of eligibility issues in the health sector currently in progress. Transitional arrangements may also be required to take account of any implications for people in residential care when the reforms are introduced.

1.65 The Group notes that the capital tax relief on nursing home construction is currently under review and has asked that the proposals arising in that context take account of the policy direction in this report, which inevitably will take some time to implement.

Co-Payment

1.66 The Group proposes the following principles in relation to cost-sharing between the State and individuals:

- access to services should, in the first instance, be based on a national standard assessment of care needs

- once access/need for services has been established, the cost should be shared by the State and the individual. The level of each individual’s co-payment should be based on ability to pay, as determined by a standard financial assessment

- this assessment should take into account his/her private income and also imputed income from assets (including their primary residence)

- an equity release type facility should be available to facilitate co-payments to be met from the value of the asset, while the care recipient would retain use of the asset during their lifetime, if that were the person’s choice.

1.67 Further issues requiring decision are:

- whether depletion of the full value of the primary residence should be required or if the assessment of financial means should exempt a certain amount of the value of the primary residence
whether there should be an element of cost-sharing between the State and the individual in all cases. This would mean that all those in need of care would receive some minimum level of support from the State, regardless of their financial means.

1.68 The Group recommends a detailed design and costing exercise to operationalise the principles set out in paragraph 1.66. There are a number of issues which require consideration as part of this process including what level of co-payment is required. For example, one option might be to extend the principle which currently underpins the approach to public residential beds of paying up to 80% of the Non-Contributory Old Age Pension. Under this approach, the care recipient might be required to contribute 80% of their assessed income towards the cost of care. However, a range of other approaches and levels of contribution will also need to be considered.

1.69 A related issue is the management of the proposed co-payment system. The State could take an implicit or explicit view of the reasonable cost of a nursing home bed based on an analysis of costings, taking account of regional variations and levels of dependency. The question then is the mechanism through which the State could channel whatever the appropriate level of financial support is assessed to be, following the co-payment assessment procedure. One option would be for the State to source beds in the first instance (whether from private or public providers), allocate them to persons assessed as needing residential care and recoup the appropriate co-payment from the individual.

1.70 Alternatively, the State could, having satisfied itself that residential care is necessary for the individual in question, and having conducted the financial assessment to ascertain the appropriate share of the cost to be borne by each of the State and the individual in each case, pay its contribution directly to the individual as a subvention which, when supplemented by the recipient’s co-payment, would allow the recipient to purchase care directly from approved nursing homes (including publicly owned ones).

1.71 The Group did acknowledge a concern about the impact on market dynamics of taking such an implicit or explicit view of nursing home bed costs and the need to avoid creating upward pressure on prices. This issue will need further consideration.

Equity Release

1.72 As noted in chapter 8, the value of housing stock owned by people aged 65 and over can be tentatively estimated at between €70 and €85 billion. Given that the average length of stay in residential care for people entering over 65 years is two years for men and three years for women, it is reasonable to conclude that there is considerable scope for people receiving care to fund their contribution from these assets without fully depleting the value of those assets.

1.73 The Group has recommended (1.66 above) that, as part of the financial assessment, an income should be imputed against the value of housing assets. Recognising the illiquid nature of housing assets, the Group accepts that it may be difficult for some people to meet the co-payment arising from housing assets, in particular, from current income. Accordingly, the Group believes that an equity release-type mechanism would be needed to facilitate a care recipient in meeting their co-payments from the value of a housing asset while retaining ownership and use of the asset during their lifetime.

1.74 It is important to emphasise that a scheme of this nature would be intended to facilitate care recipients in meeting their co-payment obligations. It would, of course, be open to any person to make their co-payment on a pay-as-you-go basis if they so wish.

1.75 Such a facility could involve receipt of payments on an on-going basis, through an arrangement between the care recipient and a private sector financial institution. Alternatively, co-payments could be rolled-up against the value of the asset and payment made posthumously.

1.76 A number of significant policy, legal and design issues need to be explored before schemes of this nature could be introduced, including the appropriate role of the State in relation to products of this type offered by the private sector.

Short-term Measures

1.77 The proposals set out above by the Group will require further consideration and consultation given their far-reaching implications. In the short-term however, the Group notes that it is proposed to revise the eligibility thresholds for nursing home subventions to reflect house price
increases taking account of regional variations in house prices. This can be carried out by regulations under existing legislation.

1.78 These changes will help to alleviate some of the immediate difficulties faced by people in funding long-term care under existing arrangements, in advance of decisions made on implementation of the more fundamental reforms proposed in this report. However, they should not form a precedent for the purpose of setting thresholds under the proposed new system.

**Regulation of Nursing Homes**

1.79 Legislation is currently being drafted to establish the Social Services Inspectorate function on a statutory basis as part of the Health Information and Quality Authority. Its functions will include monitoring standards, registering and carrying out inspections in respect of services for older people. Registration procedures will be extended to cover HSE - provided services as well as services provided on behalf of the HSE and private nursing homes. Subject to Government approval, it is intended to publish Heads of the Bill for consultation in early 2006.

1.80 It is envisaged that the most appropriate approach to ensuring quality standards in respect of home support services will be considered as part of the evaluation of the initial increment of home support packages set out at paragraph 1.24 above.

**Medical Expenses Relief**

1.81 Tax relief is currently available at the marginal rate, through the medical expenses tax relief scheme, for spending on approved nursing home charges. In the context of Government policy to maximise community-based, as opposed to residential care there is an argument that consideration be given to extending the basis on which relief for home-based nursing services is available.

1.82 However, if the Group’s wider proposals for a structured system of co-payments, covering both community and residential services and based on an assessment of financial means, are accepted, the operation of any such tax-reliefs would need careful consideration.

**Skills Availability**

1.83 Going forward, any policy decisions on the future roll-out of home support packages must be accompanied by an assessment of the availability of sufficient skilled staff, both to deliver further home support packages and to provide the required supporting community services. This issue must also be considered in the context of ongoing service expansion in other areas such as disability, as well as the requirements of the residential services sector. The Group noted that "staff shortages and staff qualifications are the number one concern of long-term care policy makers in OECD countries". Consideration must also be given to the level of capacity amongst private sector providers.

1.84 A recent FÁS Healthcare Skills Monitoring Report\(^6\) on future manpower requirements suggests that a combination of expanded training capacity and international recruitment will be able to meet demands in therapy grades, in the short/medium term. That Study did not have any reference to training and manpower needs for additional home support packages on the basis proposed in this report. The Group believes, therefore, that a more detailed planning exercise should be carried out by an inter-agency project team led by the Department of Health and Children to consider the full range of staffing requirements in relation to the care of older people, including in relation to the availability of care assistants.

1.85 In relation to therapy services, the initial expansion of home support packages will allow for flexibility between direct public provision and use of private sector providers. In the medium term, the balance of provision between publicly employed staff and the private sector will need to take account of cost-effectiveness and the evaluation will also need to have regard to this issue.

**Financing**

1.86 The provision of services to meet the long-term care needs of older people will have substantial financial costs in the years ahead. Demographic factors will also generate pressure on the public finances in the health and social welfare areas. Financing these services requires good

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economic performance, which in turn requires maintenance of budget sustainability and competitiveness. In addition, long-term care services are labour intensive and must, therefore, be viewed in the context of public service pay pressures.

1.87 The scale of cost falling on the Exchequer will depend on a number of factors:

- decisions taken following the proposed evaluation of home support packages in relation to their wider availability
- the nature and extent of co-payments required for residential and home support packages.

1.88 In relation to residential care, the Group has made an assessment of additional cost implications going forward. As stated in paragraph 1.61 above, total spend (public plus private) on residential care for the over 65s is projected to increase from €0.9 billion (0.6% GNP) in 2005 to between €6.8 billion (1.8% GNP) and €9.2 billion (2.4% GNP) in 2051, depending on the residential occupancy rate assumptions used. The extent of the financing burden which falls on the State will depend on the level of co-payment which is contributed by care recipients. In that regard, taking public and private facilities together, private individuals currently contribute some one-third of gross costs (albeit weighted towards residents of private homes) with the State meeting the balance of costs either through its direct provision of public beds or through the Nursing Home Subvention Scheme.

1.89 It is important to note that this only covers the residential costs. In the absence of firm data on the nature and level of costs in relation to community care, it was not possible to provide an evidence-based estimate of the cost of community care (including home support packages).

1.90 The Group believes that a firm estimate of the costs of community care will be required, following the initial phase of home support packages and related work identified in this report, to allow for decisions on the financing issues detailed below. Equally, a decision on a more universal roll-out of a home support model will be dependent on identifying a sustainable financing approach.

1.91 It is clear that a substantial burden will fall on the Exchequer. The Group considered a range of options and approaches to meeting these costs and these are summarised in chapter 8.

1.92 Given the scale of these costs, the Group considers that a substantial level of co-payments will be central to a sustainable approach to financing long-term care.

1.93 The Group believes that given the substantial costs arising in the medium and long-term, and related costs of ageing in areas of acute medical care and pensions, additional sources of funding beyond existing taxation sources may require consideration.

1.94 In relation to options for a social insurance type model, the Group agreed that while there would be merit in a risk-sharing approach, there are a number of difficulties including the complexity of integrating it with the Exchequer-based financing of existing health services. The social insurance model also implies an entitlement to a specific benefit arising from certain contingencies. However, while acknowledging these issues, the Group believes it warrants further consideration.

1.95 The option of pre-funding some of these costs also warrants consideration, although any decision in this regard could only be taken in the context of wider discussions on pre-funding of the costs of ageing.

1.96 Decisions on these aspects will require more accurate costings about the future level of demands on the Exchequer which should be available following progression of work on the issues outlined above.

### Implementation

1.97 The Group has proposed a very substantial programme of work to deliver improvements in the short-term and to ensure a sound basis for policy and services over the longer-term. The following table summarises the key actions arising from proposals in this report.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of additional increment of home</td>
<td>HSE</td>
<td>During 2006 and</td>
</tr>
<tr>
<td>support packages</td>
<td></td>
<td>2007</td>
</tr>
<tr>
<td>Activity Description</td>
<td>Responsible Department(s)</td>
<td>Timeline</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Formal evaluation of this additional increment of packages</td>
<td>Steering Committee, led by D/H&amp;C, to be established.</td>
<td>To be completed by mid 2007</td>
</tr>
<tr>
<td>Development of national standardised care needs assessment framework</td>
<td>HSE</td>
<td>Mid 2006</td>
</tr>
<tr>
<td>Development of national standard financial assessment framework</td>
<td>D/H&amp;C, D/SFA and D/Finance</td>
<td>Mid 2006</td>
</tr>
<tr>
<td>Development of formal protocols for case management and delivery of hsupport packages on a national basis</td>
<td>HSE</td>
<td>Mid 2006</td>
</tr>
<tr>
<td>Development of structured consultation, on a cross-departmental basis with carer representative organisations</td>
<td>D/H&amp;C, D/SFA, D/EHLG and other Departments as appropriate</td>
<td>Beginning in 2006</td>
</tr>
<tr>
<td>Establishment of a cross-departmental team to develop and oversee policy in relation to sheltered housing for older people and agree, as a priority, local structures and protocols for integrated management and delivery of housing and related care services</td>
<td>D/EHLG, D/H&amp;C and the HSE</td>
<td>Early 2006</td>
</tr>
<tr>
<td>Needs analysis of residential care requirements, including respite care beds to be undertaken</td>
<td>D/H&amp;C and HSE</td>
<td>2006</td>
</tr>
<tr>
<td>Publication of Heads of Bill to establish the Health Information and Quality Authority</td>
<td>D/H&amp;C</td>
<td>Early 2006</td>
</tr>
<tr>
<td>Planning exercise on staffing requirements</td>
<td>Inter-agency project team led by D/H&amp;C</td>
<td>End 2006</td>
</tr>
<tr>
<td>Design and costing exercise to operationalise principles on co-payment</td>
<td>D/H&amp;C, D/SFA and D/Finance</td>
<td>2006</td>
</tr>
</tbody>
</table>

1.98 It is suggested that this Group should continue to meet on a periodic basis and report back to the Cabinet Committee on Health regarding progress on implementation of the recommendations in this report.
2. INTRODUCTION

2.1 In June 2003 the Ministers for Health and Children and Social and Family Affairs jointly published two reports.

2.2 The first report, the “Review of the Nursing Home Subvention Scheme” was commissioned by the Department of Health and Children and was carried out by Dr. Eamon O’Shea, NUI Galway. The Report examines the effectiveness of the Nursing Home Subvention Scheme and provides a detailed analysis of the problems associated with the scheme.

2.3 The second report was the “Study to Examine the Future Financing of Long-Term Care in Ireland”. This report was commissioned by the Department of Social and Family Affairs and was carried out by Mercer Ltd. The report examined issues relating to the need for long-term care, needs assessment, benefit design, financing, partnership options and pre-funding.

2.4 In addition, “Quality and Fairness - A Health System for You” stated that policy proposals would be prepared following publication of the Mercer Report and that funding options to meet the cost of care would be outlined for public debate prior to preparation of legislation.

2.5 Sustaining Progress also included a commitment that a Working Group, including relevant interests, would be established to examine the strategic policy, cost and service delivery issues associated with the care of older people.

2.6 In order to make progress on these commitments, the Department of Social and Family Affairs prepared a consultation document based on the specific issues and recommendations in the Mercer Report. This document was circulated to over 70 interested parties and the feedback was then compiled.

2.7 In January 2005 the Tánaiste and the Minister for Social and Family Affairs set up the Long-Term Care Working Group. This Working Group was chaired by the Department of the Taoiseach and comprised senior officials from the Departments of Finance, Health and Children and Social and Family Affairs. The membership of the Group is listed at Appendix 1.

Terms of Reference

2.8 The terms of reference for the Group were as follows:

- Taking account of the proposals in the Mercer and O’Shea Reports to:
  - identify the policy options for a financially sustainable system of long-term care; and
  - rationalise the range of benefits, services and grants (both statutory and non-statutory) currently in place, and address associated issues.

2.9 The Group met on 16 occasions and reported its findings in November, 2005.

2.10 In addition to the reports referenced above, the Group considered a range of other relevant reports and submissions including:

- Consultation on Mercer’s Study to Examine the Future Financing of Long-Term Care in Ireland, undertaken by the Department of Social and Family Affairs in 2004.

- Attitudes towards Funding of Long-Term Care of the Elderly, ESRI (to be published in early 2006)

- Evaluation of Homecare Grant Schemes in the NAHB and ECAHB, Dr. Virpi Timonen, Department of Social Studies, Trinity College Dublin, June 2004
Submission to the Department of Health and Children on the Financing of Long-Term Care of Older People, National Council on Ageing and Older People, 28th April 2005.


Long-Term Care for Older People, OECD, 2005

Draft Report by the National Economic and Social Forum on Care for Older People, 2005.


The Group also consulted with a number of organisations including the Department of the Environment, Heritage and Local Government and the Health Service Executive.

**Budget 2006**

2.11 This report was prepared in advance of Budget 2006 and it has not been updated to incorporate announcements in the Budget. However several initiatives in the Budget are consistent with the recommendations of the report, including:

- Expansion of Home Care Packages
- Increased funding for Home Help Service
- Revised Nursing Home Subvention Eligibility Thresholds
- Increased level of Respite Care Grant
- Increased funding to support sheltered housing
- Improvements in Carer’s Allowance and Carer’s Benefit Schemes

Further details on these measures are included at Appendix 2.

**Scope**

2.12 The focus of the Group was on policy issues relating to older people, and in particular, identifying and addressing issues in relation to those aged over 65 in need of care. The focus was on personal care and certain related services but excludes general medical services. Issues relating to the care needs of people with disabilities are being considered separately in the context of the Disability Strategy.¹¹

¹¹ Department of Justice, Equality & Law Reform, 2004, National Disability Strategy
3. BACKGROUND

3.1 The Group’s work is informed by the challenges posed by demographic and social trends. In this regard, the Group reviewed the projections provided by Mercer, updated to take account of the latest CSO population projections and work done for the recent National Pensions Review (NPR)\(^\text{12}\), undertaken by the Pensions Board.

An Ageing Population

3.2 In 2006, it is estimated there will be 463,774 people aged 65 years and over. Latest population projections prepared for the National Pensions Review suggest that this figure will increase to 1,105,044 by 2036. This represents a 138% increase in the number of people over 65 over a 30 year period. The percentage of the total population comprising older people is also set to increase from 11% in 2006 to approximately 22% in 2036 and 29% in 2056.

There will be an even larger proportional increase in the numbers of those aged 85 and over. In 2006, there are 46,702 people aged 85 and over. This is set to increase to 305,112 by 2056 – an almost 7-fold increase. It is in this age group that the greatest need for long-term care can be expected.

Trends in Demand for Long-Term Care

3.3 The old age dependency ratio measures the number of working age people that support every person in the old age population (defined as the population aged 20 to 64 divided by the population over age 65). Reflecting the projected increases in the number of older people over the coming decades, the old age dependency ratio is predicted to fall from its current level of 5.5 working age adults for every older person to 2.6 in 2036 and eventually to 1.7 in 2056. Expressed differently, over 65’s as a percentage of the total working age population is projected to increase from 18% in 2006, to 39% in 2036 and 60% in 2056. Even allowing for some changes in the young age dependency ratio (those aged 0-19 years as a proportion of those aged 20-64) the net effect will be a fall in the overall dependency ratio (young and old age dependency ratio) from just 1.5 in 2006 to 1.3 in 2036 and to 1.0 in 2056.

