

Review of the Nursing Homes Support Scheme, *A Fair Deal*



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Foreword

Most older people would prefer to live in their own homes and communities than reside in a nursing home. We try to facilitate this as much as possible. Unfortunately, it is not always possible or feasible. For those that need nursing home care, we aim to ensure that a safe, quality and respectful service is provided.

The Nursing Homes Support Scheme is a key component of the provision of care for our older citizens. It was a significant departure from the systems of nursing home support that it replaced. Because of this, it was important to allow it to fully integrate before reviewing its operation. When the scheme was introduced, a commitment was made that it would be reviewed after three years and this exercise has now been completed.

This review looks objectively at the operation of the scheme. It is acknowledged that the scheme has been effectively established and operates well. It also identifies areas that need attention or further examination.

The review also includes a broader consideration of how supports for older people need to be developed. The overall message emerging from this review is that older people should be supported to stay at home for as long as possible, and that residential care must be available and accessible for those who need it if that point is reached.

The Nursing Homes Support Scheme is a progressive scheme which relieves families of potentially very onerous expense and ensures that residential care is available to those who need it. The Government has this year placed the scheme on a sustainable footing by providing additional funding of €54 million and the scheme will continue in the years ahead to be a key element of the supports that are available to our older people.

I want to thank everyone who contributed to this review; the people who responded to the call for submissions, the officials in the Department and HSE, Deloitte and Touche Consultants and all of the stakeholder groups who took the time to contribute to the process.

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Acronyms

ADL	Activities of Daily Living
CHO	Community Healthcare Organisation
CSAR	Common Summary Assessment Report
CSO	Central Statistics Office
DOECLG	Department of Environment, Community and Local Government
DOH	Department of Health
DSP	Department of Social Protection
HCP	Home Care Package
HH	Home Help
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IADL	Instrumental Activities of Daily Living
ICSH	Irish Council for Social Housing
IFA	Irish Farmers Association
ISA	Integrated Service Area
LHO	Local Health Office
LPF	Local Placement Forum
LTRC	Long-term Residential Care
NALA	National Adult Literacy Agency
NAMA	National Asset Management Agency
NHI	Nursing Homes Ireland
NHSO	Nursing Homes Support Office
NHSS	Nursing Homes Support Scheme
NTPF	National Treatment Purchase Fund
PPSN	Public Personal Services Number
PPR	Principal Private Residence
PRA	Property Registration Authority
PRTB	Private Residential Tenancies Board
SAT	Single Assessment Tool
TILDA	The Irish Longitudinal Study on Ageing
VFM	Value For Money

Overview of the Nursing Homes Support Scheme (chapter 1)

This chapter highlights the key elements of the scheme. The NHSS was established by the Nursing Homes Support Scheme Act 2009 (the Act), and provides financial support towards the cost of long-term residential care. Once an individual has been assessed as needing long-term residential care i.e residential care which requires a 24 hour nursing presence, a financial assessment is carried out to determine the financial contribution that the individual should make towards the cost of their care. An individual's contribution is based on their means, and the State, through the Health Service Executive (HSE), pays the balance of the costs in public, private and voluntary nursing homes approved under the scheme.

This chapter sets out the role of the various State agencies involved in the scheme. All nursing homes must be registered with the Health Information and Quality Authority (HIQA), which is also responsible for ensuring quality standards are met.

A private or voluntary nursing home cannot participate in the scheme unless it has agreed a price with the National Treatment Purchase Fund (NTPF). The NTPF is independent in the performance of its functions. The NTPF has no role in setting or negotiating prices for public facilities. The maximum prices to be paid in public facilities, and referred to as the cost of care, are set by the HSE, laid before the Oireachtas and are published on the HSE website.

Operation of the Nursing Homes Support Scheme (chapter 2)

The HSE has statutory responsibility for administering the scheme and it does so through a national office and 17 local support offices. The budget for long-term residential care in 2015 is €993 million. Since the scheme commenced there has been some reclassification of expenditure under the scheme, but funding has been relatively stable in the range of €900 million to €1 billion per annum since the scheme's inception.

National guidelines have been developed to ensure a standardised national approach to operating the scheme. The application process is outlined, which involves a care needs assessment and a financial assessment. The financial assessment takes account of both income and assets. Individuals can contribute up to 80% of their assessable income and 7.5% of the value of their assets per annum. The principal residence is only considered as part of their assets for the first 3 years. Where an individual's assets include land and property in the State, the

contribution based on these assets may be deferred and collected from their estate after their death. This is the optional nursing home loan element of the scheme, legally referred to as ancillary State support.

There are several important safeguards built into the scheme which ensure that both the person entering long-term nursing home care and their spouse/partner are adequately provided for:

- Nobody will pay more than the actual cost of care.
- The first €36,000 for a person's assets, or €72,000 for a couple, is not taken into account during the financial assessment.
- The principal residence (and farms/businesses in certain circumstances) is only included in the financial assessment for the first three years of a person's time in care.
- Individuals keep a personal allowance of 20% of their income, or 20% of the maximum rate of the State Pension (Non-Contributory), whichever is the greater.
- If there is a spouse/partner remaining at home, he/she will retain 50% of the couple's income, or the maximum rate of the State Pension (Non-Contributory), whichever is the greater.
- The scheme also provides for certain items of expenditure, 'allowable deductions', to be taken into account during the financial assessment. These include health expenses, levies required by law (e.g local property tax), rent payments and borrowings in respect of a person's principal residence.

Anyone who is assessed as requiring long-term nursing home care can avail of the scheme, regardless of age. However, nursing home care must be appropriate to the individual's care needs.

Approach and Methodology (chapter 3)

The review was led by the Department of Health, in collaboration with the HSE, and with input and analysis provided by Deloitte and Touche Consultants on specific issues that required specialised expertise.

The Department of Health carried out an extensive public consultation before commencing the review. The review examines five main areas:

- The scheme administration and processes,

- The price of care in private and public nursing homes,
- The re-orientation of services for older people towards the community,
- The provision of adequate long-term residential care places, and
- Financing of long-term care in the future.

Scheme Administration and Processes (chapter 4)

This chapter examines the management and administration of the scheme and the effectiveness of financial declarations. The recommendations contained in this chapter are mainly administrative in nature, and aim to achieve a more effective and consistent operation of the scheme. Recommendations under this heading cover the centralisation of certain elements of the scheme and processes, developing the use of web based systems, enhancements to the application process and increased focus on financial validation.

Price of Care in Private and Public Nursing Homes (chapter 5)

This chapter deals with the price being charged for long-term residential care in private, voluntary and public nursing homes, and the services and care that are covered by the scheme. It recommends that the existing system of fixing prices facility by facility should continue for the immediate future. However, within 18 months the NTPF should review the present system with a view to:-

- Ensuring that there is adequate residential capacity for those residents who require higher level or more complex care,
- Ensuring value and economy, with the lowest possible administrative cost for the State and administrative burden for providers,
- Increasing the transparency of the pricing mechanism so that existing and potential investors can make as informed decisions as possible.

The cost of public long-term residential care should be based on a pricing model that is objectively and consistently formulated, and which takes account of, and accurately quantifies, unavoidable cost distorting factors. A Value For Money and Policy (VFM) review will be carried out on public facilities which will recommend actions and timelines to address any cost distorting factors that cannot be attributed to inherent differences in resident profile or unavoidable costs as between the public and the private sectors.

Re-orientation of the Social Care System (chapter 6)

This chapter examines the services available for older people and outlines the range of informal and formal health and social care supports that are currently in place. To try to identify the mix of services that can best meet the needs and preferences of older people into the future, the HSE profiled and analysed in detail four geographical areas against their referral rates for long-term residential care. The analysis looked at the services currently in place, what appears to be working well, and what elements or models of services need to be developed to facilitate a more community focused service. There is growing consensus that home or community based care can be a cost-effective alternative to nursing home care for some older people.

Residential Care Capacity (chapter 7)

This chapter considers the future demand for nursing home care beds. While community based initiatives and more innovative approaches to the provision of long-term care may impact on the numbers seeking long-term residential care, prospective increases in the older population and particularly among the over 85 years population, will inevitably lead to increased demands for nursing home care services.

Based on current utilisation rates and projected increases in the numbers of older people, there will be a requirement to have over 33,000 NHSS beds in the system by 2024. This is approximately 9,000 more beds than in 2015.

The need for further incentivisation for further investment in the sector is currently being evaluated by the Department of Health. Detailed consideration should be given to whether there is potential for new models of collaboration between the public and private sectors. The review recommends that the potential of sheltered housing and assisted housing models should also be considered in consultation with the Department of Environment, Community and Local Government.