3.4 Two factors will affect the level of need for long-term care.

− The age structure of the population in future years.

− The proportion of the population in each age group with a disability, both now and into the future.

3.5 The Mercer Report used disability prevalence rates from a UK survey carried out in the mid-1980s and modified them for use on the Irish population\(^\text{13}\). The report distinguishes between three levels of care requirement:

− Moderate: less than daily (estimated at 10.5 hours per week).

− High: Significant daily care (estimated at 21 hours per week).

− Continuous: Continuous care (estimated at 42 hours per week).

\(^{12}\) National Pensions Review: Report by The Pensions Board to Seamus Brennan T.D., Minister for Social and Family Affairs, October 2005

\(^{13}\) Mercer, 2002, Study to Examine the Future Financing of Long-Term Care in Ireland, pages 66-68.
The table below updates the projections in Mercer to take account of population change.

Table 3: Projected numbers needing long-term care – age 65 and over

<table>
<thead>
<tr>
<th></th>
<th>Moderate</th>
<th>High</th>
<th>Continuous</th>
<th>Total</th>
<th>High/Continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>35,900</td>
<td>15,300</td>
<td>33,500</td>
<td>84,700</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>41,700</td>
<td>18,000</td>
<td>40,200</td>
<td>99,900</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>53,900</td>
<td>23,200</td>
<td>52,100</td>
<td>129,200</td>
<td></td>
</tr>
<tr>
<td>2032</td>
<td>72,100</td>
<td>31,900</td>
<td>73,200</td>
<td>177,200</td>
<td></td>
</tr>
<tr>
<td>2042</td>
<td>97,500</td>
<td>44,000</td>
<td>103,400</td>
<td>244,900</td>
<td></td>
</tr>
<tr>
<td>2052</td>
<td>121,900</td>
<td>55,600</td>
<td>132,400</td>
<td>309,900</td>
<td></td>
</tr>
</tbody>
</table>

Accordingly, it is projected that, by 2032 almost 2.1 times more people aged 65 and over will require some level of long-term care i.e. an increase from a total of 84,700 to 177,200. By 2052, it is projected that this number will increase to 309,900.

These projected numbers are significantly higher than previously estimated in the Mercer report (e.g. the number of persons aged 65 and over needing long-term care was 203,300 in 2051 in the Mercer central scenario). This is due in large part to the fact that the overall size of the population is much higher in the revised population projections.

It is of course questionable to use the same disability prevalence rates as before in conjunction with quite significantly different population projections, as the factors underlying the changes to the population projections e.g. higher immigration, lower mortality rates would be expected to impact on disability prevalence also. However, it would be a much larger and highly technical exercise to review the disability prevalence rates used in Mercer and outside the scope of this review.

Other Factors Affecting the Demand for Long-Term Care

There are a number of other factors which impact on the demand for formal care services and the ability of individuals to pay for such services where they are needed. These include the following:

Pensions Coverage:

As the major source of income for most older people, pension arrangements will have an impact on their ability to pay for long-term care. As women make up the majority of the very old population (in 2006, women made up approximately 69% of those aged 85 to 94 and 81% of those aged 95 and over), pensions coverage for women will be particularly important.

Availability of Family Carers:

In Ireland as in most other countries, the family has a critical role in providing long-term care. Irish families are getting smaller, more women are joining or remaining in the labour force and marriage breakdown rates are increasing. The availability of informal carers (relative to the number of people in need of care) is, therefore, likely to reduce into the future albeit that family friendly working patterns may ameliorate the trend to some extent.

Expectations:

The needs, expectations and preferences of future generations of older people may be very different to those of older people today. According to Mercer, the following factors will impact on the kind of long-term care that people will want:

− Future generations with long-term care needs will come from the “consumer society” and may have higher expectations for their care provision as a result.
− They will also, on average, have a higher level of educational attainment and have experienced greater economic prosperity.
− Older people will form a much greater proportion of the population than at present. This in itself will give rise to attitudinal changes.
International Developments

3.13 Most developed countries face similar issues as a result of an ageing population and this has moved the issue of long-term care onto the front line of policy debate in many countries. The majority of long-term care is still provided informally, by family and friends. In terms of State provision, most countries have been attempting to shift the focus from residential to home care. This is in recognition of the fact that care in the home is often better for the recipient and is usually the preferred option of those who need care. A common theme internationally is the need for better co-ordination between agencies with responsibility for health and social care.

3.14 As regards financing, most countries traditionally had only limited public coverage. There is a growing acceptance, however, of the need for greater State involvement. Countries that fund healthcare through general taxation have tended to fund long-term care in the same way. There is a broad consensus that long-term care financing schemes should cover the cost of care but not the living and accommodation costs associated with care in a residential setting.

3.15 The recent OECD report on Care of Older People\(^{14}\) in a number of selected countries describes the new developments taking place. Amongst the key issues mentioned are:

- There are favourable disability trends in regard to older people due to higher incomes, better housing standards etc.
- Home care is increasingly used as a lower cost alternative to care in institutions.
- However, OECD cautions against overly ambitious expectations of cost reductions arising from more use of home care.
- Two critical lessons for the proper use of home care are the involvement of general practitioners and a single point of entry for families who wish to avail of home care packages.
- In Sweden and the UK home care packages are increasingly focused on people with the highest level of disability. In England this is against a background of reduced nursing home beds.
- Most schemes internationally rely on informal carers to be successful. Families are providing more services even with the provision of home care packages.
- Respite care is regarded as very important whether it is day care or short term residential care.
- To support home care, it is necessary to provide respite care, training and counselling.

Conclusions

3.16 It is clear that these demographic trends alone will increase the need for services, and therefore increase the cost of caring for older people in coming decades. However, the Group noted a number of other relevant factors which make predictions about demand for long-term care difficult. These include:

- the number of people requiring long-term care is also determined by disability prevalence rates and the recent OECD report on the Care of Older People suggests that there are favourable disability trends with regard to older people internationally;

- social trends, particularly higher female labour force participation, will impact on availability of informal care;

- on the basis of the Mercer projections, there is a disparity between estimated current need (in 2006) and existing level of public service provision; while this may in part be unmet need, it may also reflect needs being met through informal care or otherwise.

3.17 Drawing on the Mercer report, which used UK disability prevalence rates, it can be projected that the number requiring some form of care will increase from 84,700 in 2002 to 177,200 in 2032. The assumed reductions in disability prevalence rates used by Mercer are set out in Appendix 7. However, as with all projections these must be treated with caution in the light of underlying assumptions and, as Mercer say, it is important to be aware of the wide “funnel of doubt” as to future needs.

3.18 In addition to demographic trends, increasing expectations about the quality and certainty of care provision appropriate to a modern society add pressure for significant reform and investment in the years ahead.

\(^{14}\) The OECD Health Project, Long-term Care for Older People, OECD 2005.
3.19 It is important to note that the cost of long-term care is only one of the implications of demographic trends. Wider implications, for example in relation to the cost of acute medical care and pensions, have not been considered by this Group. Similarly, there will be continuous pressure for service improvements in other areas of expenditure.
4. FAMILY CARE

**Introduction**

4.1 The Mercer study acknowledges that the role of the family in providing long-term care is an issue on which there are substantially divergent views. At one extreme is the view that families do not have any responsibility to provide long-term care and that comprehensive services should be provided by the State. At the other end of the spectrum is the view that the family has the primary responsibility for care and that the State should only provide care for those without support.

4.2 The Group believes that the role of the family in providing long-term care is central to future provision for older people. To date, there is no evidence of a reduced commitment to family caring in Ireland. However, the availability of informal carers (relative to the number of people in need of care) is likely to reduce, due both to demographic changes and increasing female labour force participation rates, albeit that family friendly work arrangements may ameliorate this to some extent. Mercer estimates that the impact of increased labour force participation could reduce the availability of future informal care by around 15% over the next 10 years.

**Consultation on Mercer Study**

4.3 Following the publication of the Mercer study, the Department of Social and Family Affairs consulted with over 70 interested parties, including:
- the Joint Oireachtas Committees on Health and Children and on Social and Family Affairs,
- health boards,
- interest groups and
- the social partners.

4.4 The aim of the consultation process was to focus these parties on the specific complex issues to be addressed in the policy development process. These include benefit design, delivery, cost and financing, which are discussed at length in the Mercer study.

**General Views**

4.5 There was general agreement across all groups and organisations that the present balance of responsibility for care needed to change and that people themselves, families and the State all have responsibilities in this regard. These views are set out in more detail below in order to give a flavour of the debate.

**Carer’s Representative Groups**

4.6 The main thrust of the submissions from the carers’ groups was that, at present, families receive very little support in providing care and that funding is largely biased in favour of residential care. They agree that, while the family should be able to choose if they wish to care for a family member in the home with supports or in a residential facility, the State should support family carers and maintain people in their homes where this is the preferred choice. The submissions received all referred to difficulties in balancing work, family and caring responsibilities and state that issues in this regard must be addressed.

**Groups Representing Older People**

4.7 Groups representing older people generally agree that the balance of responsibility between the person in need of care, their family and the State must change. They believe that the State must take greater responsibility in the provision of care and reinforce and support care being provided by family carers.

4.8 One particular group commented that every person has a responsibility to provide for their own future and further stated that the State, too, has responsibility in this area as it has levied taxes on people in order to maintain a reasonable level of care for every person in the State.

**ESRI Survey**

4.9 In 2004, the Department of Social and Family Affairs commissioned the ESRI to carry out a survey of some 2,000 people to examine the general public’s views and attitudes on how older
people should be cared for\textsuperscript{15}. In particular, the survey considered attitudes and views among the general public on who should fund the long-term care of older people. The principal issue discussed involved whether or not the funding of care should be the responsibility of the older person in question or his/her family on the one hand or the State on the other. In general, the results indicate that:

\begin{itemize}
  \item The overwhelming majority of the adult population (81\%) consider it very important to remain at home for as long as possible in the event of requiring long-term care.
  \item Just less than one half of the adult population (48.6\%) indicated that their first preference for receipt of long-term care would be at home from family or friends. A further 28\% indicate that they would prefer to be able to pay someone to provide the care at home. Delivery of the care by the Health Service Executive is the preferred choice of 17\% of respondents with only 5\% opting to have the care provided in a nursing home.
  \item Only 3\% of adults felt that the family should pay in full while the majority (55\%) felt long-term care needs should be co-funded by family and State. The remaining 42\% felt they should be met in full by the State.
  \item In general, a preference for shared funding was more characteristic of younger persons, those with higher levels of educational attainment and in higher income quantiles as well as among those who have no current caring responsibilities. In contrast, older persons and those in lower income and educational categories have a much higher tendency to favour State participation in funding long-term care of older people.
  \item Adults generally saw an increasing role for comprehensive State involvement in funding care in situations of increasing dependency or need. Consequently, approximately one-third of the population indicated that they felt the State should bear the full responsibility for payment of care needs in situations where the care in question was relatively low-level (where the older person needs assistance with getting up and going to bed or where the older person gets confused and needs to be checked on several times a day to make sure he or she is safe and well). Just under 54\% advocated full or comprehensive State funding in the context of an older person in need of intensive assistance, for example, among those who are living in a specially adapted flat and who are permanently in a wheelchair.
  \item In all cases where State support is advocated (either on an exclusive or co-funding basis) very substantial proportions of adults record themselves to be in favour of provision on a means-tested basis. In scenarios which represent less intensive care needs, approximately 40\% who feel that the State should pay in full feel that the assistance should be means tested. Where care requirements are more intensive, almost 70\% of that group feels that assistance should be universally available, regardless of means.
\end{itemize}

**Income Support Payments for Informal/Family Carers**

4.10 The range of relevant supports provided by the Department of Social and Family Affairs are considered in Chapter 5 and set out in Appendix 4.

**A National Family Carers Strategy**

4.11 The Carer’s Association, a voluntary group representing family carers, published a policy document entitled ‘Towards a Family Carers Strategy’\textsuperscript{16} in April 2005. The Strategy deals with issues of interest to carers under a number of headings, as follows:

\begin{itemize}
  \item the provision of services and supports for family carers;
  \item carers’ health and social well-being;
  \item remuneration for carers;
  \item education and training for carers;
  \item return-to-work and work-life balance for carers; and
  \item access to information.
\end{itemize}

4.12 The aim of the Strategy is to achieve recognition for the economic and social importance of family care and obtain the necessary supports to enable it to remain sustainable. The Association calls

\textsuperscript{15}Williams, Hughes and Blackwell, 2005, Attitudes Towards Funding of Long-Term Care of the Elderly.

\textsuperscript{16}The Carers Association, 2005, Towards a Family Carers Strategy.
for a co-coordinated inter-departmental and inter-sectoral partnership approach to implementing the Strategy.

4.13 The Strategy sets out a number of objectives and actions, which have been considered by the Working Group, for instance:

− The Association advocates the provision of an adequate range of services and appropriate supports to encourage and help sustain family carers in their roles. They envisage this being done through the implementation of a needs assessment for carers and the appointment of key workers to put a package of support in place. They also call for increased home care and day care supports as well as increased and more flexible respite services.

− The Association points out the need for appropriate equipment and home adaptations and a more developed information service on all aspects of caring.

− The provision of training courses to enhance caring skills as well as training to assist carers in returning to work when their caring commitments have ended are further priorities in the Strategy.

− The Strategy raises the issue of tax credits and their role in providing income support for carers who must reduce their working hours or leave the workforce completely to provide care.

4.14 The issues raised in this chapter provide some of the overall context for the Working Group’s discussions and are revisited later in the report.

Consultation with Carers

4.15 The Group recognises the need for structured consultation, on a cross-departmental, basis with carer representative groups in order to exchange information and inform ongoing policy development.
5. COMMUNITY BASED CARE

5.1 Existing Services

A considerable range of benefits and service are currently provided by Departments and Agencies and these are summarised in Appendices 3-6. The following table illustrates the range of providers and some of the key services/benefits provided:

Table 4: Key Benefits, services and providers for care recipients and carers

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service/Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Children/HSE</td>
<td>Home Help Services</td>
</tr>
<tr>
<td></td>
<td>Day Care</td>
</tr>
<tr>
<td></td>
<td>Meals on Wheels</td>
</tr>
<tr>
<td></td>
<td>Home Support Packages</td>
</tr>
<tr>
<td>Department of Social and Family Affairs</td>
<td>Carer’s Allowance</td>
</tr>
<tr>
<td></td>
<td>Carer’s Benefit</td>
</tr>
<tr>
<td></td>
<td>Respite Care Grant</td>
</tr>
<tr>
<td>Department of the Environment, Heritage and Local Government</td>
<td>Essential Repairs Grant Scheme</td>
</tr>
<tr>
<td></td>
<td>Disabled Person’s Grant Scheme</td>
</tr>
<tr>
<td></td>
<td>Voluntary Housing Capital Assistance Scheme</td>
</tr>
<tr>
<td></td>
<td>Special Housing Aid for the Elderly</td>
</tr>
<tr>
<td>Department of Finance/ Revenue Commissioners</td>
<td>Employment of a Carer Allowance</td>
</tr>
<tr>
<td></td>
<td>Home Carers Tax Credit</td>
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<tr>
<td></td>
<td>Dependent Relative Tax Credit</td>
</tr>
<tr>
<td></td>
<td>VAT Reliefs on aids and appliances</td>
</tr>
</tbody>
</table>

5.2 Arising from its consideration of the existing range of services, the Group believes that there should be a more integrated approach to service planning in order to guarantee the most efficient use of resources and to deliver the optimum level of service to each care recipient.

5.3 The Group considers, therefore, that a single policy framework on long-term care for older people should be developed by the Department of Health and Children, in consultation with other relevant Departments, at national level, while the lead role in service delivery should lie with the HSE.

Supporting Community-Based Care

5.4 The Group believes that a central principle of policy going forward should be to support older people to remain in the community. It is generally accepted that older people and their families have a preference for home care. The National Economic and Social Forum Project Team on the Care of Older People\(^{17}\) have cited research\(^{18}\) from England which indicates that relatively modest services, if provided at the right time, can have a major impact on older peoples quality of life and can reduce admissions to residential care and improve longevity. This approach is also in line with international trends. The recent OECD report stated that “Explicit policies with the goal of shifting the balance of long term care towards more home based care have enabled more older people, who depend on care, to remain in their own homes.” In addition, from a practical point of view, the development of a comprehensive home support package would help address capacity difficulties in the acute hospital sector.

5.5 It is recognised that in most cases, community-based care can be provided at a lower cost than residential care. However, it is important to note that the OECD have warned against overly optimistic assumptions about savings from people availing of community rather than residential care. International evidence suggests that provision of home support packages will complement, rather than substitute for, informal care by family members and others. Improved homecare support will also help to minimise requirements for residential care services.

\(^{17}\) National Economic and Social Forum, Care for Older People, NESF Report No. 32, to be published
\(^{18}\) Elkan et Al, 2001
Home Help Service

5.6 The role of the home help service is vital to the implementation of Government policy to maintain older people at home for as long as possible. The home help service is a flexible service which is designed to respond to clients’ needs. Under section 61 of the Health Act 1970 the HSE (formerly the Health Boards) are empowered, not obliged, to provide home helps and the service is thus discretionary, although in practice, all HSE areas either provide the home help service directly or make arrangements with voluntary organisations to provide them.

5.7 The service is generally free to Medical Card holders although recipients may be asked to make a contribution. Other people are asked to contribute to the cost of the service. The service is provided as a matter of priority to people who have Health Amendment Cards, older people, families with small children where a parent is dead or seriously ill and people with disabilities. Each application for home help services is considered on its own merits. The HSE may take a number of factors into account, including income, other family support available, remoteness from services and availability of suitable people to provide the service. Persons who need a home help will normally apply to the local public health nurse who assesses the need for the service and then processes the application to the HSE.

5.8 Home helps usually assist people with normal household tasks although they may also help with personal care. The home helps are expected to provide a set number of hours assistance each day or each week. The precise arrangements can usually be agreed between the recipient and the HSE. The sort of work that a home help is normally required to do includes light cleaning, possibly some shopping, cooking and laundry but it depends on individual needs. Home helps are not expected to provide nursing or medical care.

5.9 According to the HSE Service Plan for 2005, the number of persons over age 65 in receipt of the home help service in 2005 was 29,000 approximately.

5.10 An additional €5 million was made available for the home help service for 2005, giving a budget for 2005 of €112 million (as per the book of Estimates). The HSE is also providing an additional [€6.6 million] to the home help Budget for the remainder of 2005. This additional funding was made available under the A&E initiative, and it will be used to eliminate the waiting lists for people wishing to avail of the service. This brings the total budget to approximately €120 million.

5.11 The home help service is an essential foundation for any expansion of home support packages by enabling many older people with low levels of dependency to remain at home. Home help services will also normally form part of a home support package, possibly with additional hours beyond the standard level of provision. The Group considers that a flexible and good quality home help service will continue to be at the centre of community-based care over the long-term, requiring continued prioritisation within the HSE.

Home Support Packages

5.12 The Group believes that there should be a move towards provision of home support packages on the basis of a national standard approach, with clear criteria in terms of access, quality standards and availability.

5.13 While the Group supports the principle of community-based care, the decision in each individual case will depend on the needs assessment. Where high intensity care is required, this decision must also take account of the relative cost of community-based and residential care.

Pilot Home Support Packages

5.14 Pilot home support packages or grants have been in operation in two HSE areas in Dublin for some time now. These schemes are intended for older people who, without access to additional home support services, would be at risk of placement in institutional care. They are intended to enable the older person to purchase services that eliminate or delay the need for institutional care. In both areas the home support grants are intended to enable the purchasing of additional services i.e. the intention is to complement, not to replace HSE services such as home help and public health nursing services.

5.15 Different models have been piloted in each area. In one area the availability of certain community services such as home help, care attendants and day care, must be established before the grant is provided. The grant supplements rather than replaces services already in place. In this area it is the recipients and their families responsibility to find and employ the person who will provide
these extra services. Family members cannot be paid this Grant and they are advised to apply for the Carer’s Allowance.

5.16 In the other area the grant is available where the basic services of home help, care assistant and nursing are not available or not sufficient for covering the older persons care needs. In this case the grant is intended for persons whose needs exceed more than 10 hours of care per week on the assumption that Home Care Organisations can provide the first 10 hours. It remains the responsibility of recipients and their families to find and employ the person who will provide these extra services.

5.17 There are differences in the method of payment used in each case. In one area payments are made to recipients who are then free to allocate the money as they wish. This means that the older person and and/or a family member assume responsibility for the use of the grant. In the other area payment is made to the service provider after the services have been provided.

5.18 The Group considered the evaluation of these pilot home care packages and also noted that a range of other similar approaches have been developed in different HSE areas.

**Home Support Packages in 2006/7**

5.19 The Group recommends an initial, targeted approach in order to allow further work take place before decisions can be made on a longer-term programme of services. Therefore, as a first step, the Group proposes the provision of an additional increment of home support packages in 2006 and 2007. These packages should comprise services such as public health nurse, day care, occupational therapy, physiotherapy, home help services and respite care whether drawn from the existing pool of services or any additional resources which might be put in place. If appropriate, they should also take account of requirements for specialist equipment or adaptations to the house and the availability of sheltered housing options.

5.20 Each package will be tailored to the needs of the recipient, and involve the provision of services by public and/or private providers, voluntary groups and individuals. In most cases, this should be through direct reimbursement of the service provider by the HSE. However, in order to maximise flexibility it may be appropriate, in certain circumstances, to make a cash payment to the care recipient on the basis of receipted and approved expenses.

5.21 These additional packages should be focused, by the HSE, on older people currently in residential or hospital care, who have the capacity to return to their homes, and at people in the community who are considered to be at risk of requiring residential care in the absence of such intervention.

5.22 In accordance with current practice, a co-payment should be required in the case of these packages depending on the result of an assessment of the individual’s financial resources. For the purposes of this initial increment of home support packages the assessment should not take the value of the person’s primary residence into account. However, the position of the primary residence in the longer-term co-payment arrangements will need to be considered in the context of the long-term financing of community-based care following the completion of the evaluation referred to below. The general principles of access to and funding of all long-term care services are outlined in Chapter 8.

5.23 This initial, targeted approach is recommended in order to allow further work take place before decisions can be made on a more wide-ranging programme of services. In particular, the Group recommends:

(i) that a formal evaluation of these packages be completed by mid 2007; this should include an evaluation of costs and benefits, delivery model, outcomes for care recipients, availability of family or other informal care, impact on care recipients and family carers, implications of possible mainstreaming and impact on acute hospital services.

(ii) to inform this evaluation, the HSE should record detailed information on these packages, the profile of recipients and accompanying informal care provision.

(iii) that a standardised care needs assessment framework for application on a national basis be developed immediately by the HSE, possibly based on an existing model; this should be sufficiently robust to determine the need for and appropriate type of long-term care package, taking account of the needs of the care recipient and any carer, as appropriate.
(iv) development of a national standard financial assessment framework to apply for both home support and residential care; final decisions on the level of co-payment required for home support will be taken following the evaluation in 2007.

(v) that formal protocols for case management and delivery of home support packages for application on a national basis be developed by the HSE.

(vi) development of an appropriate approach to ensure quality standards in respect of home support packages.

The Group believes that further progress on all these issues is essential before informed decisions can be taken on longer-term policy in this area and approaches to financing it.

5.24 This interim approach will also provide an opportunity, in the context of the establishment of the HSE, to develop greater clarity around existing levels and types of community and home support service provision.

Evaluation

5.25 Given the importance of this evaluation to future policy-making, a steering committee should be established to oversee the design and implementation of the work. As part of this exercise, the following data should be collected:

− a full listing of the current availability of home care supports nationwide and a clear understanding of the differences between regions;

− an estimate of the number of dependent persons over age 65 broken down by level of dependency/care need (i.e. requiring help with personal care, practical tasks, assistive aids and appliances, etc);

− the quantity of services currently being provided to dependent persons in the community (Carer’s Allowance, respite care grants, home helps, care assistants, public health nurses, meals on wheels, day care centres, etc.) and the extent to which several or all of these different services are accessed by the same persons/families;

− a geographic breakdown of need and service availability;

− an estimate of the number of dependent older people with family/informal carers available to them;

− the number of these that are full-time carers and more generally, some quantification of the number of informal care hours available;

− an assessment of the capacity/ability of family/informal carers aged over 65 themselves and may have difficulty in providing the care required and the type and quantity of supports which informal carers might require to allow them to continue to fulfil their caring role;

− quantification of therapeutic needs and breakdown by type of service required; and

− an empirical evaluation of the outcomes of different interventions which would facilitate a cost/benefit analysis of home care supports.

5.26 This data should assist in ascertaining the number of dependent older people likely to need State services and the level of State support that they may need.

Income Support Payments for Informal/Family Carers

5.27 The Department of Social and Family Affairs administers the Carer’s Allowance, the Carer’s Benefit and the Respite Care Grant schemes. These supports are directed at the needs of full-time, informal carers and thereby facilitate the provision of care to the persons requiring it.
5.28 The Department seeks to provide income support to full-time carers through the Carer’s Allowance scheme which is a means tested payment. The Programme for Government\(^{19}\) contains a commitment to:

- Expanding the income limits for the Carer’s Allowance so that all those on average industrial incomes can qualify
- Implementing significant increases in the values of respite care grant for carers.

There have been significant improvements in these payments in line with these commitments.

5.29 Arrangements for carers in full-time employment comprise income support under Carer’s Benefit and employment security under the Carer’s Leave Act, 2001. The Carer’s Benefit scheme, which was introduced in October 2000, was designed to support people who must leave the workforce temporarily to care for someone who is in need of full-time care. It is a weekly income support payment operated and paid by the Department of Social and Family Affairs. This is a non-means tested payment based on PRSI contributions paid by the carer and is paid for up to 15 months (provision was made in Budget 2006 to increase the duration of Carer’s Benefit to 24 months).

5.30 Under the Carer’s Leave Act, 2001, which is the responsibility of the Department of Enterprise, Trade and Employment, an employee may avail of unpaid leave from his or her employment to enable him or her to provide full-time care and attention for a person who is in need of such care. The carer’s employment rights are protected for the duration of the caring period, up to 15 months (increased to 24 months in Budget 2006).

5.31 The Respite Care Grant was introduced in 1999 in recognition of the importance of respite for carers. Carers may spend the Grant in any way they choose. Initially, the Grant was paid only to those who received a Carer’s Allowance, Carer’s Benefit and to carers of people receiving Domiciliary Care Allowance which is paid by the HSE\(^{20}\). In 2005, the Respite Care Grant was extended to all full-time carers regardless of means but subject to certain conditions. This measure is of benefit to carers who are either in receipt of a social welfare payment, for example, Widow(er)’s Pensions, Old Age Pensions, One Parent Family Payment, Disability Benefit and Invalidity Pension, or those who are not currently receiving a weekly social welfare payment from the Department of Social and Family Affairs.

5.32 It should be noted that the Carer’s Allowance scheme, Carer’s Benefit scheme and the Respite Care Grant are paid to carers who provide full-time care and attention to people of all ages. The number of carers (relating to the care of people aged over 65) benefiting from these schemes and the associated cost are set out in Appendix 4.

5.33 Overall, the objectives of these social welfare arrangements are to:

- provide income support to full-time carers on low incomes;
- maintain people in the community; and
- recognise and support the valuable role of carers.

5.34 The Group considered the role of these social welfare payments relative to the home support packages. It believes that while these payments are based on defined eligibility criteria and provide income support for informal carers, they are an important part of overall State support of care for the older people. The Group believes that they should continue as a separate measure to home support packages, which are based on service provision as opposed to income support. The Group was aware that there have been strong arguments made by care groups and others for the abolition of the means test for Carer’s Allowance. The Group is of the view that the allowance should continue to be means tested as it relates to income support and is not a payment for caring. In addition, it considers that the level of expenditure involved in such a proposal would be better allocated to the area of home support and respite packages.

5.35 In the assessment of need to establish the level of dependency of a person, the Group considers that the presence or otherwise of a carer is obviously relevant. While the levels of payment of

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\(^{19}\) An Agreed Programme for Government between Fianna Fail and the Progressive Democrats, June 2002.

\(^{20}\) It is also paid to those in receipt of a Prescribed Relative’s Allowance (PRA) and the Constant Attendance Allowance. The PRA was the precursor to the Carer’s Allowance scheme. While this scheme is no longer available to new applicants, there are a small number of cases in payment. The Constant Attendance Allowance is paid as a weekly increase to Disablement Pension if a person has such a serious disability as to require care and assistance at home with personal needs for a period of at least 6 months.
Carer’s Allowance (or Benefit) is not relevant to this assessment (as this is the income of the carer) the presence of a carer, which is facilitated by the social welfare payment, is pertinent.

5.36 The Group believes that enhanced recognition and support for informal carers is an important aspect of community-based care and makes a number of proposals in 5.59 below.

Importance of Respite Care

5.37 As already set out, respite is provided by a number of bodies (statutory, private and voluntary), and in different ways, in cash and in kind (public and private). Respite itself can take many different forms and can be respite for the carer, the care recipient or a combination of both. The carer might, for example, go on a holiday and arrange for someone else (on a paid or unpaid basis) to provide care in the care recipient’s home. Alternatives would include the care recipient moving to a respite bed for a certain period in a public or private respite arrangement. This could be on a regular or an ad-hoc basis and would, of course, depend on the availability of respite beds in the local area.

5.38 In addition to this, actual arrangements will depend on the individual preferences of the care recipient and the carer.

5.39 The Group considered that future provision should build on the flexibility of the variety of existing arrangements but ensure delivery to the carer and the care recipient in an efficient and cost effective way. The Group was aware that different respite arrangements would be required in different circumstances and that these should be established as part of the needs assessment. In so far as possible, this should take into account the payment of the Respite Care Grant made by the Department of Social and Family Affairs, where payable, and its practical value in the particular household circumstances, together with the preferences of those concerned. In this regard, the Group noted the positive response to the Respite Care Grant, introduced by the Department of Social and Family Affairs in 2005, and considers that its potential to contribute, in a cost-effective way, to the achievement of the Government’s policy goals, should be examined.

5.40 The Group believes that respite care needs to be provided in a more planned and systematic manner, with greater certainty as to availability.

5.41 The Group believes that the proposed future policy on the provision of residential care will also have implications for the provision of respite care, the balance between public and private capacity, the method of funding such respite care and its link to the Respite Care Grant. It proposes that the Department of Health and Children and the HSE should bring forward proposals following progress on residential care policy, including the needs analysis of residential care requirements.

Costings

5.42 The potential gross cost of home support packages, will depend on

(i) the level of demand/need

(vii) the average cost of a home support package

(viii) the supporting infrastructure of community services, and

(iv) the administrative costs involved.

The net cost to the Exchequer will also depend on the level of co-payment from care recipients.

5.43 At present, there is no comprehensive assessment of need for community care services here. The Group looked at different estimates which have been produced of the need for long-term care services among the older population.

Estimates of the Number of Older People in need of Long-Term Community-Based Care.

Mercer

5.44 The Mercer Report used disability prevalence rates from a UK survey carried out in the mid-1980s and modified them for use on the Irish population. The report distinguishes between three levels of care requirement:
− Moderate: less than daily (estimated at 10.5 hours per week).
− High: Significant daily care (estimated at 21 hours per week).
− Continuous: Continuous care (estimated at 42 hours per week).

5.45 Applying the disability prevalence rates used in the Mercer report (2002) to the latest population figures leads to an estimate of the order of 70,000 older people in the community in need of care.

OECD

5.46 Table 2.3 in the OECD Report on Long-Term Care for Older People suggests that across OECD countries, on average 9% of the older people are in receipt of home care services. The percentage of recipients varies widely between countries, with the UK providing home care services to over 20% of their population and the US supplying home care services to less than 3% of their older population. If we were to apply the 9% OECD average figure to the Irish population of over-65s, this would give a figure of roughly 40,000 people currently in need of home care services.

NCAOP

5.47 The National Council on Ageing and Older People based their estimate of need on the numbers of people in receipt of home care packages in Scotland.21 On this basis, the Council then assumes that 2-3% of the population aged 65-79 years may find themselves on the margins of community and residential care and that, as the need for intensive home care increases with age, 5% of the over-80 population may be in need of home care. The resulting estimate is that between 12,322 and 15,808 persons may need intensive homecare packages.

5.48 As can be seen from the above, the existing estimates of need for home care services vary dramatically, thus reinforcing the need for an objective assessment of need requirements. The actual demand will also depend on the nature of the needs assessment, the level of co-payment decided on and other factors.

5.49 The Mercer figures seek to capture those in the over-65 population above a certain threshold of disability, i.e. - requiring 10 hours or more of help with personal care tasks (bathing, eating, dressing etc.) However, the Mercer study (2002) did not take into account the extent of informal care services provided to the dependent older population by their families/friends, an aspect which is critical to future service planning in this area. It is only when this has been done, that a meaningful estimate can be produced of the number of older people likely to require State intervention to help manage their care needs.

5.50 The Group believes that the provision of home support packages can only be fully successful when combined with enhancement of the wider infrastructure on community services. The Group has identified in particular housing for older people, home helps and respite care. Identifying the medium and long-term cost of home support packages will need to take account of these wider community services.

5.51 After the evaluation of the initial roll-out of the home support packages, the HSE should be in a position to provide figures for the range, distribution and average cost of caring for older persons in the community.

Support for Carers

5.52 Informal, usually family-provided, care will remain a cornerstone of long-term care policy. The expansion of home support packages and other community care measures should be seen as a complement to informal care provision.

5.53 The Group noted the Carers Association report, ‘Towards a Family Carers Strategy’. As mentioned in Chapter 4, the Strategy raises issues in the areas of:

− services and supports for family carers;
− carers’ health and social well-being;
− remuneration for carers;

21 NCAOP, 2005, Submission to the Department of Health and Children on The Long-Term Care Needs of Older People.
5.54 The Group noted that informal care is not provided exclusively to older people.

5.55 The Group acknowledges that the Carer’s Allowance, Carer’s Benefit and Respite Care Grant payments from the Department of Social and Family Affairs are part of the infrastructure for supporting informal carers.

5.56 The Group also notes initiatives in the area of training and education which are beneficial to carers who wish to re-enter the workforce when their caring responsibilities have finished.