Future Financing of Services for Older People (chapter 8)

The future financing of the scheme is considered in the final chapter of this review. At present long-term residential care is financed by a combination of direct State support and a contribution from residents based on their means. The Nursing Homes Support Scheme is a progressive scheme with residents' contributions based on their means. There are extensive exclusions from the property or cash asset based contributions, including a substantial portion of

the value of the principal private residence. It is also an expensive scheme for the State, with a budget of €993 million in 2015. While those in long-term residential care contribute to the costs of care in accordance with their means, the average contribution amounts to only 25% approximately of the cost of care.

Short-stay beds are substantially financed by the State with patients subject to a maximum charge of €175 per week where in excess of 30 days services have been received over the previous 12 month period. Home care and other community based services are currently provided based on need and there is no means test or personal contribution.

This chapter identifies a range of technical policy options that may be the subject of further consideration in ensuring that the care needs of an increasing number of older people can be met into the future.

Background to Review of the Nursing Homes Support Scheme

The Nursing Homes Support Scheme (NHSS) or Fair Deal as it is commonly referred to, is a system of financial support for people who require long-term nursing home care. It replaced the various systems of support that existed prior to that, i.e. subvention for people in private nursing homes or long-stay charges for people in public nursing homes and contract beds.

The systems that existed prior to the introduction of the NHSS were acknowledged as being inequitable. There were vastly different levels of support available to residents in the public system and residents in the private system. Individuals who obtained a public bed were charged a maximum of up to 80% of the State Pension (Non-Contributory) towards the cost of their care. In contrast, individuals who availed of a private nursing home bed may have been entitled to a level of subvention, based on their means, but otherwise were obliged to meet the full cost of their nursing home care.

When the NHSS commenced, a commitment was made that it would be reviewed after three years. The reason for allowing this period to elapse was to ensure that the scheme had bedded in, and that established and validated trends and statistics would be available in order to inform the work of the review. In addition, the Programme for Government 2011-2016 committed to reviewing the 'Fair Deal' system of financing nursing home care with a view to developing a secure and equitable system of financing for community and long-term care which supports older people to stay in their own homes and communities for as long as possible.

The Terms of Reference for the review are:

Taking account of Government policy, demographic trends and the fiscal situation –

1. To examine the on-going sustainability of the Nursing Homes Support Scheme,
2. To examine the overall cost of long-term residential care in public and private nursing homes and the effectiveness of the current methods of negotiating/setting prices,
3. Having regard to 1. and 2. above, to consider the balance of funding between long-term residential care and community based services,
4. To consider the extension of the scheme to community based services and to other sectors (Disability and Mental Health), and
5. To make recommendations for the future operation and management of the scheme.

Chapter 1: The Nursing Homes Support Scheme

1.1. Overview

The NHSS provides financial support towards the cost of long-term residential care. Once an individual has been assessed as needing long-term residential care (i.e. care which requires a 24 hour nursing presence) a financial assessment is carried out to determine the financial contribution that the individual should make towards the cost of their care. An individual's contribution is based on their means, and the State, through the Health Service Executive (HSE), pays the balance of the costs of care in public, private and voluntary nursing homes approved under the scheme.

1.2. Statutory Basis for the Scheme

The NHSS was established by the Nursing Homes Support Scheme Act 2009 (the Act). The Act was signed into law by the President on the 1st July 2009 and came into operation on the 27th October 2009. The Act was amended by the Health (Amendment) Act 2013, and the Health (General Practitioner Service) Act 2014.

1.2.1. Regulations

The Act was commenced on a phased basis. Commencement Orders were drafted to enable:

- the National Treatment Purchase Fund (NTPF) to begin price negotiations on the price of nursing home care with private nursing homes,
- the care representative process to commence for those with diminished capacity availing of the loan element of the scheme, and
- the preparation by the HSE of the forms necessary for the operation of the scheme.

A number of regulations have been introduced since the scheme commenced to rectify anomalies that have emerged in the administration of the scheme.

1.3. Statutory Role of State Agencies

1.3.1. Health Service Executive (HSE)

The HSE has statutory responsibility for administering the scheme. The role of the HSE includes the preparation of guidance material and application forms, accepting applications, assessing an applicant's care needs , conducting a financial assessment to determine the level of contribution

from the resident and disbursing payments to approved nursing homes in respect of the State contribution towards the cost of care. Details of the scheme, including the application form, are available on the HSE website www.hse.ie. A list of approved nursing homes in each county is also published on the website.

1.3.2. Health Information and Quality Authority (HIQA)

Under the Health Act, 2007, all nursing homes both public and private must register with the Health Information and Quality Authority (HIQA) and comply with the conditions and requirements laid down by HIQA in this context. Fees are payable by operators of nursing homes for initial registration, for variations of conditions of registration and an annual fee is also payable by each registered provider. Under the Health Act, 2007 HIQA can inspect nursing homes for registration purposes and to ensure quality standards are being met.

1.3.3. National Treatment Purchase Fund (NTPF)

Under the scheme the National Treatment Purchase Fund (NTPF) negotiates the total price paid to each private and voluntary nursing home for residents in receipt of support from the Nursing Homes Support Scheme. The NTPF is independent in the performance of its functions. A nursing home cannot participate in the scheme unless it has agreed a price with the NTPF.

1.3.4. Revenue Commissioners

The Revenue Commissioners are the appointed agents for the HSE in the collection of the repayable monies under the optional loan element of the scheme.

1.4. Other Key Elements of the Scheme

1.4.1. Care Needs Assessment

To be eligible for financial support under the scheme a determination must be made to confirm that an applicant needs nursing home care. The care needs assessment is carried out by appropriate health-care staff using a standardised common summary assessment report (CSAR) and considers healthcare needs and family and social supports of an applicant.

1.4.2. Age

Anyone who is assessed as requiring long-term residential care can avail of the scheme, regardless of age, as long as the person's care needs can be appropriately met in a nursing home that participates in the scheme.

[1.4.3. Contribution Based on Means](#)

Once an applicant has been confirmed as requiring long-term residential care, their income and assets are assessed to determine the level of their personal contribution and the level of financial support to be provided by the HSE. Nobody will pay more than the actual cost of care.

[1.4.4. Safeguards](#)

The scheme contains a number of safeguards to ensure that personal contributions reflect individual circumstances and that both the person entering long term residential care and their spouse/partner are adequately provided for.

[1.4.5. Nursing Home loan](#)

Where an applicant's assets include land or property held in the State, the contribution based on such assets may be deferred and collected after the applicant's death. This is the optional loan element of the scheme (the legal name is ancillary State support) and is designed to ensure that the applicant does not have to sell his/her home during their lifetime to pay for their care. If an applicant does not have full capacity, a care representative, appointed by the Circuit Court acts on behalf of the applicant in relation to the loan element of the scheme.

[1.4.6. Resident Choice](#)

Once an applicant to the scheme is approved, s/he can choose to enter any approved nursing home that has an available bed and can cater for his/her care needs. The applicant can choose a public, private or voluntary nursing home, and their level of contribution is unaffected by their choice of nursing home.

[1.4.7. Placement List](#)

In order to manage the available funds within budget throughout the year, a national placement list for the release of funding is operated by the HSE. Funding approvals issue to applicants in chronological order, to ensure equity nationally. Applicants are placed on the national placement list in order of their approval date and funding is released in order of their place on this list. The length of time spent on the placement list depends on the number of applicants currently receiving financial support, the number of new applications and the available budget.

[1.4.8. Money Follows the Patient](#)

The scheme is based on the principle of ‘money follows the patient’. In relation to private beds there has always been a direct link between activity and funding, but prior to the introduction of the scheme, public facilities were block funded, regardless of activity levels. When the scheme commenced some cost drivers of the process had not been centralised e.g. payments to public facilities. During 2011 a process was put in place to centralise payments under the scheme and as a result, with effect from 2012, all payments made under the scheme have been processed by the NHSS national office on a named patient basis. Implementing money follows the patient in public units has been a significant achievement of the scheme.

[1.4.9. Cost of Care](#)

The scheme provides financial support towards the cost of the standard components of nursing home care which are:

- nursing and personal care appropriate to the level of care needs of the person;
- bed and board;
- basic aids and appliances necessary to assist the person with the activities of daily living, and
- laundry service.

[1.4.10. Eligibility for Other Schemes](#)

A persons eligibility for other schemes such as the medical card scheme or the drugs payment scheme is unaffected by participation in the NHSS or by residence in a nursing home.