5.57 FÁS, in recognition of the need to provide flexible and easily accessible training and employment services, particularly to women who wish to return to work after an extended absence, developed the Expanding the Workforce (ETW) process. This process offers a gateway for women wishing to return to the labour market, providing interventions suited to the needs of the individual and offers on-the-job training.

5.58 With regard to training in the skills required by informal carers to enhance their ability to provide personal and social care, a number of voluntary groups representing the interests of family and informal carers provide training in caring skills for their members. The HSE funds such voluntary groups to provide training on their behalf but acknowledges that this is done on an ad-hoc basis from area to area.

5.59 In particular, the Group proposes that:
- enhanced support and recognition of the role of carers should form part of the development and implementation of policy for long-term care.
- while Carer’s Allowance and Carer’s Benefit should remain income support measures, there may be potential to enhance them within the existing policy framework.
- training for carers, both during their caring role and after their caring responsibilities have ceased, should be supported. In particular, a more unified and co-ordinated approach to training informal carers in the skills required to provide care should be adopted.
- respite services should be provided in a manner to maximise support and certainty for carers.
- the needs of informal carers should be taken into account within the needs assessment process.

5.60 As already indicated, the Group proposes that future policy on these and related issues should be informed by structured consultation, on a cross-departmental basis, with carer representative organisations.

Skills Availability

5.61 The Group noted the work which has been undertaken in the context of the SKILL (Securing Knowledge Intra Lifelong Learning) Project with regard to the training and development of staff employed in the Irish health and personnel social services. Those who benefit from the initiative include health care assistants, family support workers, home helps, therapy assistants, laboratory aides, household staff, catering staff, porters, laundry workers, other key support grades and their supervisors. Funding of €60 million has been agreed to cover the five year period from 2004-2008 with ongoing funding of €12 million linked to the consumer price index to be made available once it has been demonstrated that the initiative has had a direct impact on improving services to patients and clients of the health and social services.

5.62 Going forward, any policy decisions on future roll-out of home support packages must be accompanied by an assessment of the availability of sufficient skilled staff, both to deliver further home support packages and to provide the required supporting community services. This issue must also be considered in the context of ongoing service expansion in other areas such as disability, as well as the requirements of the residential services sector. The Group noted that “staff shortages and staff qualifications are the number one concern of long-term care policy
“makers in OECD countries”. Consideration must also be given to the level of capability amongst private sector providers.

5.63 A recent FÁS Healthcare Skills Monitoring Report\(^{22}\) suggests that a combination of expanded training capacity and international recruitment will be able to meet demands in therapy grades, in the short/medium term. That Study did not have any reference to training and manpower needs for additional home support packages on the basis proposed in this report. The Group believes, therefore, that a more detailed planning exercise should be carried out by an inter-agency project team led by the Department of Health and Children to consider the full range of staffing requirements in relation to the care of older people, including in relation to the availability of care assistants.

5.64 In relation to therapy services, the initial expansion of home support packages will allow for flexibility between direct public provision and the use of private sector providers. In the medium term, the balance of provision between publicly employed staff and the private sector will need to take account of cost-effectiveness and the evaluation will also need to have regard to this issue.

6.1 As mentioned earlier in this report, Government policy has traditionally been to assist older people to live in their own homes for as long as possible. When it is no longer feasible for them to live at home, the only option for many older people has been to move directly into a long-term care institution. A basic requirement in enabling older people to continue to live in their own homes or in a community-based setting, rather than seek institutional care, is the availability of appropriate housing and the ancillary care necessary to support the older person in that housing for as long as possible. The National Economic and Social Forum project team on the Care of Older People have stressed the importance of housing supports and, in particular, sheltered housing. In considering a continuum of care spectrum for older people consideration must be given to the need for intermediate housing and care solutions. Both group housing with visiting support and sheltered housing with higher levels of support/care services have important roles to play in this regard.

6.2 The following illustrates a possible “continuum of care” model in relation to housing provision for older people in Ireland.

For many older people there has been little opportunity to avail of the intermediate steps and the lack of appropriate facilities and care/support in their own homes is frequently cited as reason for premature movement to institutional care or stays in hospital which are unnecessary in medical terms, with consequent cost implications for the State. The housing and particularly the “care in the home” dimension cannot, therefore, be ignored in any examination of the funding of long-term care for older people and the following paragraphs set out the current position as well as recommendations for future development of this area.

Existing Dwellings

6.3 A vital element in any strategy to address the long-term needs of older people should be to ensure that older people can remain in their own homes for as long as possible and that those who are in acute hospitals can return home without delay when their treatment has been completed. This entails ensuring that the physical fabric of their dwelling is maintained to an acceptable standard and that their increasing mobility needs can be met within the dwelling.

6.4 There currently exist a number of grant schemes which are designed to address the housing issues involved. The Essential Repairs Grant scheme (ERG), operated by Local Authorities and the Scheme of Special Housing Aid for the Elderly (SHAE), administered by the HSE, both provide funding to enable applicants to make a dwelling habitable for continuing occupation. In addition, older people are making increasing use of the Disabled Persons Grant (DPG), also operated by Local Authorities, to ensure that their age related mobility needs are catered for. In addition, a separate funding scheme for the provision of adequate heating systems in Local Authority rented dwellings, including those occupied by older persons, is now in operation. An income eligibility limit does not apply to any of the schemes. More details on these schemes are in Appendix 6.

Disabled Persons Grant (DPG)

6.5 Demand for, in particular, the DPG has increased significantly in recent years, partly as a result of its use by older people. In particular, the increase in 2001 of the effective maximum grant under the scheme to its current level of €20,320 and up to 90% of the cost of eligible works led to significantly greater activity under the scheme. The DPG has become a significant source of funding in allowing older people to meet their age related mobility needs. A report prepared for
the Management Services Committee of the Local Government Management Services Board in 2003 found that over 69% of the applicants sampled were over 60 years old, 54% were over 70 and almost 25% of all applicants were aged between 81 and 100 years old. The increased demand for assistance under the scheme has caused difficulties for a number of Local Authorities in both the administration of the scheme and in meeting their own one-third contribution. The majority of Authorities have reviewed their schemes over the past few years with a view to streamlining their operation. The introduction of systems of prioritisation on the grounds of medical and financial need as well as standardisation of costs and improved arrangements for the use of Occupational Therapists has enabled Authorities to manage the schemes more effectively and has allowed them to tackle the backlog of applications which had been allowed to build in a number of areas. A review of the DPG scheme is currently underway in the Department of the Environment, Heritage and Local Government with the aim of ensuring that the available funding be targeted to those persons in greatest need of such assistance. The views of Local Authorities and relevant voluntary organisations have been taken into account in the review of the scheme. The review also incorporates the relationship of the DPG scheme with the ERG and the SHAE. The outcome of the review will enable the Minister to make the amendments necessary to ensure that the scheme meets the needs of those persons who are most in need of its assistance.

6.6 Support from these programmes needs to be integrated, as far as possible, with home support packages, through liaison and protocols at local level. The Group welcomes the current review being carried out by the Department of Environment, Heritage and Local Government and believes this is an opportunity to ensure these supports are effectively channelled to those most in need and that the application and payment process is as streamlined as possible.

**Sheltered Housing**

6.7 The Group believes that the provision of sheltered housing can play a significant role in allowing older people to remain in the community. Local Authorities themselves do provide some sheltered housing for older persons normally referred to as “Older Person Dwellings”. However, the extent of such provision is relatively limited. Such housing is allocated by Local Authorities in accordance with their statutory assessments of housing need and their schemes of letting priorities.

6.8 The voluntary sector, supported through the Capital Assistance Scheme which is detailed below, already plays an important role and has the potential to do even more in the future. However, it is essential to ensure that the ongoing care element of such provision is addressed at the same time as the construction element.

**Voluntary Sector Dwellings**

6.9 In addition to some 12,800 dwellings provided by Local Authorities for older people as part of their Local Authority housing programme, the Capital Assistance Scheme (CAS), operated by Local Authorities under the aegis of the Department of the Environment, Heritage and Local Government, provides 95% capital grant funding to voluntary housing bodies to provide accommodation to meet special housing needs including those of older people, people with disabilities and homeless people. These bodies now manage in the region of 17,500 units of accommodation for people in housing need throughout the country. Approved not-for-profit housing bodies in the voluntary/co-operative housing sector provided some 1,600 dwellings for older people in the period 2000 to 2004.

6.10 A loan under the CAS may only be made where the housing authority is satisfied that the accommodation is being provided to meet housing needs in the area and that at least 75% of the units being provided, excluding any caretaker/welfare accommodation, will be used full time as residential accommodation for:

- persons whose need for accommodation has been included in a housing authority’s most recent assessment of housing need;

- homeless persons;

- tenants or tenant purchasers of houses provided by a housing authority who provide the authority with vacant possession of the house by surrendering the tenancy or by conveying the house without compensation to the authority;

- older emigrants returning to reside in this country (up to 25% of the accommodation) who are on the Safe Home waiting list.
Management and Maintenance of Voluntary Sector Housing

6.11 Responsibility for the management and maintenance of the accommodation provided under the CAS is a matter for the relevant housing body. Management and maintenance costs arising are met from the rental income from the letting of the accommodation. The scheme is not designed to provide care and support services nor does the rental income allow the housing bodies to cover the cost of such services.

6.12 With the acknowledged need to assist older persons to live in their own homes and/or in the community for as long as possible, the provision of group or sheltered housing by the voluntary sector can be a valuable second option and a means of bridging the gap between older people living at home and having to move to a nursing home or similar high support facility. In addition to providing accommodation, sheltered housing can comprise a range of on-site social and care services such as access to group meals, laundry facilities, assistance with hygiene and visiting support from GPs, etc. Sheltered housing has been readily accepted in other countries as a mainstream intermediate solution between living at home and moving to a nursing home or other form of institutional care. It has become a central plank of community care policy for older people in several other EU Member States.

6.13 Research undertaken by the Irish Council for Social Housing (ICSH)\(^{23}\) which surveyed some 79 housing associations providing housing for older people found a total of 3,165 units of accommodation in either low support group housing or high support sheltered housing. The ICSH found that the level and consistency of additional supports can vary between group/sheltered housing schemes for older people with over 33% (1,049) of the units found to have a high level of support services. Such schemes would have a number of significant services including on-site facilities and communal areas, on-site staff such as a warden and the provision of care supports such as providing meals or assistance with personal hygiene.

6.14 The provision of dedicated voluntary sector housing for older people without adequate provision for their progressive care needs will do little in the medium or long-term to help such people to remain in the community or prevent them from needing long-term nursing home or hospital treatment. Under current arrangements the limited funding available from the HSE to assist in the area of services for sheltered housing is generally provided on an ad hoc basis by way of discretionary grants and practice can vary on a regional basis. Funding is not always available when a project is completed and there is no guarantee that it will be available from one year to the next. This lack of funding and the uncertainty caused by the current funding system are a source of continuing concern to the voluntary sector and will act as a serious deterrent to any voluntary bodies which might otherwise have been interested in such provision. The issue is the subject of ongoing discussions between the Departments of the Environment, Heritage and Local Government and Health and Children and the voluntary sector. The provision of a dedicated sum of €400,000 to the HSE for the purpose in 2005 is a welcome development.

6.15 However, if the Government’s efforts to enable older people to remain in their own homes or to be cared for in the community are to succeed, the twin issues of accommodation and care must be tackled simultaneously. To provide the certainty and transparency necessary for the continued provision of supported/sheltered housing by the voluntary sector it is essential that a greater clarity attach to funding arrangements in order to meet the agreed care costs associated with the provision of the accommodation. It is imperative to ensure that there is coherence between the capital outlay on a project and the current funding arrangements required for that project.

6.16 The ICSH Report, referred to above, estimates that the funding of care required in existing sheltered housing would cost approximately €2.5 million per annum. Increased provision of sheltered housing would entail an increase in the funding needed but this would have to be offset against the alternative cost of providing long-term institutional care for the occupants. To obtain optimum use of such funding, arrangements should be put in place at local level to ensure that the care element of new CAS projects is dealt with at the same time as the construction element. Applications for capital and current funding should be submitted simultaneously to the Local Authority and the HSE and a joint decision should issue in respect of qualifying projects.

6.17 Assuming a significant increase in sheltered housing provision and ancillary care services at local level, there should be a strong incentive for older people to consider sheltered housing, where appropriate, as a preferred option to forms of institutional care. Whatever financing model is

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\(^{23}\) Irish Council for Social Housing, 2005, Policy and Research Series "An Overlooked Option for Caring for the Elderly. A report on sheltered and group housing provided by housing associations in Ireland"
finally adopted, it should not in any way discriminate against older people who enter sheltered housing instead of long-term institutional care. This would not necessarily preclude an appropriate financial contribution being made by the people involved towards the cost of services in sheltered housing where they have the means to do so.

6.18 Where persons are unable/unfit to remain in their own homes, the second stage solution as mentioned above, should be to facilitate the transfer of such older persons to some form of sheltered accommodation, with on-site care facilities as necessary. The third stage, which should be seen as only a solution of last resort and where the two options above have been exhausted or are inappropriate for the older person’s needs, would be to facilitate the transfer of the older person to a long-term care institution.

Conclusions

6.19 The Group also notes that the increase in house values should provide scope for innovative solutions to funding community/voluntary accommodation for older people, with potential roles also for private and State provision. This will require a structured approach by the HSE to deciding on and providing ongoing support for care services in sheltered housing settings. Likewise, the potential to facilitate older people who wish to ‘downsize’ into more suitable private accommodation should be explored.

6.20 The Group believes that the key to accelerating progress in this area is improved institutional structures at national and local level. It therefore proposes:

− a cross-departmental team comprising of the Department of the Environment, Heritage and Local Government, Department of Health and Children and Health Service Executive. This team should liaise directly with voluntary housing representatives to develop and oversee detailed policy in this area.

− that the cross-departmental team should, as a priority, agree on local structures and protocols for integrated management and delivery of housing requirements and the provision of care. This should include appropriate links with assessments of need carried out by the HSE.
7. RESIDENTIAL CARE

Short-Term Measures

7.1 The far-reaching proposals contained in this report will require further consideration and consultation. In the short-term however, the Group notes that it is proposed to revise the eligibility thresholds for nursing home subventions to reflect house price increases taking account of regional variations in house prices. This can be carried out by regulations under existing legislation.

7.2 These changes will help to alleviate some of the immediate difficulties faced by people in finding long-term care under existing arrangements, in advance of decisions made on implementation of the more fundamental reforms proposed in this report. However, they should not form a precedent for the purpose of setting thresholds under the proposed new system.

Existing Services

7.3 The table below provides an estimate, based on the most recent data available from the HSE, of the number of people over 65 in long-term care in Ireland, broken down between private and public sectors (it should be noted that the estimate provided for 2001 is different from that used in the Mercer Report (2002).) This analysis is based on the most up-to-date data available to the Group from the HSE. However, the up-to-date needs analysis proposed in paragraph 7.18 below should provide a stronger evidence base to support future policy making.

7.4 It is estimated that, in 2004, there were almost 19,500 people over 65 in residential long-term care in Ireland, representing 4.3% of the over 65 population. 12,000 of these reside in private nursing homes with the remaining 7,500 being cared for in public long-stay units.

Table 5: Percentage of total population over 65 in residential care

<table>
<thead>
<tr>
<th>Year</th>
<th>Private Nursing Home Patients</th>
<th>Public Long-Stay Patients</th>
<th>Total Nursing home pop.</th>
<th>Total pop over 65</th>
<th>% of total pop over 65</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No subvention</td>
<td>Receiving subvention/contract beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>3,331</td>
<td>8,259</td>
<td>6,969</td>
<td>18,559</td>
<td>430,000</td>
</tr>
<tr>
<td>2002</td>
<td>3,940</td>
<td>8,469</td>
<td>7,182</td>
<td>19,591</td>
<td>436,000</td>
</tr>
<tr>
<td>2003</td>
<td>4,244</td>
<td>8,420</td>
<td>7,162</td>
<td>19,826</td>
<td>442,500</td>
</tr>
<tr>
<td>2004</td>
<td>3,334</td>
<td>8,840</td>
<td>7,242</td>
<td>19,416</td>
<td>450,800</td>
</tr>
</tbody>
</table>

Source: Department of Health and Children, Central Statistics Office

7.5 The Group noted that of the 19,500 in residential long-term care in 2004, approximately 30% (5,600) are classified as low or medium dependency suggesting significant scope to reduce the current level of residential care with enhanced community-based services.

Public Residential Beds

7.6 Residents of public facilities are required to pay a flat rate of up to €132.80 per week (i.e. 80% of the Old Age Non-Contributory Pension rate) or €6,900 per annum towards the cost of their care. This equates to around 12% of the average cost of providing a public long-stay bed or 15% of the average cost across all beds (whether public or private).

7.7 If a public bed is not available, the prospective patient either waits for a vacancy or seeks a bed in a private facility. There are two complicating factors in this regard:

(i) persons requiring high levels of care may not be able to find a suitable bed in a private facility; and

(ii) the financial incentive to seek a public over a private bed.

Private Nursing Home Beds
As noted above, over 3,000 residents of private nursing homes pay the full cost of their care themselves. Just under 9,000 receive some form of financial support from the State through the Nursing Home Subvention Scheme.

There are a variety of different practices across the old health board areas with regard to both personnel carrying out assessments and the criteria used to measure dependency but, typically, in order to qualify for a subvention, a person must:

(i) be assessed by the public health nurse or area medical officer in the HSE region as having the necessary degree of dependency to require nursing home care; and

(ii) satisfy a means test applied by the local Community Welfare Officer.

There are three rates of subvention i.e. medium €114.30, high €152.40, and maximum €190.50. Once entitlement to a subvention has been established, the amount payable in any case is determined by the degree of dependency/disability assessed rather than any assessment of relative financial need. However, an increasing number of people now receive “enhanced” subventions – these are discretionary payments at local level paid at a rate higher than the “maximum” rate of €190.50 per week. There are no set criteria to qualify for an enhanced subvention or for the amount payable in any case. The average subvention now being paid is about €300 per week, with regional variations. However, it seems that, where these have been awarded by health boards in the past, it has generally been on the basis of financial hardship in bridging the gap between standard subvention rates and the full cost of a private bed.

Estimating Future Need

Mercer estimated that the rate of occupancy of residential beds for over 65s would actually increase from 4.6% to 5.4% by 2051 in line with the increasing share of the very old (over 80s) among the over 65 population. Mercer’s projection:

− assumed static age-related probabilities of entering residential care;
− was apparently informed by a view that there was limited potential for expansion of home care services to divert a significant proportion of older people from residential care; and
− was set in the context of then prevailing OECD residential rates (which saw Ireland in a group with rates ranging from 4.5% to 5.5%)24.

More recent research from the OECD (2005) suggests that:

− Public policy has, over time, shifted a larger share of resources to support home care services25.
− There is a declining trend in nursing home use generally. Those countries for whom the definition of residential care is comparable to Ireland’s (i.e. refers exclusively to nursing home care or similar) having rates which generally fall between 3.5% and 4.0%26.

The OECD concludes that there is no inexorable upward trend in the rate of nursing home use as the population ages. In general, the rate is fairly stable as a proportion of the older population but, as the older population is itself ageing, this implies reducing rates of use at each age within that older population. This indicates that there is no demographic imperative whereby nursing home places will be needed at the same rate for each age group in the future as is the case today27.

These OECD findings, taken together with the latest data available, the number of current nursing home residents classified as low or medium dependency and the proposed expansion of home care services (see Chapter 5), leads the Group to conclude that, even with an increasing number of people aged 80 years and over, there is scope to reduce the proportion of people in residential care.

However, having reviewed recent OECD research, and pending the outcome of the bed needs analysis referred to in paragraph 7.18 below, the Group considers that a target residential occupancy rate of 4% may be achievable in the medium term, if the correct policy mix is

24 Mercer, 2002, Study to Examine the Future Financing of Long-Term Care in Ireland, page 52.
27 The OECD Health Project, Long-term Care for Older People, OECD 2005, page 41-42.
implemented, particularly in regard to significant community-based supports including respite care.

7.16 As the OECD itself points out, however, international data is not always wholly comparable. This estimate must, therefore, be treated with caution in advance of the proposed assessment by the HSE set out below.

7.17 The following table illustrates the projected long-stay bed requirement if a 4% rate is applied to the latest population projections (outlined in chapter 3). This is compared to projections based on 4.6% and 5.4% assumptions.

Table 6: Projected long-stay bed requirement from 2005 to 2051

<table>
<thead>
<tr>
<th>Year</th>
<th>2005 Actual</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
<th>2031</th>
<th>2041</th>
<th>2051</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population over-65</td>
<td>456,000</td>
<td>543,000</td>
<td>621,000</td>
<td>726,000</td>
<td>974,000</td>
<td>1,251,000</td>
<td>1,496,000</td>
</tr>
<tr>
<td>Numbers in Need of Residential Care</td>
<td>20,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4% assumption</td>
<td>22,000</td>
<td>25,000</td>
<td>29,000</td>
<td>39,000</td>
<td>50,000</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>4.6% assumption</td>
<td>25,000</td>
<td>29,000</td>
<td>33,000</td>
<td>45,000</td>
<td>58,000</td>
<td>69,000</td>
<td></td>
</tr>
<tr>
<td>5.4% assumption</td>
<td>29,000</td>
<td>34,000</td>
<td>39,000</td>
<td>53,000</td>
<td>68,000</td>
<td>81,000</td>
<td></td>
</tr>
</tbody>
</table>

7.18 The Department of Health and Children estimates that the current long-stay bed-stock (public and private sector) is approximately 22,000. However, an up-to-date needs analysis of residential care requirements should be carried out by the HSE in conjunction with the Department of Health and Children. An assessment was carried out 5 years ago by the Health Boards and an up-to-date review should take account of recent developments such as home support packages which may form a significant alternative to residential care, the growth in private sector capacity and the geographic spread of needs and supply. It should also be informed by the 4% medium-term target suggested by the Group. This analysis should be completed within 6 months and cover residential needs of older people only.

High Dependency beds

7.19 A related issue is the need for, and availability of, high dependency beds. Even though the data indicates that there should be an adequate supply of beds now, there are anecdotal reports of a shortage of high-dependency beds. High dependency patients typically suffer from a range of disabilities including psychiatric, physical and dementia and require intensive care which is frequently not available in private nursing homes, in particular (although there are examples of where such high level services have been successfully sourced in the private sector). This may also be contributing to problems with delayed discharge of patients in acute hospitals in so far as some such patients may require high-level (although not acute) care in a high-dependency setting.

7.20 However, there is a dearth of information currently available on the situation in this regard. As a first step, it is absolutely essential that the analysis of residential care requirements to be carried out by the HSE cover this aspect. In particular, the HSE should survey existing facilities to establish the actual number of high-dependency beds currently in the system. This could then be matched up against demand in order to assess the extent, if any, of the shortfall in supply. In the event that a shortfall in supply becomes evident, it may be that some existing residential beds could be refocused to provide the necessary high dependency care.

Cost of Projected Nursing Home Provision

7.21 In 2005, the State spent €429 million on providing 7,415 long-stay beds. This averages at approximately €58,000 per bed or about €1,100 per week.
7.22 The Department of Health and Children estimates the cost of a private bed at between €600 and €850 per week depending on location with the highest prices being charged in Dublin. The average country-wide is approximately €720 per week.

7.23 On this basis, the average cost of a residential bed across the public and private sectors is €44,800 per annum or €860 per week.

7.24 The difference in cost between the public and private sectors is thought to be due to the relatively high proportion of high-dependency beds in public facilities. As noted above, there may be a need to re-examine the provision of care for high dependency patients. The Group sees no reason why residential care of either high or low dependency levels cannot be satisfactorily provided in either public or private settings. It would be a matter for the HSE, in the first instance, to investigate whether better value for money could be obtained through contracting or otherwise delivering beds through the private sector or by directly providing such residential care in the public sector.

7.25 For the purpose of this costing exercise, we simply use the €860 average as above. This assumes that the current proportions of higher and lower dependency beds will remain unchanged into the future. [We apply the same price inflation assumptions as used by Mercer – i.e. cost distribution of 50% care costs; 25% staff costs and 25% non-labour costs with care costs assumed to increase by 1% above earnings, staff costs to increase in line with earnings and non-labour costs to increase in line with price inflation.]

Applying these costs to the projected bed numbers set out above gives the following:

Table 7: Residential cost projections to 2051 and implied impact on tax rates to fund incremental public spend

<table>
<thead>
<tr>
<th></th>
<th>2005 Actual</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
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</tr>
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<td>1,496,000</td>
</tr>
<tr>
<td>Numbers in Need of Residential Care</td>
<td>19,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4% assumption</td>
<td>22,000</td>
<td>25,000</td>
<td>29,000</td>
<td>39,000</td>
<td>50,000</td>
<td>60,000</td>
<td></td>
</tr>
<tr>
<td>4.6% assumption</td>
<td>25,000</td>
<td>29,000</td>
<td>33,000</td>
<td>45,000</td>
<td>58,000</td>
<td>69,000</td>
<td></td>
</tr>
<tr>
<td>5.4% assumption</td>
<td>29,000</td>
<td>34,000</td>
<td>39,000</td>
<td>53,000</td>
<td>68,000</td>
<td>81,000</td>
<td></td>
</tr>
<tr>
<td>Projected Cost Per Bed ('05 prices)</td>
<td>€45,000</td>
<td>€51,000</td>
<td>€57,000</td>
<td>€64,000</td>
<td>€78,000</td>
<td>€95,000</td>
<td>€114,000</td>
</tr>
<tr>
<td>Annual Cost of Residential Care</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4% assumption</td>
<td>1.1</td>
<td>1.4</td>
<td>1.9</td>
<td>3.0</td>
<td>4.8</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>as % GNP</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>1.1%</td>
<td>1.4%</td>
<td>1.8%</td>
</tr>
<tr>
<td>4.6% assumption</td>
<td>1.3</td>
<td>1.6</td>
<td>1.9</td>
<td>3.0</td>
<td>5.5</td>
<td>7.9</td>
<td></td>
</tr>
<tr>
<td>as % GNP</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.6%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>5.4% assumption</td>
<td>1.5</td>
<td>1.9</td>
<td>2.5</td>
<td>4.1</td>
<td>6.4</td>
<td>9.2</td>
<td></td>
</tr>
<tr>
<td>as % GNP</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.1%</td>
<td>1.4%</td>
<td>1.9%</td>
<td>2.4%</td>
<td></td>
</tr>
</tbody>
</table>

28 Costings are based on latest available data from the Department of Health and Children on the number of public beds in 2005 and the number of private beds in 2004.
7.26 Provision of additional beds will also generate capital costs. The distribution of these costs will depend on whether these beds are provided in the public or private sectors. If provided by the private sector under existing taxation arrangements, the cost to the State will be 42% of the total capital cost in tax revenue foregone. Again it would be a matter for the HSE in the first instance to establish the business case in value for money terms for either directly providing some or all of the beds or seeking to source the necessary capacity from the private sector.

7.27 The Group notes that the capital tax relief on nursing home construction is currently under review and has asked that the proposals arising in that context take account of the policy direction in this report, which inevitably will take some time to implement.

7.28 Even a 4% residential occupancy rate has very significant cost implications and an initial assessment of these based on certain assumptions is outlined in the table above. In summary, if 4% of people over 65 require residential care the total estimated cost would increase from €0.9 billion (0.6% GNP) in 2005 to €6.8 billion (1.8% GNP) in 2051. Alternatively, at a 4.6% figure, the cost would be €7.9 billion (2.0% GNP) in 2051, while the Mercer estimate of 5.4% implies a cost of €9.2 billion (2.4% GNP) in 2051. The Exchequer commitment arising from this would depend on the size of the co-payment contributed by individual recipients, as discussed below.

New Policy Approach

7.29 Residential care is currently provided by a combination of private and public facilities, with a range of factors determining the level of financial contribution required by the older person or their family.

7.30 The Group proposes that the following principles should inform a new policy approach to residential long-term care:

− a national standardised needs assessment should determine whether a person has a sufficiently high level of dependency to require residential care (i.e. that community-based care is not appropriate);

− a financial assessment would be carried out according to a national standard to determine the level of co-payment appropriate;

− the co-payment assessment should be indifferent as to whether that care is provided in a public or private facility; and

− the co-payment assessment would take account of assets, including housing, owned by the person.

7.31 Significant legislative change will be required to implement these reforms and this should be prioritised with a target of publication in 2006. These reforms will need to be consistent with the outcome of the wider review of eligibility issues in the health sector currently in progress. Transitional arrangements may also be required to take account of any implications for people in residential care at the time the reforms are introduced.

Co-Payment

7.32 As with community-based services, the question arises as to the extent to which the State or the patient themselves should meet the cost of care. Again, the general principle which guides the Group is that individuals should contribute in accordance with their ability to pay. In addition the Group proposes that a single co-payment regime should apply across public and private sectors. Details of the principles underlying the proposed system of co-payment are outlined in Chapter 8.

7.33 The Group recommends a detailed design and costing exercise to operationalise the principles set out in Chapter 8. There are a number of issues which require consideration as part of this process including what level of co-payment is required. For example, one option might be to extend the principle which currently underpins the approach to public residential beds of paying up to 80% of the Old Age Non-Contributory Pension. Under this approach, the care recipient might be required to contribute 80% of their assessed income towards the cost of care. However, a range of other approaches and levels of contribution will also need to be considered.
A related issue is the management of the proposed co-payment system. The State could take an implicit or explicit view of the reasonable cost of a nursing home bed based on an analysis of costings, taking account of regional variations and levels of dependency. The question then is the mechanism through which the State could channel whatever the appropriate level of financial support is assessed to be, following the co-payment assessment procedure. One option would be for the State to source beds in the first instance (whether from private or public providers, allocate them to persons assessed as needing residential care and recoup the appropriate co-payment from the individual.

Alternatively, the State could, having satisfied itself that residential care is necessary for the individual in question, and having conducted the financial assessment to ascertain the appropriate share of the cost to be borne by each of the State and the individual in each case, pay its contribution directly to the individual as a subvention which, when supplemented by the recipient’s co-payment, would allow the recipient to purchase care directly from approved nursing homes including publicly owned ones.

The Group did acknowledge a concern about the impact on market dynamics of taking such an implicit or explicit view of nursing home bed costs and the need to avoid creating upward pressure on prices. This issue will need further consideration.

Equity Release
As noted in Chapter 8, the value of housing stock owned by people aged 65 and over can be tentatively estimated at between €70 and €85 billion. Given that the average length of stay in residential care for people entering over 65 years is two years for men and three years for women, it is reasonable to conclude that there is considerable scope for people receiving care to fund their contribution from these assets without fully depleting the value of those assets.

The Group has recommended that, as part of the financial assessment, an income should be imputed against the value of housing assets. Recognising the illiquid nature of housing assets, the Group accepts that it may be difficult for some people to meet the co-payment arising from housing assets, in particular, from current income. Accordingly, the Group believes that an equity release type mechanism would be needed to facilitate a care recipient in meeting their co-payments from the value of a housing asset while retaining ownership and use of the asset during their lifetime.

It is important to emphasise that a scheme of this nature would be intended to facilitate care recipients in meeting their co-payment obligations. It would, of course, be open to any person to make their co-payment on a pay as you go basis if they so wish.

Such a facility could involve receipt of payments on an on-going basis, through an arrangement between the care recipient and a private sector financial institution. Alternatively, co-payments could be rolled up against the value of the asset and payment made posthumously.

A number of significant policy, legal and design issues need to be explored before schemes of this nature could be introduced, including the appropriate role of the State in relation to products of this type offered by the private sector.

Regulation of Nursing Homes
Legislation is currently being drafted to establish the Social Services Inspectorate on a statutory basis as part of the Health Information and Quality Authority. The Inspectorate will carry out the following functions:
- Monitor standards in respect of services for:
  - people with disabilities
  - older people
  - children provided in accordance with the Child Care Act 1991 and Part 2 of the Children Act 2001 (Family Welfare Conferences)
- Register and carry out inspections in respect of those services.

Registration procedures which will replace existing procedures for nursing homes and child care services will be established and extended as outlined above to cover HSE provided services as well as services provided on behalf of the HSE and by private nursing homes. The legislation will provide for:
- Registration;
- Powers of inspection;
Closure of services where appropriate; and
Improvement orders.

7.44 The Group notes that, subject to Government approval, it is intended to publish Heads of the Bill for consultation in early 2006. It believes this legislation is an important contribution to guaranteeing high standards of residential care for older people in Ireland.

Medical Expenses Relief

7.45 Tax relief is currently available at the marginal rate, through the medical expenses tax relief scheme, for spending on approved nursing home charges. In the context of Government policy to maximise community-based, as opposed to residential, care there is an argument that consideration be given to extending such relief to home-based nursing services also.

7.46 However, if the Group's wider proposals for a structured system of co-payments, covering both community and residential services and based on an assessment of financial means, are accepted the operation of any such tax-reliefs would need careful consideration.
8. FINANCING OF SERVICES

8.1 Long-term care is acknowledged as just one of a number of areas, including health and social welfare, where pressure will come on the public finances as a result of population ageing. For example, a recent ESRI paper on this topic\(^\text{29}\) suggests that on a no policy change basis, spending on health, long-term care and social welfare combined could rise from 17.7 per cent of GNP in 2005 to 29.4 per cent in 2050. There will also be continuing pressures for service improvement in other sectors (education, transport infrastructure etc.). The future financing of long-term care and other services requires that economic performance be sustained and enhanced over the longer term. Medium and longer term economic prospects depend on maintaining budget sustainability and competitiveness.

**Budgetary Sustainability**

8.2 Going forward, the budgetary approach must balance the wide range of competing spending priorities and focus on:
- Developing efficient and cost-effective public services that are consistent with sustainable economic growth.
- Prioritising productive investment to enhance the capacity and the competitiveness of the economy and improve the quality of life.
- Providing for the budgetary impact of an ageing population and containing the overall fiscal burden in order to maximise our economic growth potential.

**Competitiveness**

8.3 Competitiveness is key to future economic performance. Pay and earnings are central determinants in dictating the price of goods and services, particularly in the traded goods and services sectors.

8.4 We have lost competitiveness in recent years. Further declines will impact on future growth performance and reduce our ability to deal with social issues. It is vital, in the coming period, to ensure that wage levels in Ireland do not increase faster than our Eurozone partners.