[1.4.11. Transitional Arrangements](#)

Anyone who was resident in a nursing home prior to the introduction of the NHSS cannot be made worse off by the scheme and residents were given an option to continue with the arrangements they had in place. These are known as ‘saver’ cases and at end 2014 there were 2,741 residents in this category.

[1.4.12. Appeals](#)

Applicants to the scheme can appeal certain decisions of the HSE including the results of the care needs assessment and the financial assessment. Appeals may also be made to the High Court on a point of law.

[1.4.13. State Funding](#)

Funding for the scheme is provided annually by the Oireachtas. The HSE may only provide financial support from within the resources allocated in any given financial year. €993 million was provided for the NHSS in 2015.

[1.4.14. Patient Contribution \(2014\)](#)

In addition to monies allocated by the Oireachtas, residents contribute to the cost of their care. Resident contributions amounted to approximately €293 million in 2014. At end 2014 the average weekly contribution from residents in a public unit was €285 and in a private unit was €294. An analysis of scheme participants has identified:

- Average cash assets of scheme participants:- €49,590;
- Average value per participant of other relevant assets (including principal private residence and other property):- €88,941;
- 18% of scheme participants have no declared cash assets;
- 15% of participants have no declared cash or other relevant assets;
- Just over 9% of applicants opt to defer the portion of their contribution that is based on other relevant assets including property;
- 15% of applicants have no declared income other than the Non-Contributory Old Age Pension;
- The average declared income for applicants assessed on a single basis is €281 per week;
- The average declared income for applicants assessed jointly (as part of a couple) is €562 per week.

2. Operation of the Scheme

2.1. Funding

The budget for long-term residential care in 2014 was €939 million. Additional funding of €54 million was allocated for 2015, increasing the budget to €993 million. This provision supports the care costs not only of participants in the scheme, but also of those who were in long-term residential care prior to the introduction of the NHSS. In 2014, non-scheme participants accounted for expenditure of approximately €166 million from the scheme's allocation.

Funding for the scheme since its introduction in 2009 and the number of people being supported under the scheme are set out in Table 1. There has been some element of reclassification and refinement of expenditure under the scheme, but even allowing for this, funding has been relatively stable in the range of €900 million to €1 billion per annum. However, future demographic trends (as outlined further in chapters 7 and 8) will involve increases in the costs of operating the scheme.

Table 1: Funding and Activity by Year¹

Year	Funding (€m)	People at Year-End	No. of Saver cases	Applications received
2009 ²	€909m	Not available ³	Not available	5,252
2010	€979m	Not available	Not available	12,697
2011	€963m	21,548	Not available	9,323
2012	€994.7m	22,065	5,147	10,225
2013	€974m	23,007	3,690	10,406
2014	€939m	22,360	2,741	9,757
2015	€993m	23,960		

¹ Figures taken from the Revised Estimates for Public Services for the relevant year, with the exception of 2011 and 2015. The REV figure was adjusted in 2011 because some funding for ancillary services was captured in the long-term residential care subhead. This was transferred out of the subhead in 2012. The 2015 includes €44 million allocated in April 2015 to reduce the number of delayed discharges in acute hospitals.

² The NHSS only commenced in October 2009. Therefore, funding for that year would have been used for pre NHSS arrangements up to that point.

³ Not Available as ICT System was not fully operational at that point.

2.1.1. Management of Scheme

The scheme is managed by the HSE from the NHSS national office in Tullamore. As well as overseeing the scheme nationally, the responsibilities of this office include the processing of monthly nursing home invoices and payments and processing applications for the nursing home loan. The national office is supported by 17 local HSE nursing homes support offices (NHSOs) around the country. Each NHSO is responsible for processing applications, and completing monthly administration activities from within their allocated regions.

As a result of the new aspects of the scheme, it was critical for the HSE to develop links with the Courts Service, Property Registration Authority, Revenue Commissioners and the National Treatment Purchase Fund. Significant work was involved in putting in place processes and procedures to deal with the various work streams of the scheme.

2.1.2. National Guidelines for the Standardised Implementation of the Nursing Homes Support Scheme

The HSE has published *National Guidelines for the Standardised Implementation of the Nursing Homes Support Scheme*. These are approved by the Minister for Health, and are published on the HSE's website.⁴ The guidelines include:

- Qualifying criteria,
- Applying for the scheme,
- Care needs assessment,
- Financial assessment,
- Reviews and appeals.

The guidelines outline how the scheme is operated and the rights and obligations that apply. The guidelines are updated as required. Work processes for the scheme have been developed by staff in the nursing homes support offices, national office and the HSE finance directorate.

2.1.3. Application Process

Completed application forms are submitted to the local NHSOs. The first step in the application process is a care needs assessment which is carried out by healthcare professionals and approved by

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<http://www.hse.ie/eng/services/list/4/olderpeople/nhss/National%20Guidelines%20for%20the%20Standardised%20Implementation%20of%20the%20Nursing%20Home%20Support%20Scheme.pdf>

the 'Local Placement Forum' (LPF). The LPF is made up of medical and other healthcare staff in each local NHSO area, who approve the common summary assessment report (CSAR). Meetings are generally held by the LPF on a weekly basis, although in some instances they meet fortnightly or at different intervals. The LPF review the CSAR reports and make a decision on the need for care. They inform the NHSO of their determination within 10 days which confirms whether or not long-term residential care is required for the applicant.

[2.1.4. Source of Applications](#)

Since the NHSS commenced to end 2014, the majority (41%) of applications have come from people in acute hospitals. This was closely followed by people in the community at 38%, with a further 10% coming from people who resided in private nursing homes. In 2014, 43% of applicants came from acute hospitals, 40% from the community and 9% from private nursing homes, with 1% coming from the mental health and disability sectors.

[2.1.5. Processing Times](#)

Once completed application forms are submitted it takes the HSE approximately 4 weeks to process them to decision. Delays in processing can occur where applicants do not submit all the relevant documentation, or if the loan application is particularly complex.

[2.1.6. Financial Assessment](#)

Once it has been determined that long-term residential care is the most appropriate option, a financial assessment is carried out to determine the person's contribution towards the cost of their care.

The financial assessment takes account of both income and assets. Individuals contribute up to 80% of their assessable income and 7.5% of the value of any assets per annum (5% of assets if the application was made prior to the 25th July 2013). Where one member of a couple requires long-term residential care, the assessment is based on half of the couple's combined income and assets.

[2.1.7. Nursing Home Loan](#)

Where an individual's assets include land and property held in the State, the portion of the contribution based on such assets may be deferred and collected from their estate. This is the optional nursing home loan element of the scheme (the legal name for this is ancillary State support). A nursing home resident can apply for the loan at any stage. Where an applicant is of

diminished mental capacity a care representative is appointed by the Circuit Court to act on behalf of the applicant in applying for the loan and allowing a charge to be made on the relevant property.

2.1.8. [Safeguards contained in the Scheme](#)

There are several important safeguards built into the scheme which ensure that both the person entering long-term residential care and their spouse/partner are adequately provided for:

1. Nobody will pay more than the actual cost of care;
2. The first €36,000 of a person's assets, or €72,000 for a couple, is not taken into account for the financial assessment;
3. The principal private residence is only included in the financial assessment for the first three years of a person's time in care;
4. Individuals keep a personal allowance of 20% of their income, or 20% of the maximum rate of the State Pension (Non-Contributory), whichever is the greater;
5. Certain items of expenditure, called allowable deductions, can be taken into account for the financial assessment. These allowable deductions include health expenses, payments required by law (e.g local property tax), rent payments and borrowings in respect of a person's principal private residence;
6. The scheme includes provision for reviews and appeals of decisions taken;

The Act enables a specified person ⁵ to act on behalf of an applicant where s/he is not of full mental capacity. This ensures that people who are not of full mental capacity can still avail of the scheme. However, a specified person can only apply for State support. They cannot apply for the nursing home loan element of the scheme, which can only be done by the Court appointed care representative. Furthermore, a specified person cannot, for example, access the applicant's bank account or set up direct debits from the applicant's bank account to a nursing home, unless they already had this power through another mechanism, e.g. Enduring Power of Attorney/Ward of Court.

⁵ A specified person is defined as a) the Committee of a Ward of Court, b) a person appointed under a valid, registered enduring power of attorney who is not restricted from applying for the scheme, c) a care representative appointed under the Nursing Homes Support Scheme Act, d) the applicant's spouse or partner, e) a relative of the applicant who is 18 years of age or over, f) a next friend appointed by a court, g) the applicant's legal representative, or h) a registered medical practitioner, nurse or social worker.

2.2. Monitoring the Scheme

The development of a national IT system to track the scheme and gather a wide range of data was put in place in 2011. Given the short lead in time of four months from the enactment of the legislation to the commencement of the scheme, it was not possible for the HSE to have an IT system in place to deal with all of the various aspects of the new scheme. As a result, the HSE put in place an interim IT solution which enabled payments of financial support to be processed and provided limited client and management information. A new IT system was procured and was fully rolled out to all of the nursing homes support offices in October 2011.

This is the primary system of records of applicants, clients and nursing homes in the scheme. Payments to nursing homes and details of resident contributions are recorded. Application and administrative activities are all managed and tracked through the system.

The development of a financial management system enables the HSE to manage the budget and plan for the number of residents that can be supported under the scheme during the year. The HSE submit monthly performance reports to the Department of Health on activity and funding.

2.3. Average Length of Stay

Government policy is to support older people to stay in their own homes and communities for as long as they can safely do so. Admission to long-term residential care should only be considered where the relevant person cannot be supported at home. This accords with the wishes of most older people.

In line with this policy, admission to long-term residential care has been taking place at a later stage i.e further along the older person's care path than was previously the case. The average length of stay in a nursing home for those who entered nursing homes before the scheme commenced is 6.6 years in private nursing homes and 7.3 years in public facilities.

When the scheme first commenced the average length of stay was approximately 4 years and at end 2014 had reduced to 1.9 years in private and in public facilities for those who had entered long-term residential care since the scheme commenced. At end 2014, taking account of 'saver' cases (1.4.11), the overall average length of stay for private nursing homes was 2.9 years and 3.9 years for public nursing homes. The overall average length of stay was 2.93 years (35 months)

2.4. Complaints Procedures

Under the Health Act 2007, all facilities providing residential services for older people are required to have complaints processes and procedures and an independent appeals process in place. As regulator of the sector HIQA does not investigate individual complaints, but will take account of all information that it receives, including any allegations or complaints made against a nursing home in discharging its registration and inspection functions. Nothing in the legislation prevents or prohibits any person dissatisfied with the service provided in a public facility or by the HSE from referring the complaint to the Office of the Ombudsman. The remit of the Office of the Ombudsman is currently being extended to cover private nursing homes that are approved under the scheme.

3. Approach and Method of Review

This review was carried out by the Department of Health, in collaboration with the HSE, with analysis and recommendations from an external service provider on specific issues which required specialised expertise.

3.1. Public Consultation

A public consultation process was initially undertaken to inform the work of the review. 61 submissions were received from a range of individuals, nursing homes, statutory and private organisations, voluntary bodies and organisations representing the interests of older people.

Almost 150 recommendations were made in the submissions. An analysis of the submissions was conducted and a summary report entitled *Nursing Homes Support Scheme, A Fair Deal – Summary of Submissions Received to Inform the Review of the Scheme* is published on the Department of Health website.⁶ The recommendations received and the themes identified have informed this report.

3.2. International Comparisons

The Department of Health conducted an examination of how long term care services for older people are provided and financed across a number of comparable international settings. A summary of the results of this exercise is set out in Appendix A.

3.3. External Expertise

A public procurement process was conducted in 2013, to engage specialised expertise on certain operational and financial elements of the scheme. Deloitte and Touche Consultants were engaged by the Department of Health and they provided input on the following:

- the processes and administration of the scheme, including application process and client satisfaction,

⁶ <http://health.gov.ie/blog/publications/review-of-the-nursing-homes-support-scheme-summary-of-submissions/>

- the effectiveness of processes for verifying financial declarations by clients of income and assets for the purposes of the scheme,
- the processes and methods for setting prices for long-term residential care services in public, private and voluntary nursing homes.

The consultants were asked to make recommendations for the future management and operation of the scheme arising from their consideration of the above issues.

In order to acquire a complete view of the processes and administration involved in the scheme, a series of meetings was conducted by Deloitte and Touche Consultants with key stakeholders and account was taken of submissions to the public consultation process. An in-depth analysis of the process around financial declarations was also conducted.

3.4 Mental Health and Disability Sectors

It is not considered that the present NHSS funding model would match the needs and characteristics of the mental health and disability model of service delivery at this point in time, in particular as significant reform is on-going in these areas. Accordingly, the possible extension of the scheme to these sectors is not included in this review.

4. Review of Scheme Administration and Processes

4.1. Centralisation of Functions

The first issue addressed by the consultants was the structure and functions of the HSE offices responsible for the administration of the scheme.

At present, certain functions are carried out by local nursing homes support offices (NHSOs) and others are carried out by the national office in Tullamore. Consideration was given to whether additional centralisation of functions would improve overall efficiency. Deloitte and Touche Consultants concluded that the processing of nursing home invoices and the calculation of the amount to be repaid to the Revenue Commissioners in respect of the nursing home loan could be carried out more efficiently in the national office. However, the consultants considered that other functions are more suited to decentralised management for example, review and input of applications, care needs assessments, financial assessments, reviews, nursing home applications, release of funding and loan applications.

The basis for the consultants view is that proximity to the applicants is required to efficiently discharge these functions and sometimes the centralising of functions can be seen as leading to longer and less effective lines of communication, to less accessibility, and to less responsiveness. The Department of Health considers that centralisation can work well provided that key elements are done well. These include effectively designing centralised business processes, providing adequate numbers of staff with appropriate training and providing effective IT and other supports. In addition, there should be clear guidance material and easy access for applicants to staff in the centralised location.

The HSE is planning to consolidate the existing 17 local NHSOs into 4 regional NHSOs by end 2015, but there will still be a facility in existing local offices to deal with queries from the public. In implementing this consolidation, the HSE should ensure that the key elements referred to in the previous paragraph above are effectively addressed.

4.1.1. Invoices

Each month the HSE's contribution to nursing home bills is paid directly to the relevant nursing home. Residents are responsible for paying their own contribution. Invoices are sent by nursing homes to the local NHSO for processing, where relevant data is inputted to the IT system. This appears to be less than optimally efficient. A standard web based form, submitted electronically by each nursing home would reduce the processing needed in HSE offices.

Invoices from private nursing homes are processed by local NHSOs, but those from public nursing homes are processed by the national office. Efficiency would be improved, and the need for HSE staff and inputting time reduced, by adapting a system of standardised invoices for both public and private facilities and centralising the functions in one central office.

4.1.2. Repayment of Loans to Revenue

The calculation of the amount of due to be repaid to the Revenue Commissioners from availing of the loan element is currently carried out in both the national office and the local NHSOs. This could be more effectively carried out by the national office.

4.2. Standardisation of Work Practices

Irrespective of the decision about consolidation of the local NHSOs from 17 to 4, it is vital that there is consistency across administrative locations. In this context, the consultants noted that there appeared to be some variations in work practices across the existing local NHSOs. This can result in variations in application processing times across locations. For example, some NHSOs use alternative work methods (.i.e. that differ from the HSE's standard operating procedures) in order to speed up the application process for the applicant. The HSE is confident that there is a good level of standardisation across the main business processes but will review in order to address any variations that may have developed.

The standard method of communicating with applicants is by letter. However, some staff also make contact with applicants by telephone in order to speed up the process. The consultants concluded that some NHSOs review the entire application upon receipt and immediately seek any outstanding information/documentation, and that others only review the section of the application relating to a financial assessment after the care needs assessment has been completed. The HSE's view is that the care needs assessment and financial assessment normally run in parallel with each other to minimise delays. However, the HSE will review the position.

4.2.1. Advice to Applicants

Some NHSOs advise applicants not to apply for the nursing home loan if they have sufficient means to pay their contribution. This means that there is no money to be repaid to the Revenue Commissioners at a later date and, accordingly, reduces the administrative burden associated with the loan element of the scheme. The HSE should prepare clear central guidelines on how applicants should be advised on such issues.

4.2.2. Tax Relief

Applicants should also be consistently advised about the possibility of claiming tax relief for health expenses. These expenses include doctors' and consultants' fees, drugs or medicines prescribed by a doctor, nursing home fees and contributions required under the NHSS. Full details are available on the Revenue Commissioners' website.⁷

4.3. Application Process

4.3.1. Clarity of Explanatory Documentation

The consultants found that some applicants have experienced difficulty in understanding the process and found that the explanatory literature currently available unclear, resulting in incomplete application forms being submitted and subsequent delays in the process. The HSE has generally received very positive feedback about the clarity of the NHSS literature, and has gone to considerable lengths to make it accessible including the production of a "Quick Guide" to summarise the essentials of the scheme. However, the HSE has undertaken to review all relevant literature to see if it can be made more easily understood and to provide clear guidance on where relevant information/documentation can be obtained. Consideration should be given to developing documents with advice from the National Adult Literacy Agency (NALA). It may also be useful to provide applicants with sample completed application forms.