**Impact of Public Service Pay**

8.5 Care services, generally, are highly labour intensive, with wages making up the vast bulk of costs of formal care service provision. Wage moderation is therefore critical to the sustainability of the financing of long-term care services in the future.

8.6 Public service pay also affects competitiveness in a number of ways. If public service pay rates are set too high they can influence upwards pay rates in the private sector through competition for workers and through the demonstration effect.

8.7 Higher public service wage costs increase the burden on the overall economy by taking up ultimately scarce resources. The Exchequer pay and pensions bill is close to €15bn and is expected to show an increase in 2005 over 2004 of 9%.

8.8 Higher public service wage costs have to be met from taxation and/or through diversion of funds from other public expenditure. If such wage costs are met from taxation, an increased tax burden creates disincentive effects in terms of job creation and investment because it costs more to employ people.

8.9 Where increased public service wage costs are met through reductions in other areas of public expenditure, there are opportunity costs in terms of other investment foregone.

8.10 For all of the above reasons, it is essential that public service pay levels do not lead wage levels in the economy, that there is pay restraint and that the cost to the Exchequer is contained.

**International Context**

\(^{29}\) Barrett and Bergin, 2005 “Assessing Age-Related Pressures on the Public Finances, 2005 to 2050” presented at the ESRI Budget Perspectives 2006 conference.
8.11 The recent OECD Study on Long-Term Care for Older People compares country’s expenditure relative to the share of older people in the population between countries. There are generally strong caveats which apply to international comparisons of Irish social protection expenditure with other countries, such as our favourable demographic situation and poor coverage of private expenditure in these statistics. While acknowledging these limitations the study shows that there is some correlation between expenditure on long-term care as a percentage of GDP and the share of older people in the population. This is illustrated by Figure 1 which plots overall spending levels against the percentage of persons aged 80 years and older - the largest group of service users under long-term care programmes. (While this report concentrates on the over-65 population, figures from the Department of Health for the end of 2003 show that 70% of older residents in nursing homes were aged 80 years and over).

8.12 Figure 1 provides at least prima facie evidence that, adjusting for the different demographic situations, Irish spending on long-term care services for older people (albeit that the graph refers specifically to over-80s) is broadly in line with OECD averages. However, it should be noted that efficiency comparisons can only be carried out if the expenditure and population comparisons cover the same groups. For example, Ireland probably has a higher share of long-term care expenditure in respect of people aged under 65 (due to our demographic structure) and aged 65-74 (due to our lower life expectancy, care costs could be expected to be incurred at earlier ages) than most other OECD countries, which would not be reflected in these comparisons.

Figure 1. The correlation between total long-term care spending and the population share of the very elderly, 2000

Source: OECD, 2005

8.13 The above graph suggests that spending on long-term care will increase as a percentage of GDP, in line with population ageing, even in the absence of any policy change. In Ireland, the proportion of over-80s in the population is currently estimated at 2.6%. This will increase to 4% by 2026, 6% by 2036 and 9% by 2050. The ESRI analysis, cited earlier, suggests that spending on long-term care for older people would rise from 0.8 per cent of GNP in 2005 to 2.4 per cent in 2050 as a result of population ageing.

Estimates of Cost

8.14 The scale of cost falling on the Exchequer will depend on a number of factors. In this regard the following will be important:

- decisions taken following the proposed evaluation of home support packages in relation to their wider availability; and

- nature and extent of co-payments required for residential and home support packages.

Community Based Care
8.15 The Group has recommended an initial phase of development of home support packages, comprising a small-scale, focussed approach to service delivery, to allow further evaluative work take place so that decisions can be made on a more wide-ranging programme of services.

8.16 This short-term initiative is to be evaluated by mid-2007. This evaluation is expected to generate the information and data sets which will allow full consideration of a strategic, long-term policy approach to community and home-based services. Until then, it will not be possible to determine coverage or content of home care services or by extension, costs over time of these services.

Residential Care

8.17 There will, in any event, continue to be a need for residential care for some older people. Mercer estimated that 4.6% of the over-65 population were in long-term care. However, as outlined in chapter 7, the Group proposes that a target of 4% should be achievable in the medium term if appropriate community care services are in place.

8.18 Based on certain technical assumptions regarding:

- growth in the over-65 population (National Pension Review projections),
- price inflation in the residential care sector (estimated using the Mercer formula), and
- GNP growth rates,

the table below sets out projections of the likely costs of residential care out to 2050 in constant 2005 prices. Using the current figures for numbers of people aged over-65 in residential care and then applying the 4% target rate to the population projections for this group from 2011 onwards, shows the potential number of people in residential care. This figure is then multiplied by the average annual bed costs to estimate the total cost of residential care in each given year.

8.19 If the 4% target is not achieved, the cost of residential care going forward will be correspondingly greater. (As stated in Chapter 7, total spend (public plus private) on residential care for the over 65s is projected to increase from €0.9 billion (0.6% GNP) in 2005 to between €6.8 billion (1.8% GNP) and €9.2 billion (2.4% GNP) in 2051, depending on the residential occupancy rate assumptions used).

8.20 As seen in Chapter 7, taking public and private facilities together, individuals currently contribute some one third of gross costs (albeit weighted towards residents of private homes) with the State meeting the balance of costs either through its direct provision of public beds or through the Nursing Home Subvention Scheme.

8.21 Solely for illustrative purposes, the table below shows what the Exchequer financing implications would be if private contributions continued to meet one third of the cost of residential care. To the extent that co-payments exceed or fall short of this level, the Exchequer financing bill will be correspondingly lesser or greater.

8.22 Also, **purely for illustrative purposes**, the table shows the impact of the expenditure trend on existing tax rates going forward.

Table 8: Projected residential care costs to 2051

<table>
<thead>
<tr>
<th>RESIDENTIAL COST PROJECTIONS TO 2051</th>
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<tr>
<td>2005</td>
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48
8.23 Again, it **should be stressed that this is based on a 4% occupancy target for residential nursing homes, which will require significant investment in community care in order to be achieved**. If the 4% is not achieved, the residential cost projections will increase accordingly.

**Co-Payment**

8.24 Given the scale of costs arising in meeting the long-term care needs of older people, the Group considers that a substantial level of co-payments will be central to a sustainable approach to financing long-term care.

8.25 The Group proposes the following principles in relation to cost-sharing between the State and individuals:

− access to services should, in the first instance, be based on a national standard assessment of care needs

− once access/need for services has been established, the cost should be shared by the State and the individual. The level of each individual’s co-payment should be based on ability to pay, as determined by a standard financial assessment

− this assessment should take into account his/her private income and also imputed income from assets (including their primary residence)

− an equity release type facility should be available to allow co-payments to be met from the value of the asset, while the care recipient would retain use of the asset during their lifetime.

8.26 Further issues requiring decision are:

− whether depletion of the full value of the primary residence should be required or if the assessment of financial means should exempt a certain amount of the value of the primary residence
whether there should be an element of cost-sharing between the State and the individual in all cases. This would mean that all those in need of care would receive some minimum level of support from the State, regardless of their financial means.

8.27 The Group recommends a detailed design and costing exercise to operationalise the principles set out in paragraph 8.25. There are a number of issues which require consideration as part of this process including what level of co-payment is required. For example, one option might be to extend the principle which currently underpins the approach to public residential beds of paying up to 80% of the Old Age Non-Contributory Pension. Under this approach, the care recipient might be required to contribute 80% of their assessed income towards the cost of care. However, a range of other approaches and levels of contribution will also need to be considered.

8.28 These principles in relation to cost-sharing between the State and individuals in relation to residential care should also be applied in the case of home support packages, although this will only be finalised following the evaluation proposed in mid 2007. In particular, the position of the person’s primary residence in making assessments for home support packages will need to be considered at that stage. (It will not be considered for the initial increment of packages proposed.) A related issue is the extent to which different levels of co-payment are required as an incentive to use community-based, as opposed to residential care.

8.29 In recognition of the illiquid nature of many housing assets, chapter 7 notes a series of proposals in relation to an equity-release type facility. A number of significant policy, legal and design issues need to be explored before schemes of this nature could be introduced, including the appropriate role of the State in relation to products of this type offered by the private sector.

8.30 Box 1 below attempts to set out in broad terms, some information on the size of the income and asset pool available to the over-65 population. This can be expected to increase substantially in future years in line with growing wealth and income of the people currently in the working age cohorts.

<table>
<thead>
<tr>
<th>Box 1</th>
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<tr>
<td><strong>Estimating the income and asset pool of the over-65 population</strong></td>
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</table>

**Private Income:**
The ESRI has estimated that more than 90% of the 465,000 people over 65 years had an income from social welfare pension schemes in the year 2000. They estimate that one-third of pensioners receive income from a private pension plan.

2002 data from the Revenue Commissioners suggests that circa 150,000 over-65s have income in excess of social welfare pension rates. The average gross income of this group is estimated at €348 per week in 2005*

**Private Homes and Other Capital Assets:**
Census 2002 puts the total number of houses in Ireland at 1.3m. The National Economic and Social Council (NESC) more recently estimated a figure of 1.6m based on ESB connections. Taking the over 65 age group to be 18% of the house-owning population (i.e. aged 25+), this shows that between 234,000 and 288,000 houses are owned by individuals in this age group. Applying a 2004 average house value of €295,000 to these figures would value housing stock owned by older people at €70bn and €85bn respectively.

**Private Savings:**
There is very little available data on savings held by the over-65 age group, other than SSIAs. Commentators generally predict the maturity value of SSIAs by 2007 at something of the order of €15 billion in total. 15% of account holders, or 168,000 persons, are over 60 years of age which, on a simple proportionate basis, implies a total value of €2.2 billion in savings for this age group, or €13,500 per individual account holder. It might be noted that the first €20,000 of savings is generally disregarded by the Department of Social and Family Affairs when assessing means on its schemes.

*It should be noted that Revenue records only 220,000 persons in the over 65 age group. We know that this is just over half the total number in that age cohort.

**Public Financing Options**

8.31 Notwithstanding whatever co-payment arrangements may be put in place, it is clear that a substantial burden will fall on the Exchequer. The Group believes that given the substantial costs arising in the medium and long-term and related costs of ageing in areas of acute medical care and pensions, additional sources of funding beyond existing taxation sources may require consideration.

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While we have attempted to project costs for residential services in the preceding section, the Group takes the view that it would be inappropriate to consider longer-term financing arrangements for residential care services in isolation from community services. Accordingly, the Group will not be in a position to give full consideration to, or propose recommendations on, specific financing mechanisms for long-term care services into the future until after the 2007 evaluation.

In the meantime, the Group has noted the different financing options to be considered and these are discussed at paragraphs 8.34 to 8.52 below. Whatever proposals for community care services are eventually put forward should be clearly costed over both the short and long-terms and explicit financing mechanisms to fund them should be considered.

Pre-funding

Given the current favourable demographic position and above-trend rates of economic growth, an opportunity exists, from an economic perspective, to pre-fund long-term care costs. It would seem that pre-funding might best be achieved through some form of social-insurance type contribution and fund, e.g. by establishing a separate long-term care fund financed by a specific long-term care levy/contribution. This issue influenced the Mercer recommendation favouring a social insurance type approach. However any decision in this regard could only be taken in the context of wider discussions on pre-funding the cost of ageing.

General Taxation

A 1% increase in the standard rate of income tax would yield €446m in a full year. A 1% increase in the top rate would yield €207m. A 1% increase in the standard and reduced rates of VAT (currently 21% and 13.5%) would yield about €355m and €308m respectively.

Any increase in consumption taxes (VAT or excise) would impact on the Consumer Price Index (CPI). International experience generally suggests that greater budget control can be exerted over tax-financed health systems, largely because such a financing system facilitates the imposition of budget caps.

Other arguments put forward by Mercer in favour of tax-based financing related to:
- the wide tax-base available,
- facilitating risk pooling and
- income redistribution.

Disadvantages as seen by Mercer include:
- expected unpopularity of tax increases (especially income tax) to fund service improvements;
- the inability to ring-fence funding for long-term care services which would, therefore, be subject to the usual budgetary prioritisation process;
- incompatibility with an entitlement-based approach; and
- difficulties with pre-funding.

The consultation process conducted on the Mercer Report found most groups not in favour of financing improvements in long-term care through general taxation. In an ESRI telephone survey on Attitudes towards Funding of Long-Term Care of the Elderly, which was commissioned by the Department of Social and Family Affairs, just over 40 per cent of adults recorded themselves to be in favour of increasing income tax and/or PRSI levels with 46 per cent being opposed to it (the remaining 14 per cent being undecided). In general, higher preferences were expressed in favour of an increase in social insurance levels than direct income tax – with all consequent implications regarding the nature of the cover provided by the revenue in question.

Of the 40% of adults who agreed in principle with the use of tax or social insurance contributions as an instrument for generating revenue to fund long-term care, the threshold at which they would be willing to pay is quite low when actual values for weekly or annual increases were presented to them. At the threshold of €8 per week in 2004, we saw that almost two-thirds of those who initially indicated themselves to be in favour of an increase in tax or PRSI in principle were opposed to the suggested level. Ultimately just over 14 per cent of adults would be in favour of a tax or social insurance increase of €8 or more each week.

14 40 per cent of adults in favour of tax/PRSI increase. At €4 per week 63.8 per cent of these said they would oppose the level in question – 36 per cent would accept it. 36 per cent of the original 40 per cent gives the 14 per cent in question.
8.39 In the survey, just over 25 per cent of adults indicated their willingness to consider an increase in VAT to help fund long-term care of older people with just over 60 per cent opposed. However, as many as 71 per cent of those who agreed in principle with such an increase, indicated their opposition to a threshold of €8 or more per week. This means that only 7.5 per cent of all adults would be in favour of an increase of €8 or more per week in VAT.

Social Insurance

8.40 A 1% increase in both employer and employee Class A PRSI rates (currently 10.4% and 4% respectively) would yield approximately €725 million per annum.

8.41 On balance, Mercer favoured a social insurance approach because it:
- would facilitate pre-funding;
- is arguably a more “acceptable” form of taxation – particularly if linked to an entitlement-based approach; and
- would ensure a clear link between contributions and benefits.

8.42 Other advantages mentioned by Mercer are the ability of social insurance to support a standardised needs assessment, the creation of a bias in favour of home care, the separation of financing and service delivery, an end to the welfare stigma associated with means tests and the provision of long-term stability to the financing regime.

8.43 Disadvantages noted by Mercer included:
- a reduction in Government’s ability to control expenditure;
- a need for a parallel social assistance system to cater for those not covered by social insurance;
- a relatively narrow funding base;
- potential to exacerbate the intergenerational effect – although this could be addressed by requiring pensioners to continue to pay contributions;
- potential adverse impact on the economy, particularly in relation to competitiveness; and
- potential need for Exchequer top-up in the event of economic downturn.

8.44 The consultation process on the Mercer report found widespread support for the view that people should contribute during their working life for a better long-term care system in old age. (In the ESRI telephone survey, only 40% of adults agreed in principle with the use of tax or social insurance contributions to fund long-term care). There is also support for the scale of PRSI increase that is mentioned in the report (an increase of 2.1% in PRSI contributions for each of the employer, employee and self-employed categories over the full period to 2051). However, it was felt that any increase in PRSI should be ring-fenced to pay for long-term care. All those who commented would like to see the PRSI option developed further.

8.45 In relation to options for a social insurance type model, the Group agreed that while there would be merit in a risk-sharing approach, there are a number of difficulties including the complexity of integrating it with the Exchequer-based financing of existing health services. The social insurance model also implies an entitlement to a specific benefit arising from certain contingencies. However, while acknowledging these issues, the Group believes it warrants further consideration.

Ear-marked tax

8.46 1% increase in the health levy would yield approximately €507m in a full year. The characteristics of an ear-marked tax would seem to depend on whether it more closely approximates general taxation or social insurance. Mercer saw it as being closer to social insurance in that it could be backed by legislative entitlements, be used to pre-fund long-term costs and contributions would be perceived by the public as being directly linked to benefits. Mercer also envisaged an ear-marked tax supporting universal rather than means-tested benefits although this is certainly not an inevitable feature of such an approach. Traditionally, this country has not favoured hypothecation of tax revenues on the basis that it reduces the Government’s room for fiscal manoeuvre.

8.47 The consultation on the Mercer Report found no support for funding long-term care through the Health Levy. There was also a feeling that improvements should not be paid for through an ear-marked tax. Concern was expressed that any approach that aims to ring-fence long-term care expenditure would blur the boundary between long-term care and medical care.
Estate Taxes

8.48 Mercer concluded that the option of an estate tax to fund long-term care benefits would not garner sufficient political and public acceptance to be a viable policy option. They estimated that a taxation rate of the order of 25% might be necessary to finance long-term care. The following outlines the current position and recent history with experience of estate taxes and attempts to estimate potential yield from this source.

8.49 Capital Acquisitions Tax (CAT) is currently levied at 20% on the taxable amount of gifts and inheritances. CAT raised €190m in 2004, mostly on inheritance. The main reliefs and exemptions are as follows:

- total exemption of the spouse of the disposer;
- 90% relief where the property involved is either business property or agricultural property (as defined);
- exemption for the residence where the beneficiary has lived in the house prior to the inheritance and retains it for some years afterwards and has no other residential property.