The list of nursing homes provided to applicants does not contain any information on which homes can accommodate particular care needs, e.g. dementia. If possible, additional information should be provided in order to make the process of identifying a suitable nursing home easily understood by applicants and their families. However, consideration will be needed as to whether the capacity of

⁷ <http://www.revenue.ie/en/tax/it/leaflets/it6.html>

private facilities to cater for particular care needs requires external verification, if it is to be included in HSE literature/websites.

Explanatory documentation should make it very clear for how long the application form documentation and the care needs assessment form(CSAR) remain valid, without any new processes or medical assessments.

[4.3.2. Structure of the Application Form](#)

The validity and purpose of each question on the application form should be reviewed. There may be merit in including additional questions which could assist in the financial assessment (e.g. “Has the applicant ever lived abroad?” to allow assessment of any foreign pension or other income). The application form should also include a mechanism for an applicant to authorise a representative to submit the application on their behalf.

The consultants pointed out that the first priority for an initial application is to trigger a care needs assessment, for which information on income/assets etc. is not required. This assessment identifies whether the applicant needs long-term residential care or whether the applicant can be supported to continue living at home.

If the care needs assessment confirms that long term residential care is required, the local NHSO will inform the applicant and will then commence the applicant’s financial assessment. Accordingly, the consultants suggested that the application form be split into two parts, viz., PART A (existing parts 1, 2 and 5) to be submitted initially, and PART B (existing parts 3, 4 and 6) to be submitted subsequently. This would avoid delaying the care needs assessment process while applicants gather the necessary financial information and documentation. In this context, it appears that some applicants find the financial elements of the application to be challenging, and it is therefore imperative that the guidance material provided by the HSE, on this area in particular, be as understandable and specific as possible about what is needed, where relevant documentation can be obtained, and on where further advice can be obtained.

The consultants suggested that it would be beneficial to establish an NHSS best practice group (consisting of local NHSO and national office staff members) to share experiences and agree on best practice. Once best practice has been agreed, standard operating procedures should be developed and/or amended and utilised nationally thereafter.

The HSE NHSS national office already meets or holds conference calls with local NHSO managers at least on a six weekly basis and there is ongoing daily contact between the national office and local offices on issues as they arise. However, the HSE will examine the situation to establish whether further co-ordination is required.

4.3.3. [Correspondence](#)

It was observed that the letter correspondence templates on the NHSS IT system are not user friendly and do not automatically populate with an applicant's details. This results in staff having to manually format and update each letter, which is time consuming. It was considered that the current correspondence templates should be reviewed and, where possible, replaced with alternative, quicker forms of communication.

In addition, correspondence between local NHSOs and applicants should provide a greater level of clarity in order to avoid confusion/misunderstanding, e.g. more detail about how the applicant's contribution is calculated.

4.3.4. [Transmission of Documentation](#)

Completed forms are photocopied and posted between NHSOs and the national office, e.g. the application for the nursing home loan and the signed 'acknowledgement and consent to creation of a charge' form. This causes delays. The consultants concluded that it would be more efficient to scan documents and send them electronically.

4.3.5. [Application for the Nursing Home Loan](#)

Where an applicant's assets include land and property in the State, the 7.5% contribution may be deferred and collected from the applicant's estate. In this scenario, the HSE pays the money on behalf of the resident, and it will subsequently be collected by the Revenue Commissioners from the resident's estate after his/her death. If an applicant has reduced capacity to make certain decisions, a care representative appointed by the Circuit Court may act on behalf of the person. The national office identifies all new approved loan applications and creates new charging orders against the properties.

It appears that many applicants are under the impression that they require legal advice in order to complete the application form for the nursing home loan (section 6 of the application form). As a result, some people do not complete section 6 of the application form when they initially apply. The

local NHSO staff then have to contact applicants to query whether they wish to apply for the nursing home loan and, if so, to obtain the outstanding information. The information booklet and/or application form should make it clear that a solicitor is not required in applying for the loan. However, the HSE points out that the placing of a charge on a property is a significant decision for applicants and their families, so it will continue to be necessary to advise applicants of their option to obtain legal advice on the issue, if they deem this necessary.

The Revenue Commissioners act as agent for the HSE in respect of collection of monies due as a result of availing of the loan. The Revenue Commissioners only accept cases for recoupment of the nursing home loan where the details of the responsible person have been supplied by the HSE, including the PPSN. The HSE makes every effort to obtain the name, address and PPSN of the responsible person but this is not always possible. Therefore, the consultants recommended that a condition of availing of the loan should be the provision of the required details, including the PPSN of the responsible person. The HSE points out that the responsible person at the time of application may no longer be the responsible person at the death of the scheme participant, and in a small number of cases HSE has had difficulty obtaining the responsible person's PPSN. In consultation with the Revenue Commissioners, the HSE will consider all available options to streamline and improve the operation of this aspect of the scheme.

4.4. Financial Assessments

Under the Act, financial assessments are carried out on income, cash assets and other relevant assets (generally property). The definition of income covers all income types. Relevant assets are defined as all forms of property, whether in the State or elsewhere, other than cash assets. The financial assessment also considers any assets transferred within the previous five years or transferred from the applicant's ownership any time after the applicant enters residential care.

4.4.1. [Current Process](#)

Once the local NHSO has been provided with the required financial information on income and assets, it will calculate the resident's contribution towards their long-term residential care. The applicant will contribute up to 80% of their income and 7.5% of the value of any assets per annum. The applicant's principal private residence (PPR) will only be included in the financial assessment for a maximum of three years (22.5% of the value of the asset or 11.5% if a couple), regardless of the length of time spent in nursing home care.

4.4.2. [Validation of Financial Declarations](#)

NHSOs have stated that they rely heavily on the honesty of applicants in the context of financial declarations. This is understandable given that undeclared assets can be very difficult to track down, and that NHSOs lack the resources and the specialised expertise needed for this task. Spot checks on financial declarations are undertaken by the HSE, but verification can be difficult.

Currently approximately 56.4% of applicants to the scheme have been assessed as owning a principal private residence (PPR).⁸ This contrasts with survey evidence which indicates that home ownership among the general population of this age cohort is much higher. *The Survey on Income and Living Conditions - Thematic Report on the Elderly 2004, 2009 and 2010* gives home ownership rates at 88% in 2010.⁹ The second wave TILDA¹⁰ Report (2014) gives owner occupied housing rates at 85% for this cohort.

The HSE believes that reasons for the low rate of PPR ownership declared under the scheme may include-

- People are paying privately and waiting 3 years before applying for NHSS.
- 5% of clients were admitted more than 3 years before applying for financial support under the scheme and consequently, such clients did not need to submit details of their PPR.
- Farmers are transferring the farm and PPR to their adult child and retaining a '*right of residence*' in the PPR for the remainder of their lives. In such cases the PPR is in the name of the son/daughter and cannot be included as an asset in the financial assessment - where the asset was transferred five years before applying for the scheme.
- Applicants having transferred their PPR to a family member wait until the five year term is up before applying for the scheme.
- Applicants have sold their PPR and are renting a smaller more manageable PPR. Generally the proceeds of the sale are lodged to an account and are included in the financial assessment as a cash asset.
- Where a couple's PPR is valued at €72,000 or less and there are no cash assets, the value of the PPR is disregarded as per the legislation.

⁸ Based on 2014 analysis.

⁹ <http://www.cso.ie/en/media/csoie/releasespublications/documents/silc/2010/elderly0409and10.pdf>

¹⁰ <http://tilda.tcd.ie/assets/pdf/Wave2-Key-Findings-Report.pdf>

While the foregoing may provide partial explanations, the fact remains that declared levels of home ownership by NHSS applicants warrant further consideration, and the HSE is undertaking further analysis to see if there are any other reasons accounting for the disparity that exists.

The approach to verifying financial declarations is focused on gathering property information, bank statements, pension and other income supporting documentation. The focus of the property section is the private principal residence in which the client lived prior to entering the scheme. The consultants considered that there was no standard practice across local NHSOs when reviewing and validating financial declarations. Some NHSOs have a designated Community Welfare Officer (CWO) who can assist in assessing declarations by carrying out spot checks on bank statements or by using Pension Board systems to confirm pension income. However, other NHSOs do not have access to such a resource and stated that they find it difficult to verify the financial information provided by applicants.

[4.4.3. Sources of Financial Information](#)

Some local NHSOs have access to additional sources of data regarding individuals' finances. These can be used to assist in the processing of applications, e.g. to verify that the information being provided is accurate and complete, and facilitate a greater degree of certainty in calculating both the applicant's and the State's contribution.

There are a number of sources of information available to the NHSOs to verify an applicant's financial information. The property registers maintained by the Property Registration Authority can be used to identify all properties or land attached to the applicant's name. The Private Residential Tenancies Board (PRTB) can confirm whether properties are being rented and therefore earning rental income. The property valuation guide for the purposes of local property tax will give an estimation of the value of a property in a given locality. The website of the Courts service provides a probate service search tool which can provide information on the personal representative and the assets of a deceased person. All of these sources of information are available on-line.

The consultants considered that there was a need to establish what databases exist that may contain useful data and whether it is possible for all NHSOs to gain access to these. This may require the applicant's consent at the time of application (failure to give such consent might mean that the relevant application could not be processed.)

A consistently applied standard operating procedure for a robust initial financial assessment based on all available sources of information should be developed and applied to all cases. A policy of undertaking more intensive random and targeted spot checks should be established. Finally, the NHSOs should rigorously follow-up on the requirement for the personal representative to make a full declaration of assets following the death of a client, with appropriate follow up by the NHSO using the probate records when returns have not been received.

The Department of Health and the HSE have held high-level discussions with the Revenue Commissioners to consider the advice or assistance that can be provided by the Revenue Commissioners in this context. In the course of these discussions a number of issues were identified for further consideration, including penalties for incorrect declarations and the format of financial declarations. In addition, there will be further engagement to identify further advice and assistance that Revenue may be able to give in the areas of property valuations, risk management, training and sharing of information. It is also intended to have discussions with the Department of Social Protection (DSP) on relevant experience which might benefit the scheme's administration.

4.4.4. [Property Valuations](#)

Applicants to the scheme must provide a valuation for any non-cash assets. With regard to principal private residences, this requirement is normally met by providing a valuation from an independent local valuer. However, this approach has obvious limitations. In a changing market it can be difficult to accurately estimate what a property will realise, and it would not be surprising if NHSS applicants were to encourage or even pressure valuers to set estimates towards the lower end of the range that a property might realise.

The consultants have proposed that the HSE consider accepting the valuation bands used by the Revenue Commissioners for local property tax in order to minimise the cost and time associated with an applicant obtaining a property valuation. This would also base values on valuations which although quite general would better reflect regional price trends. The HSE will also seek the advice of the Revenue Commissioners about the most appropriate approach to be taken in cases where NHSS applicants propose a valuation which is significantly below the local property tax valuation bands set for the relevant area.

A possible alternative approach would be for the HSE to appoint a local valuer or panel of valuers for each area of the country to carry out property valuations for NHSS applications. While there would

be some administration involved in selecting the valuers, after that the system could operate very simply. Each applicant would contact the relevant valuer (applicants could no longer choose their own valuer) and arrange and pay for the valuation directly. Such a system would be stronger than what currently applies in that NHSS valuers would be designated for a two to three-year period after which these positions could be re-advertised, and the valuers would be primarily responsible to the HSE (rather than to the NHSS applicant) for maintaining robust standards.

[4.4.5. Treatment of Productive Assets](#)

As of now, those who are self-employed, including farmers, are assessed both on the income that they derive on their business and on the capital value of those assets. The Irish Farmers' Association (IFA) have made the case that this creates particular problems for farming families. Farms are often not disposed of when the owner dies, but are traditionally passed down through a family line of succession. A charge on a property deriving from availing of the loan element of the scheme can be a significant impediment to the viability of a farm when it is taken on by a younger family member. IFA argue that there should therefore be a cap applied to the % charge on non-residential productive assets.

The IFA argument appears to be a reasonable one for cases where a farm is passing on through a direct family line of succession. For equity, any change to the treatment of non-residential farming assets would also have to apply to non-farming businesses where a family member intends to carry on the business as his/her main livelihood. Currently, 3% of clients fall into this category. The average value of a farm in this category is €161,000 and the average value of a small business is €120,000. Consideration should be given to whether a cap should be applied to the charge for nursing home care based on non-residential productive assets which are passed on to a direct family member after, or in the five years prior to, the death of an NHSS participant, and where the new owner carries on the farm or other business as their principal livelihood.

[4.4.6. Reviews](#)

A review takes place after three years for those applicants who declared a principal private residence as part of their financial assessment, as the principal private residence is no longer included after the first three years spent in long-term residential care. There are provisions in the legislation for further assessments by the HSE when circumstances change, and failure to notify the HSE is an offence. In the context of three-yearly reviews, the consultants found that the documentation sought and the level of detail addressed can vary across local NHSOs.

It was also found that NHSOs do not in all cases review a schedule of assets from the Revenue Commissioner after each client's death. It should be noted that a schedule of assets will not be available for all deceased clients. A sample survey carried out by the HSE showed that in the 30% of cases where a schedule of assets was available, almost a quarter had under-declared cash assets. Under the Act, it is an offence to provide false or misleading information.

The Act provides that when a person in receipt of financial support under the scheme passes away, their personal representative must provide the HSE with notice in writing of their intention to distribute the deceased's assets and a schedule of the assets at least three months before the estate is distributed. The Act enables the HSE to recover monies from the deceased's estate if there has been a non-disclosure or misstatement in relation to the assets. However, reviews of a client's statement of assets obtained by the Revenue Commissioners are not in all cases carried out by each local NHSO following the death of a client.

The HSE should, as soon as possible, standardise its procedures in relation to reviews across all NHSOs and should ensure that for all financial reviews, whether three-yearly, after-death, or otherwise, all available information is utilised and accessed. This will ensure that each client has made or is making the correct statutory contribution to the cost of their care, and would correct the position where this is not happening or has not happened.

The legislation underpinning the review process provides for the value of assets at the time the application for funding was made, rather than at the time of the review. Consideration should be given to amending the Act to enable the HSE to apply current values when conducting reviews.

4.4.7. [Placement List](#)

Funding from the scheme is released at a rate that allows the available budget to be managed across the full year. When applications exceed the amount that can be released waiting times increase. All approved applicants to the scheme, once they have been assessed as needing long-term residential care, are placed on the list in order of when their application was fully approved. The placement list is managed to ensure equity of access to funding nationally, regardless of whether the applicant is at home or in hospital. It was designed so that access to available funding under the scheme would be fair, impartial and transparent.

The average number of applicants on the placement list and the waiting times for approval of funding are set out in table 2. Prior to December, 2012 this information is not available.

Table 2: Numbers and Waiting Times on the National Placement List

Month	Number of People on the National Placement List	Average Number of Weeks spent on the National Placement List
December 2012	656	5
January 2013	727	5
February 2013	684	4
March 2013	525	3
April 2013	873	7
May 2013	777	6
June 2013	959	6
July 2013	588	4.5
August 2013	512	3
September 2013	523	3.5
October 2013	394	3
November 2013	302	2
December 2013	467	4
January 2014	629	4
February 2014	756	5
March 2014	913	5.5
April 2014	1,043	7
May 2014	1,265	8
June 2014	1,465	11.5
July 2014	1,688	12
August 2014	1,842	14
September 2014	2,040	15
October 2014	2,135	15
November 2014	1,898	14
December 2014	1,411	11.7

When a determination has been made that nursing home care is required, the placement list should continue to operate in chronological order, as all those on the list are assessed as requiring long-term residential care.

4.4.8. [Un-cooperative Applicants](#)

The Nursing Homes Support Scheme Act, 2009 amended the Health Act 1970 to enable the HSE to charge a person in an acute setting if they are no longer receiving medically acute care and treatment and have been assessed as needing long-term residential care, but who are refusing to co-operate with the NHSS application process. The charge applicable is the average cost of long-term residential care in public nursing homes.

The 1970 Act was amended in 2013 to extend this provision to public nursing homes. As a result, where a person enters a public nursing home for services other than long-term residential care, e.g. respite or rehabilitation, and has subsequently been deemed by a registered medical practitioner to require long-term residential care services, the HSE may charge them the average cost of care in public nursing homes. This is an enabling provision and will only apply where an individual refuses to co-operate with the application process for the NHSS.

4.5. Legislative Changes

In the context of this review a number of changes were suggested that would require legislative changes, but would improve the overall operation of the scheme. The Revenue Commissioners are of the view that 12 months is too tight a timeframe (under Article 3(2) of the NHSS Collection & Recovery of Repayable Amounts) Regulation 2009) for repayment of the loan element of the scheme and that it should be increased to 18 months.

The scheme is available to all those who are ordinarily resident in the State. The guidelines underpinning the scheme, and approved by the Minister, define ordinarily resident as those who have been living in Ireland for a year or that intend to live in Ireland for at least a year. The definition should be amended to define ordinarily resident as those who have been living in Ireland for at least a year.