The exempt threshold amounts for each beneficiary (which amounts are increased each year in line with the CPI) are:

<table>
<thead>
<tr>
<th>Group</th>
<th>Exempt Threshold (€m)</th>
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<tbody>
<tr>
<td>I</td>
<td>466,725</td>
</tr>
<tr>
<td>II</td>
<td>46,673</td>
</tr>
<tr>
<td>III</td>
<td>23,336</td>
</tr>
</tbody>
</table>

8.50 Probate tax applied on estates from mid-1993 until December 1999 and was abolished in the 2000 Finance Act. It was designed to be a low tax rate (2%) on a wide revenue base. The main reliefs included:

- full exemption for the spouse (of the deceased);
- 30% reduction for agricultural land and buildings;
- exemption for jointly-owned property;
- exemption for the share of the family home passing to dependent children or relatives; and
- an offset against CAT on the beneficiary.

The yield from probate tax was €37.5m in 2000 (its last full yield year).

8.51 Intuitively, as the population grows older, the aggregate value of assets available to that population should also increase and can be expected to be reflected in increasing yield from inheritance taxes. Thus it may be that there is a correlation between potential yield from this source and spending pressures as the population ages. However, the Group has already recommended that the value of assets be taken into account in the financial assessment at individual level.

8.52 Both wealth and property taxes have existed at different times in the past. Each has proved controversial. The main concerns about wealth tax surround flight of capital and incentives to enterprise. Property tax suffered problems regarding geographical value differences.

8.53 Decisions on these aspects will require more accurate costings about the future level of demands on the Exchequer which should be available following progression of work on the issues outlined above.
9. IMPLEMENTATION

Implementation

9.1 The Group has proposed a very substantial programme of work to deliver improvements in the short-term and to ensure a sound basis for policy and services over the longer-term. The following table summarises the key actions arising from proposals in this report.

Table 9: Key actions arising from proposals in the report

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Timescale</th>
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<tbody>
<tr>
<td>Provision of additional increment of home support packages</td>
<td>HSE</td>
<td>During 2006 and 2007</td>
</tr>
<tr>
<td>Formal evaluation of this additional increment of packages</td>
<td>Steering Committee, led by D/H&amp;C, to be established.</td>
<td>To be completed by mid 2007</td>
</tr>
<tr>
<td>Development of national standardised care needs assessment framework</td>
<td>HSE</td>
<td>Mid 2006</td>
</tr>
<tr>
<td>Development of national standard financial assessment framework</td>
<td>D/H&amp;C, D/SFA and D/Finance</td>
<td>Mid 2006</td>
</tr>
<tr>
<td>Development of formal protocols for case management and delivery of home support packages on a national basis</td>
<td>HSE</td>
<td>Mid 2006</td>
</tr>
<tr>
<td>Development of structured consultation, on a cross-departmental basis with carer representative organisations</td>
<td>D/H&amp;C, D/SFA, D/EHLG and other Departments as appropriate</td>
<td>Beginning in 2006</td>
</tr>
<tr>
<td>Establishment of a cross-departmental team to develop and oversee policy in relation to sheltered housing for older people and agree, as a priority, local structures and protocols for integrated management and delivery of housing and related care services</td>
<td>D/EHLG, D/H&amp;C and the HSE</td>
<td>Early 2006</td>
</tr>
<tr>
<td>Needs analysis of residential care requirements, including respite care beds to be undertaken</td>
<td>D/H&amp;C and HSE</td>
<td>2006</td>
</tr>
<tr>
<td>Publication of Heads of Bill to establish Health Information and Quality Authority</td>
<td>D/H&amp;C</td>
<td>Early 2006</td>
</tr>
<tr>
<td>Planning exercise on staffing requirements</td>
<td>Inter-agency project team led by D/H&amp;C</td>
<td>End 2006</td>
</tr>
<tr>
<td>Design and costing exercise to operationalise principles on co-payment</td>
<td>D/H&amp;C, D/SFA and D/Finance</td>
<td>2006</td>
</tr>
</tbody>
</table>

9.2 It is suggested that this Group should continue to meet on a periodic basis and report back to the Cabinet Committee on Health regarding progress on implementation of the recommendations in this report.
Appendix 1

Membership of the Group

Ms Mary Doyle, Department of Taoiseach, (Chair)
Mr John Shaw, Department of Taoiseach
Ms Lisa Hennessy, Department of Taoiseach
Mr Dermot Smyth, Department of Health and Children
Mr. Donal Devitt, Department of Health and Children
Mr David Wolfe, Department of Health and Children
Mr Oliver O’Connor, Special Adviser to the Tánaiste and Minister for Health and Children
Mr Michael Errity, Department of Finance
Ms Mary Mc Keon, Department of Finance
Mr Joe Mooney, Department of Finance
Mr Tom Murphy, Department of Finance
Ms Kate Levey, Department of Finance
Ms Alice O’Flynn, Department of Social and Family Affairs
Ms Anne Vaughan, Department of Social and Family Affairs
Ms Elaine Soffe, Department of Social and Family Affairs
Ms Niamh Fitzgerald, Department of Social and Family Affairs
Ms. Gráinne Heslin, Department of Social and Family Affairs

The Group would like to recognise the contribution of Mr David Wolfe, whose untimely death during the course of this project is very much regretted.

The Group would also like to acknowledge the assistance of Ms. Regina Buckley and Ms. Mo Flynn, HSE and Ms. Mary O’Donoghue, Department of the Environment, Heritage and Local Government
Appendix 2

Budget 2006 Announcements

Department of Health and Children

An investment package of an additional €150 million has been put in place for Services for Older People for 2006/2007, which is the largest ever increase in funding for such services. The investment package is focused on caring for people at home, and is a major step in focusing new resources on home care first and foremost, while still supporting appropriate residential care.

1. Home Care Support Packages

Home care packages deliver a wide range of services and have been piloted successfully in several regions in recent years. They include the services of nurses, home care attendants, home helps and the various therapists including physiotherapists and occupational therapists. A home care package will vary according to the care needs of the person so that, for example, there might be a greater emphasis in some packages on home care assistants while other packages may require a greater level of therapy and nursing.

The priority will be older people living in the community or who are inpatients in an acute hospital and who are at risk of admission to long-term care. The home care packages will also be available to those older people who have been admitted to long-term care and who now wish to return to the community. In addition, the packages will be offered to people who are already using existing core services, such as home helps, but need more assistance to continue to live in their community.

The packages are delivered through the HSE, by a range of providers including the Health Service Executive itself, voluntary groups and the private sector. The scheme will be as flexible as possible and highly responsive to the real needs of the individual so that where a family or friends of an older person wish to provide these services, they will be encouraged to do so, with support, and linking in with the HSE, voluntary or private sectors.

About 1,100 home care packages are provided to people at present. By the end of next year a total of 2,000 additional home care packages will have been provided. This will amount to a trebling of the current service provision.

The 2,000 packages will support more than 2,000 persons as, for example, individuals could in some cases need a care package on a temporary basis. The major thrust of this initiative is to be directed at older people. However, there will be some flexibility, so that a person who is under 65 and may need home care may receive it, as appropriate.

2. Home Helps

Home helps are an essential part of supporting older people at home and thereby delaying or preventing admission to long-stay residential care. They also help to keep people out of acute hospitals or help their early discharge from hospitals.

There is a continuing demand for home helps because of the increased number of older people. An additional €33 million full year cost is now being allocated for this programme (€30 million of which will be for 2006). This represents a significant increase over the Estimates provision of €112 million for 2005.

The additional funding of €30 million will provide 1.75 million more home help hours. As with home care packages, it is expected that these additional resources will be implemented in a flexible way by the HSE so that particularly vulnerable individuals, who need a home help, but who are under 65 years of age, can access the service.
3. Day/Respite Care Centres
Day care and respite care are an integral part of delivering a comprehensive community service for older people. The service provided may include:

- A mid-day meal and a bath and physiotherapy, occupational therapy, chiropody, laundry and hairdressing
- Social contact amongst older people
- Respite for family members and/or carers
- Social stimulation in a safe environment for older people with mild forms of dementia

The provision of €9 million in a full year will allow for an additional 1,325 places per week in such centres. The number of older people who will benefit from these new places will be substantially more than 1,325, since, over the whole year, one place can provide a service for more than one person.

The investment of €9 million will allow for additional programmes for specific needs such as activity therapy. It will also mean that many day care centres can open for five or seven days a week, rather than two or three days as is often the case at present.

There will be an investment of €7 million in 2006 with the balance of €2 million being provided the following year.

4. Specialist Palliative Care
€9m is being allocated to specialist palliative care, including home care and community initiatives in 2006. A further €4m is being allocated in 2007 to develop the service, giving a full year cost of €13m. The funding provides for:

- €1.9 million to open 6 palliative care beds at Blackrock Hospice under the management of Our Lady’s Hospice in Harold’s Cross (24 extended beds will also be provided at Our Lady’s Hospice).
- 10 new palliative care beds in Milford Hospice - €1.9m.
- €1m - increased funding for St Francis Hospice in Raheny.
- €2 million for the development of palliative home care and community based initiatives throughout the country. This level of funding will also facilitate the HSE to develop action plans in accordance with the recently published Needs Assessment on Palliative Care for Children, and to introduce targeted pilot projects which will provide experience based knowledge and baseline information to assist in the further development of services.
- Development of palliative care services in the midland, western and southeast areas. This will continue to develop services and build capacity.
  - Southeast: €1.2m
  - Midlands and Western: €1million

5. Meals on Wheels
There will be a significant increase in the resources available to the “meals on wheels” service. An estimated €10 million was spent on the service in 2004 and additional funding of €2.5 million will be provided next year together with a further €2.5 million in the following year making for an increase of about 50% on the 2004 level. Again, this is part of the range of services which help support older people to continue living in their own homes.

6. Sheltered Housing
The Tánaiste strongly supports the development of sheltered housing accommodation for older people, as it provides a real alternative to residential care and reflects the desire of older people to live with as much independence as possible. To support the development of sheltered housing, a full year commitment of €1 million will be allocated, split evenly between 2006 and 2007, to provide front line health service support for sheltered housing, such as therapists and public health nurses.
7. Other Initiatives in Primary/Community Care for Older People
The Tánaiste will ask the HSE to develop proposals in the Primary and Community Care areas which are new ways of delivering service and/or reflect best practise elsewhere. The proposals should reflect the very significant emphasis on home care and involve non-statutory agencies working in partnership with the HSE.
A total of €4 million, €2 million in each of the next two years, is being provided by the Tánaiste to the Health Service Executive for such initiatives to improve and increase service delivered to older people.

8. Elder Abuse
A total of €2 million is being allocated to address the issue of elder abuse, again split evenly between 2006 and 2007. This level of funding will facilitate the implementation of the full range of recommendations contained in the Report “Protecting Our Future.” About €2.5 million has already been made available in recent years towards implementing the Report. It will also provide for the development of a research function in this area.

9. Development of the Nursing Home Subvention Scheme and Additional Long-Stay Bed Capacity
A total of €20m is being allocated to the Nursing Home Subvention Scheme for residents of private nursing homes. This represents an increase of 14% over 2005, which has an estimated spend of €140 million.

The €20m is a 2006 full year cost and will go towards supporting increasing numbers entitled to basic nursing home subvention as a result of a substantial change upwards in the means test limits, reducing waiting lists for enhanced subventions and bringing greater consistency to the different levels of enhanced subvention support throughout the country.

€8m is being provided to cover the cost of 250 extra nursing home beds which the HSE is already in the process of sourcing from private nursing homes.

The Tánaiste is updating the subvention scheme for payments to people in nursing homes. The purpose of this change is to make the assessment criteria for subventions, which have not been updated since 1993, reflect the major changes in property values.

The property ceiling that was set at €75,000 (€95,000) in the 1993 Nursing Home Subvention Regulations is now being increased (having regard to the Department of the Environment, Heritage and Local Government house price indices) to €500,000 for Dublin and €300,000 for the rest of the country. The assets ceiling is also being increased to €36,000 from £20,000 (€25,359). Previously, the first £6,000 (€7,618) of an applicant’s assets would be disregarded when applying for a subvention - this is now being increased to €11,000.
## SUMMARY

**Budget Day Package for 2006 Older People including Palliative Care**

<table>
<thead>
<tr>
<th>Items</th>
<th>Full year cost (€m)</th>
<th>2006 (€m)</th>
<th>2007 (€m)</th>
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<tbody>
<tr>
<td>Home Care Packages</td>
<td>55</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>Home Helps</td>
<td>33</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Day/Respite care</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Specialist Palliative Care/Our Ladys Hospice, Harold's Cross (extended care beds also)</td>
<td>13</td>
<td>9</td>
<td>4</td>
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<tr>
<td>Meals on Wheels</td>
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<td>2.5</td>
<td>2.5</td>
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<tr>
<td>Sheltered Housing</td>
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<td>0.5</td>
<td>0.5</td>
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<tr>
<td>Other Initiatives in Primary/Community for Older People</td>
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<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Elder Abuse</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Development of Subvention Scheme / Additional 250 Beds</td>
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<td>28</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>150</strong></td>
<td><strong>110</strong></td>
<td><strong>40</strong></td>
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## Specific Budget Improvements for Carers and Implementation Dates

<table>
<thead>
<tr>
<th>Improvement Description</th>
<th>Cost (full year)</th>
<th>€m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rates Increases (January 2006)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increase of €26.40 a week to €180 for recipients of Carer’s Allowance under age 66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increase of €30.20 a week to €200 for recipients of Carer’s Allowance over age 66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increase of €17 a week for recipients of Carer’s Benefit/Constant Attendance Allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Weekly income disregard for Carer’s Allowance increased by €20/€40 to €290 (single) and €580 (couple) (April 2006)</td>
<td></td>
<td>2.47</td>
</tr>
<tr>
<td>- Extend the duration of Carer’s Benefit by 9 months to 24 months (May 2006)</td>
<td></td>
<td>1.50</td>
</tr>
<tr>
<td>- Respite Care Grant to increase by €200 from €1000 to €1,200 in respect of each care recipient (June 2006)</td>
<td></td>
<td>7.20</td>
</tr>
<tr>
<td>- Increase in the number of hours that recipients of Carer’s Allowance, Carer’s Benefit and the Respite Care Grant are entitled to work from 10 hours per week to 15 hours per week (June 2006)</td>
<td></td>
<td>4.61</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
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<td>53.61</td>
</tr>
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</table>
Appendix 3

Supports from the Department of Health & Children for those over 65 in need of care

Nursing Home Subvention Scheme
The Health (Nursing Homes) Act, 1990 provided the legal basis for the introduction of the Nursing Home Subvention Scheme in 1993. Prior to the introduction of the Act there were a number of designated nursing homes and a person in one of these homes could avail of a capitation grant, which was not means tested, to pay for the cost of the private nursing home bed. The number of nursing homes which were designated had been capped for a number of years. The Act did away with the designation system and introduced a system whereby all nursing homes had to be registered with the local health authorities and anybody entering a private nursing home could apply for subvention. It also introduced choice of public versus private long-term care and a system to assist a person with the cost of private nursing home care. Most recent figures show that there are approximately 8,300 people in receipt of subvention payments.

Funding of approximately €140 million has been allocated to the Nursing Home Subvention Scheme in 2005.

Home Help Service
The policy of the Department of Health and Children in relation to the development and delivery of services for older people in the community is to maintain them in dignity and independence at home for as long as possible in accordance with their wishes, as expressed in many research studies; to restore to independence at home those older people who become ill or dependent; and to encourage and support the care of older people in their own community by family, neighbours and voluntary bodies. The role of the home help service is vital to the implementation of this policy. The home help service by its nature is a flexible service which is designed to respond to clients’ needs. The service is targeted at high and medium dependency clients in accordance with their assessed need. As a result, therefore, the level of service required in individual cases will fluctuate from time to time. To ensure effective prioritisation of the service, assessments are undertaken at local sector level and are carried out by the public health nursing services.

A total of 8,828,899 hours of home help were delivered in 2003. This increased to a total of 8,963,383 hours in 2004.

Funding of approximately €119 million has been allocated to the home help service in 2005.

Sheltered Housing for Older People
A number of older people live in sheltered housing complexes run by voluntary organisations and they can remain living in the community because of the supports offered in such centres. One issue which has arisen in the recent past is the question of medical/nursing cover people living in sheltered housing complexes. In some areas the local health authority provides nursing cover whereas in other areas there is no cover.

Funding of €2 million was provided in 2005 to provide medical/nursing cover for older people living in sheltered housing complexes.

A & E Initiative
In November 2004, the Tánaiste announced additional funding of €70 million to implement a 10-point Action Plan to improve the delivery of emergency services. The Tánaiste has met with senior management of the Health Service Executive (HSE) and the Department of Health and Children is working closely with the HSE to ensure early implementation of these measures. Theses measures include the transfer of 100 high dependency patients to suitable private nursing home care, negotiating with the private sector to meet the needs of 500 people annually for
intermediate care of up to six weeks and an expansion of home care packages to support 500 additional older people at home. It is not yet clear the exact amount of the €70 million which will be allocated to Services for Older People.

**Delayed Discharges**
Funding of **€16.8 million** has been made available to the former Eastern Regional Health Authority which will result in over 600 patients being discharged to more appropriate settings. A total of **€5 million** has also been provided to the former Southern Health Board under the delayed discharges initiative in 2003/2004 to facilitate the discharge of patients from the acute hospital system.