4.6. Recommendations on the Administration of the Scheme

Having examined the scheme administration and processes, the following changes are recommended:

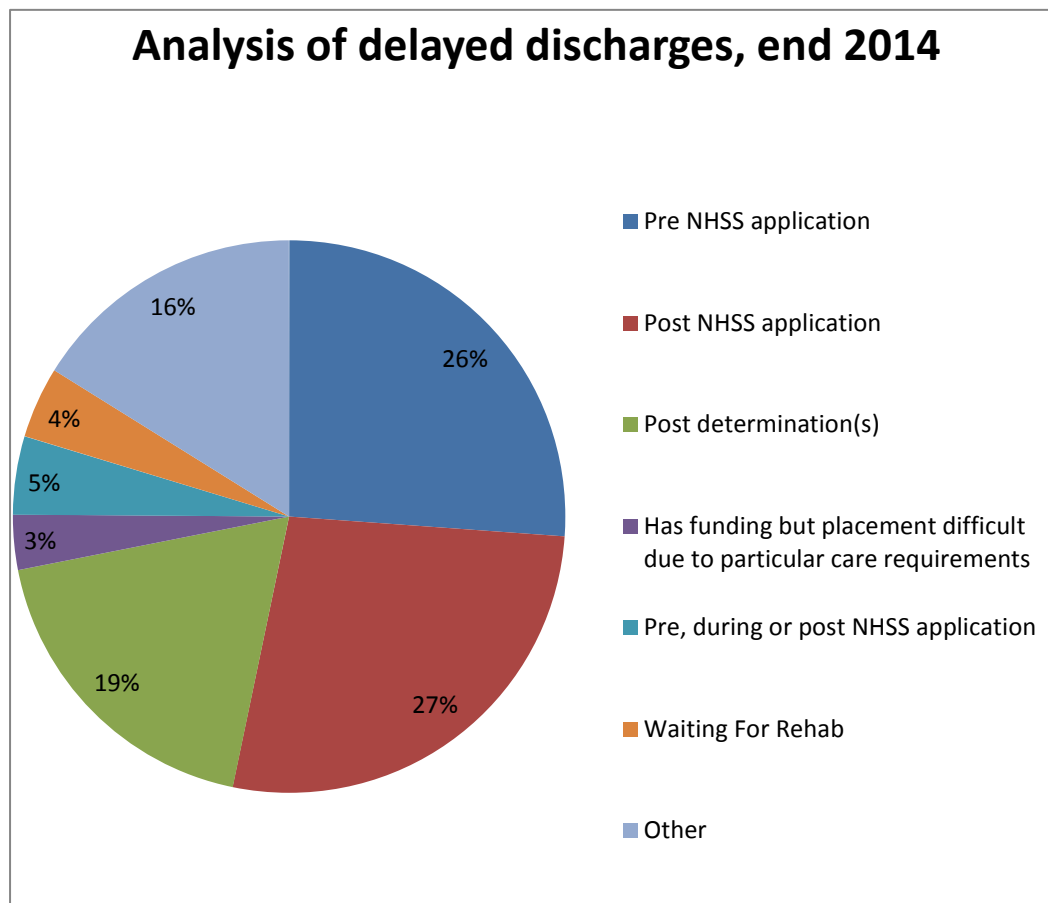
- 1) Centralise certain elements of the scheme where appropriate, with built in appropriate management and training processes to ensure customer service is maintained.
- 2) Consolidate local NHSOs (from 17 to 4)
- 3) Develop a web based form to enable nursing homes to submit invoices electronically.
- 4) Centralise the processing of invoices.
- 5) Centralise the calculation of loan repayments.
- 6) Clarify for how long the application Form/documentation and the CSAR form remain valid without any new processes or medical checks.
- 7) Provide additional information regarding nursing homes to assist with the process of identifying one that is suitable.
- 8) Review documents and application forms with advice from the National Adult Literacy Agency to ensure they are sufficiently user-friendly and informative and that they include clear guidance on where relevant information/documentation can be obtained.
- 9) Consider whether any additional questions should be included in the application form.
- 10) Make sample completed application forms available.
- 11) Include in the application form a mechanism for an applicant to authorise a representative to submit the application on their behalf.
- 12) Consider the need to establish an NHSS Best Practice Group (consisting of NHSO/national office staff) to share experiences and agree on best practice.
- 13) Consider splitting application form into two parts to avoid delaying the care needs assessment while financial information and documentation is being assembled.
- 14) Standardise informal advice provided to applicants regarding the nursing home loan, including clarity re legal aspects.
- 15) Provide advice regarding the possibility of claiming tax relief for medical expenses/nursing home fees.
- 16) Review current letter templates and, where possible, replace with alternative, quicker forms of communication.
- 17) Review content of correspondence to ensure it is as clear as possible.
- 18) Examine the possibility of scanning/electronic transmission of forms and documentation from NHSOs to the national office.
- 19) Clarify that the involvement of a solicitor is not required in order to apply for the loan.
- 20) Consider making it a condition of availing of the loan that the required details, including the PPSN of the responsible person are provided.
- 21) Complete analysis of home ownership levels.

- 22) Establish what databases exist that may contain useful data for the financial assessment and establish the access by NISOs to these, including standard operating procedures, requiring review, of such information sources.
- 23) Develop a consistently applied standard operating procedure for the initial financial assessment based on available resources of information.
- 24) Introduce a policy of undertaking random spot checks of financial data.
- 25) Follow up with the Revenue Commissioners on the scope for improved validation of declarations of income/assets.
- 26) Consider the options to encourage realistic valuations of declared property assets.
- 27) Standardise procedures in relation to reviews across NISOs and ensure that all available information is utilised and accessed.
- 28) Consider amending legislation to provide for fluctuating values of assets and incomes.
- 29) Continue to operate the national placement list in chronological order.
- 30) Increase time for recovery of loan to 18 months.
- 31) Amend definition of ordinarily resident to 'those who have been living in Ireland for at least a year'.
- 32) Consideration should be given to whether a cap should be applied to the charge for nursing home care based on non-residential productive assets which are passed on to a direct family member after, or in the five years prior to, the death of an NHSS participant, and where the new owner carries on the farm or other business as their principal livelihood.

5. Price of Long-Term Residential Care

5.1. Long-Term Residential Care

The funding for the Nursing Homes Support Scheme (NHSS) is allocated by the Oireachtas annually and the HSE cannot spend in excess of the amount allocated. The HSE manages the available funding by releasing funds at an appropriate rate over the course of the year. Delays in the release of funding can have significant impacts on the management of older people in the community, the numbers of delayed discharges in acute hospitals with knock on implications for emergency and scheduled admissions to acute hospitals and the financial uncertainty for families where nursing home care is needed in advance of funding being released. The chart below shows the percentage of delayed discharges in acute hospitals at end 2014, who were awaiting long-term residential care.



19% of the delayed discharges were approved, but were on the placement list awaiting the release of funding. A further 27% had applied for the scheme, but were awaiting approval and 26% had not

yet submitted an application. The total number of delayed discharges on 31 December, 2014 was 719.

5.2. Cost of Care Components

The NHSS covers the cost of the standard components of long-term residential care which are:-

- nursing and personal care appropriate to the level of care needs of the person,
- bed and board,
- basic aids and appliances necessary to assist a person with the activities of daily living,
- laundry service.

A person's eligibility for other schemes, such as the medical card scheme or the drugs payment scheme, is unaffected by participation in the NHSS or residence in a nursing home. In determining the services covered by the NHSS, it was considered that if elements already provided for under other schemes were also to be included under the NHSS the taxpayer could effectively end up paying for the same services twice.

5.2.1. [GP Services](#)

General Practitioner (GP) services can play a vital role in the maintenance of a resident's health in a nursing home. A high proportion of nursing home residents have medical cards. At end 2014, 423,440 or 72% of those aged over 65 have medical cards with a further 36,548 (6. %) having a GP visit card. 223,328 people or 90% of those aged over 75 have medical cards with a further 19,719 (8.0%) having GP visit cards. Currently more than 90% of those in receipt of financial support under the NHSS are aged over 70 years and it is a stated priority of Government that all those over 70 years will be issued with GP visit medical cards.

Whilst HIQA guidance is that residents may choose to retain their own GP on admission to a nursing home, and this should be facilitated where it works well, there is a strong case for requiring nursing homes to offer access to a "house" doctor in each facility. This would facilitate the development of effective channels of communication and good working relationships between the GP and the nursing home staff, which would only be of benefit to residents.