Total funding of **€21.8 million** has been provided under the Delayed Discharges Initiative to assist with the discharge of older people from the acute hospital sector.

**Incontinence Wear**
Funding of approximately **€7.5 million** is expended by the Health Service Executive on providing incontinence wear to patients in nursing homes.

**Home Care Grant**
Funding of **€2 million** is expended by the Health Service Executive in providing the Home Care Grant nationwide.

**Medical Cards**
In 2003 there were **374,668 persons** aged 65 years and over covered by the GMS Scheme.

Cost breakdowns such as you request are not routinely available. It may be possible to get this information from the Primary Care Re-imbursement Services (formerly GMS (Payments) Board), and we have asked them to get this information. In the interim, it is estimated that of the total amount paid, in 2003, an approximate figure of €500 million was made in respect of payments to doctors and pharmacists for services to medical card holders aged 65 years and over.

**Funding**
Since 1997, additional revenue funding of over **€287 million** has been allocated to services for older people, with an further **€15.228 million** allocated in the 2005 estimates.

It is not possible to determine the total core grant of funding to services for older people. As the services were developed over the years, some funding have crossed over through various other programmes, e.g. public health nurses also look after people with intellectual disabilities in the community. The FISP system being undertaken by the HSE will clarify this situation in the future.
Appendix 4

Supports from the Department of Social and Family Affairs for Carers

Carer’s Allowance
Carer’s Allowance is a means-tested payment for people who provide full-time care and attention to persons who require full time care and attention. The maximum personal rate of payment is €153.60 per week and up to €16.80 per week may be paid in respect of each child dependant.

Numbers benefiting*: 23,030 in 2004
Cost: €191.0 million in 2004

Carer’s Benefit
Carer’s Benefit is a payment made to insured people who leave the workforce to provide full time care and attention to persons who require full time care and attention. The Benefit is payable for a period of 65 weeks for each care recipient and may be claimed over separate periods. The maximum personal rate of payment is €163.70 per week and up to €16.80 per week may be paid in respect of each child dependant.

Numbers benefiting*: 679 in 2004
Cost: €7.0 million in 2004

Respite Care Grant
When it was introduced in 1999, the annual Respite Care Grant was paid to Carers in receipt of Carer’s Allowance and Carer’s Benefit. Budget 2005 made provision for the extension of the Respite Care Grant to all full-time carers, regardless of their income but subject to certain conditions. The Grant is payable on the first Thursday in June each year to cover the cost of respite care. The amount of the Grant is €1,000.00 from June 2005 in respect of each care recipient and it is paid to all carers providing full-time care and attention.

Numbers benefiting: 23,709 in 2004
Cost: €20.0 million in 2004

Back to Work Allowance for Former Carers
The Back to Work Allowance Scheme encourages long-term unemployed people and former carers to take up employment or self-employment opportunities by allowing them to retain a reducing proportion of their social welfare payment plus secondary benefits over three years.

Numbers benefiting: 96 people who had been caring for people aged 65+ in 2004
Cost: €0.6 million in 2004

Back to Education Allowance for Former Carers
The Back to Education Allowance is an educational opportunities scheme for certain persons in receipt of one of certain Social Welfare payments, including those previously in receipt of Carer’s Allowance.

Numbers benefiting: 17 people who had been caring for people aged 65+ in 2004
Cost: €0.1 million in 2004

(Note: It is estimated that approximately half of Carer’s Allowance, Carer’s Benefit and Respite Care Grants are paid in respect of care recipients aged 65 years and over.)
Appendix 5

Tax-based supports available to individuals in need of care

INCOME TAX ALLOWANCES

**Employment of a Carer Allowance**
Can be claimed where a spouse or a relative is permanently incapacitated by reason of a physical or mental disability and a person is employed to care for the person with a disability. The allowance applies at an individual’s marginal rate of tax for expenses up to €30,000 per annum - increased from €12,700 in 2002.

*Numbers benefiting:* 600 people in 2002

*Cost:* €0.6 million

**Medical Expenses Relief**
Tax relief is available at an individual’s marginal rate in respect of unreimbursed nursing home, doctors, hospitals and other health expenses. The first €125 per annum in respect of a single person and €250 per annum in respect of a family is excluded. There is no upper limit on the relief.

*Numbers benefiting:* 144,000 people in 2002

*Cost:* €63 million

*Note:* This is the **total** cost and numbers of those availing of tax relief on Medical Expenses. It is not possible to isolate the cost and numbers availing of tax relief specifically for nursing home fees.

**Dependent Relatives Tax Credit**
A tax credit of €60 per annum can be claimed, *inter alia*, by a person who maintains at their own expense a relative with a disability or older relative who is unable to maintain themselves, including a relative of their spouse.

*Numbers benefiting:* 16,600 people in 2002

*Cost:* €1 million

**Relief on long-term care insurance schemes**
Tax relief is available in respect of premia on qualifying insurance policies designed to cover in whole or part for the future care needs of individuals who are unable to perform at least two activities of daily living or who are suffering from severe cognitive impairment. The relief is standard rated and is given under a relief at source system. Qualifying policies must be approved by Revenue and may be taken out by an individual in respect of himself or herself, his or her spouse and children and other relatives.

*Numbers benefiting:* Nil. It is understood that no qualifying insurance products have yet to come on the market.

*Cost:* Nil

**Blind Persons Tax Credit**
Can be claimed by a blind person. For the current tax year the credit is worth €1,000 for a single person or €2,000 in the case of a married couple (both blind).

*Numbers benefiting:* 850 people in 2002

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32 Figures for the ‘cost’ and ‘numbers benefiting’ refer to the total cost and the total number of people availing of the credits/reliefs, **not just those aged over-65**.
Cost: €0.7 million

**Deeds of Covenant**
Tax relief, not exceeding 5% of the covenanter’s total income, is available on covenants in favour of adults aged over 65 (regardless of their level of infirmity, if any).

*Numbers benefiting:* 1,100 people in 2002

Cost: €2.9 million

**Home Carer’s Tax Credit**
Can be claimed in respect of those spouses of married one income families, jointly assessed, who work in the home caring for certain dependent persons. The definition of dependent person includes a person aged 65 years (regardless of their level of infirmity, if any). The definition of a dependent person does not include a spouse. The maximum tax credit due for the tax year is €770 where the home carer’s income does not exceed €5,080.

*Numbers benefiting:* 105,500 in 2006 (forecast)

Cost: €78 million in 2006 (forecast)
CAPITAL TAX ALLOWANCES

Capital Allowances for Nursing Homes
Since December 1997, capital allowances are available for capital expenditure on buildings used as private, registered nursing homes and for expenditure on the conversion of an existing building into such a nursing home.

The writing down allowance to be granted is at a rate of 15 per cent per annum for 6 years, and 10 per cent in year 7, of the capital expenditure incurred on the construction or refurbishment of the registered nursing home. Allowances will be clawed back if the building ceases to be a qualifying nursing home within 10 years.

Cost: No data expected to be available before early 2006 for these capital allowance schemes. Changes to the tax return forms for 2004 will yield additional information required to estimate cost of this scheme but 2004 returns will not be filed until October 2005.

Capital Allowances for Private Convalescent Facilities
Similar allowances apply to capital expenditure incurred from December 1998 on the construction, extension and refurbishment of, or conversion to, a private convalescent facility. Again, allowances are at the rate of 15% per annum for the first 6 years and 10% in year 7.

The facilities are to be used as an alternative to hospital care for patients recovering from acute hospital treatment and must be approved by the Health Service Executive. Such approval will be subject to meeting certain requirements of the Health (Nursing Homes) Act 1990. Allowances will be clawed back if the building ceases to be a qualifying convalescent facility within 10 years.

Capital Allowances for Housing Units for the Aged and Infirm
Capital allowances for expenditure incurred during the five year period from March 2002 on the construction or refurbishment of housing units associated with a registered nursing home. These residential units are intended for older people who wish to maintain their independent living status within a sheltered caring environment. Specified facilities must be available on site and the units must be leased only to those who are certified by a medical doctor to require such accommodation by virtue of old age or infirmity.

Again, allowances are at the rate of 15% per annum for the first 6 years with the balance of 10% being written off in year 7 and allowances are subject to a claw-back if the units are sold within 10 years.

VAT RELIEFS

VAT Zero-rating for medical equipment and appliances
A zero rate of VAT applies to a limited range of medical equipment and appliances including:

- invalid carriages, and other vehicles (excluding mechanically propelled road vehicles), of a kind designed for use by invalids or infirm persons;
- orthopaedic appliances, surgical belts, trusses and the like, deaf aids, and artificial limbs and other artificial parts of the body excluding artificial teeth, corrective spectacles and contact lenses; and
- walking frames and crutches.

VAT rates do not distinguish users on an age basis i.e. the goods mentioned carry a zero rate for all users.
Value-Added Tax (Refund of Tax) (No. 15) Order, 1981
A refund of VAT can be claimed on the purchase of goods which are aids and appliances designed to assist a disabled person to overcome his/her disability in the performance of daily functions or in the exercise of a vocation. Examples of eligible goods include:

- Necessary domestic aids (e.g. drinking and eating aids designed solely for the disabled);
- Walk-in baths designed for the disabled;
- Commode chair, etc.;
- Lifting seats and specified chairs designed for the disabled;
- Hoists and lifters designed for invalids including stair lifts;
- Pendant alarm systems for older people.

For this purpose, a “disabled person” is defined in wide terms and includes both physical and mental disabilities.

Cost: estimated at c. **€1.2 million** per annum in respect of all claimants. No breakdown is available on the cost of this relief in respect of older persons specifically.
Appendix 6

Supports from the Department of the Environment, Heritage and Local Government for those over 65 in need of care

**Essential Repairs Grant Scheme**
The Essential Repairs Grant Scheme is designed to enable people whose houses cannot be made habitable in all respects at a reasonable cost to have basic repairs carried out. The scheme is administered by Local Authorities. The types of work allowable under the scheme include repairs to roofs, chimneys, gables, repair/replacement of windows and doors, drylining, rewiring, provision of central heating, etc. The Department of the Environment, Heritage and Local Government recoups to Local Authorities two thirds of their expenditure on these grants to a maximum of €6,348, while the Authorities provide the remaining third from their revenue accounts. The effective maximum grant under the scheme is, therefore, €9,523 and can cover up to 100% of the cost of the works.

**Disabled Persons Grant Scheme**
The Disabled Persons Grant Scheme, which is also administered by Local Authorities, provides grant assistance for works necessary for the proper accommodation of people with disabilities. The types of work allowable under the scheme include the provision of access ramps, downstairs toilet facilities, stairlifts, accessible showers, adaptations to facilitate wheelchair access, extensions etc. The Department of the Environment, Heritage and Local Government recoups to Local Authorities two thirds of their expenditure on the grants to a maximum of €13,546 while the Authorities provide the balance from their own revenue resources. The effective maximum grant under the scheme is, therefore, €20,320 and can cover up to 90% of the cost of the works.

**Special Housing Aid for the Elderly Scheme**
The Special Housing Aid for the Elderly Scheme was established in 1982 to provide assistance, by way of necessary emergency repairs, to improve conditions in the existing house of older persons living alone in unfit or unsanitary conditions. Typically, aid is available for necessary repairs to make a dwelling habitable for the lifetime of the occupant e.g. structural/roof repairs or improvement, wiring, damp proofing, repairs to windows and doors, the provision of water and sanitary facilities, provision of suitable heating systems etc. The scheme is administered by a Task Force under the aegis of the Department and is operated at local level by the Community Care sections of the Health Service Executive who are responsible for determining the eligibility of applicants and having the necessary works carried out.

**Voluntary Housing Capital Assistance Scheme**
The Capital Assistance Scheme assists approved voluntary housing bodies to provide accommodation to meet special housing needs, such as those of older people, people with disabilities, homeless people and disadvantaged families.

A loan under the scheme may only be made where the housing authority are satisfied that the accommodation is being provided to meet housing needs in the area and that at least 75% of the units of accommodation being provided, excluding any caretaker/welfare accommodation, will be used full time as residential accommodation for:

- Persons whose need for accommodation has been included in a housing authority’s most recent assessment of housing needs under section 9 of the Housing Act, 1988, or who have been accepted for inclusion in the next such assessment. In this connection, it should be noted that it is open to a housing authority at any stage to make a determination that a person has been accepted for inclusion in the next assessment of housing needs, e.g., to include persons who are victims of family violence or desertion, single parents, etc.;
- Homeless persons as defined in section 2 of the Housing Act, 1988;
- Tenants or tenant purchasers of houses provided by a housing authority who provide the
authority with vacant possession of the house by surrendering the tenancy or by conveying
the house without compensation to the authority.
- Older emigrants returning to reside in this country (up to 25% of the accommodation) who
  are on the Safe Home waiting list.

The scheme is not designed to provide nursing home or other accommodation where residents
would require extensive medical, nursing or institutional-type care.

In the last 5 year period (2000 - 2004 incl.) funding in excess of €408 million was provided by the
Department of the Environment, Heritage and Local Government under this scheme to approved
housing bodies towards the provision of some 3,942 units of accommodation. Accommodation for
older people comprised some 40% of these units (1611 units).

Central Heating Programme for Local Authority Dwellings
Older people will also benefit from the central heating programme introduced by the Department
of the Environment, Heritage and Local Government in July 2004. The programme is designed to
assist Local Authorities in providing central heating facilities in their rented dwellings which lack
them. In conjunction with the provision of central heating, eligible works must also include, where
necessary, measures to ensure the energy efficiency of the building such as attic insulation to
Building Regulations standards, draught-proofing to existing windows and doors, the lagging of
exposed pipework and hot water storage cylinders and the installation of a mains operated smoke
alarm. When the scheme was introduced, Authorities were reminded that a key NAPS target is
the provision of adequate heating systems by end 2007 in Local Authority rented dwellings
provided for older people. Grants totalling €12 million were paid by the Department in 2004
enabling works to be undertaken on some 2,900 homes. The scheme has been extended for a
further period in 2005, with a sum of €30 million being made available by the Department to
support the scheme in 2005.
Activity under the Essential Repairs Grant, Special Housing Aid for the Elderly and Disabled Persons Grant Schemes

Table 10: Essential Repairs Grants 2000 to 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Grants Paid</th>
<th>Value €000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>1,366</td>
<td>5,117</td>
</tr>
<tr>
<td>2001</td>
<td>1,917</td>
<td>8,977</td>
</tr>
<tr>
<td>2002</td>
<td>3,274</td>
<td>16,099</td>
</tr>
<tr>
<td>2003</td>
<td>2,842</td>
<td>13,303</td>
</tr>
<tr>
<td>2004</td>
<td>2,075</td>
<td>9,585</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>11,474</td>
</tr>
</tbody>
</table>

Table 11: Special Housing Aid for the Elderly Scheme 2000 to 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of households assisted</th>
<th>Allocation to HBs (now HSE) €000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>3,601</td>
<td>10,158</td>
</tr>
<tr>
<td>2001</td>
<td>5,237</td>
<td>10,993</td>
</tr>
<tr>
<td>2002</td>
<td>4,998</td>
<td>11,903</td>
</tr>
<tr>
<td>2003</td>
<td>4,169</td>
<td>11,536</td>
</tr>
<tr>
<td>2004</td>
<td>4,414</td>
<td>15,600</td>
</tr>
<tr>
<td>Total</td>
<td>22,419</td>
<td>60,130</td>
</tr>
</tbody>
</table>

Table 12: Disabled Persons Grants 2000 to 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Grants</th>
<th>Value €000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>3,646</td>
<td>27,693</td>
</tr>
<tr>
<td>2001</td>
<td>4,883</td>
<td>41,736</td>
</tr>
<tr>
<td>2002</td>
<td>5,932</td>
<td>52,599</td>
</tr>
<tr>
<td>2003</td>
<td>5,739</td>
<td>50,481</td>
</tr>
<tr>
<td>2004</td>
<td>5,222</td>
<td>45,814</td>
</tr>
<tr>
<td>Total</td>
<td>25,422</td>
<td>218,323</td>
</tr>
</tbody>
</table>
Appendix 7

Assumed reduction in disability prevalence rates (2001 base / % per annum)*:

<table>
<thead>
<tr>
<th>Men</th>
<th>Prevalence in 2001</th>
<th>% annual fall, 2001-2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>9</td>
<td>0.67%</td>
</tr>
<tr>
<td>70-74</td>
<td>11</td>
<td>0.67%</td>
</tr>
<tr>
<td>75-79</td>
<td>19</td>
<td>None</td>
</tr>
<tr>
<td>80-84</td>
<td>29</td>
<td>None</td>
</tr>
<tr>
<td>85+</td>
<td>40</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women</th>
<th>Prevalence in 2001</th>
<th>% annual fall, 2001-2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>11</td>
<td>0.90%</td>
</tr>
<tr>
<td>70-74</td>
<td>14</td>
<td>0.90%</td>
</tr>
<tr>
<td>75-79</td>
<td>24</td>
<td>None</td>
</tr>
<tr>
<td>80-84</td>
<td>36</td>
<td>None</td>
</tr>
<tr>
<td>85+</td>
<td>65</td>
<td>None</td>
</tr>
</tbody>
</table>