5.2.2. Therapies

Concerns have been raised about the lack of uniformity for nursing home residents when accessing certain services, and in particular therapies e.g physiotherapy that they may be eligible for. For the majority of residents, therapy input can be provided on a consult basis, involving a small number of visits. Therapy services are not funded under the NHSS, but are funded by the HSE Community Health Organisations (CHO). In some areas where demand exceeds what can be provided, there appears to be a de-prioritisation of nursing home residents and in these circumstances the only option remaining is to pay for such therapies privately. National policy foresees equal access to primary care services, regardless of the place of residence, which means that a person in a long-term residential care setting should receive the same level of services as they would if they remained in their own home, and it is important that this policy is implemented consistently by the relevant HSE personnel.

5.3. Price of Care

The average weekly cost of care in a public facility was €1,390 and in a private or voluntary facility was €893 at end 2014. The price of care has no direct impact on the resident, as the resident's contribution is determined according to their means and is independent of their choice of nursing home. The weekly cost of long-term residential care in each approved nursing home is published on the HSE website.¹¹ The headline price differential in the average cost of care between public and private facilities is approximately 58%.

5.4. Price Setting in Private Nursing Homes

The price to be paid for the provision of care in both private nursing homes and voluntary nursing homes is negotiated by facility by the National Treatment Purchase Fund (NTPF). The NTPF has statutory independence in the performance of its functions. A nursing home cannot be considered an 'approved' nursing home for the purpose of the scheme unless it has agreed a price for the provision of care with the NTPF.

Prices paid historically and prices prevailing within a given geographic area are relevant to the price setting process as is the need to achieve maximum value for taxpayers' funds. On agreement of the price at which care will be provided, the NTPF enters into an "Approved Nursing Home Agreement" with the proprietor of the nursing home. The Deed of Agreement is the contract between the NTPF

¹¹ <http://www.hse.ie/eng/services/list/4/olderpeople/nhss/costs.html>

and the nursing home, specifying the maximum price that can be charged for NHSS residents and the commencement and expiry dates of the Deed. The prices are fixed for the duration of the Deed. Details are provided to the HSE on a monthly basis and the agreed prices are published on the HSE website.¹²

Residents have individual contracts with the nursing home and pay their contribution directly to the nursing home. The HSE pays the balance directly to the nursing home on behalf of the resident.

5.4.1. [Review Procedure](#)

If negotiations between nursing home proprietors and the NTPF cannot reach agreement there is a three stage review process available. The first stage is a peer review, where an NTPF representative not previously involved will carry out a review and make a further offer on price. If there is no agreement at this stage, the file is passed to the NTPF Director of Finance for a second stage review. If agreement cannot be reached at this stage, a third and final review will be carried out by the Chief Executive Officer of the NTPF. At each stage of the process the nursing home may contribute additional information to support their case.

Between 2009 and end 2014 approximately 2,300 pricing contracts were negotiated by the NTPF under the scheme. Of these, 36 have used the NTPF review process. These 36 were resolved as follows:

- 17 at Stage 1 (A second NTPF Account Manager not previously involved in negotiations)
- 14 at Stage 2 (As stage 1 and then the Director of Finance)
- 5 at Stage 3 (As stage 1&2 and then the NTPF Chief Executive Officer)

If pricing agreements cannot be reached the HSE is informed that the relevant nursing home is no longer an approved facility for the purpose of the scheme.

5.4.2. [Issues Arising with the Current Process for Setting Prices](#)

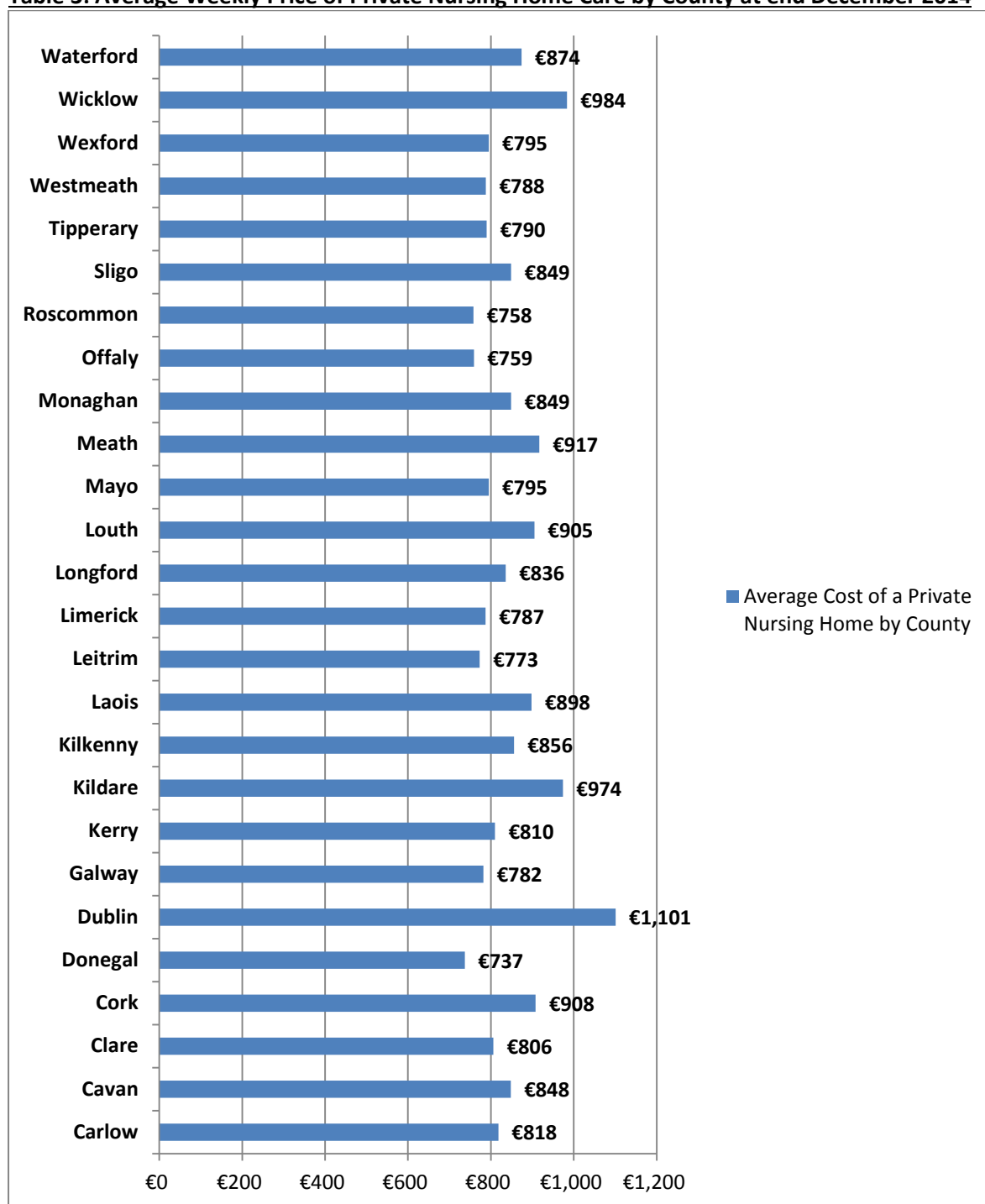
In order to maximise take-up of the scheme when it was first introduced in 2009, and to ensure there were no delays for those wishing to avail of the scheme, the NTPF used inherited historic prices with in-built price disparities as an initial baseline for agreements with proprietors of nursing homes. Good progress has been made since then in reducing price disparities, though differences still remain

¹² <http://www.hse.ie/eng/services/list/4/olderpeople/nhss/Cost.pdf>

between facilities and regions, sometimes delineated by county boundaries. Prices can range from less than €500 per week to more than €1,500 per week.

Table 3 gives a breakdown of the average weekly prices in private and voluntary nursing homes by county. This highlights the significant variations depending on location, with prices in Dublin and the East in general being significantly higher.

Table 3: Average Weekly Price of Private Nursing Home Care by County at end December 2014



Source: National Treatment Purchase Fund

Although prices vary significantly between facilities, at individual facility level a single price is given for all residents regardless of the level of dependency and need for care. Nursing home operators have argued that higher rates should be paid for residents with more complex needs, including those with dementia. However, the NTPF counter that existing prices are averaged to take account of the levels of dependency that currently prevail among nursing home residents, and this already includes a significant proportion of people with dementia. Difficulties have arisen in recent times in finding suitable places for patients with higher levels of dependency. At end 2014, approximately 3% of delayed discharges were due to difficulties with finding a suitable placement due to the complexity of care needs.

The fact that facilities receive the same price regardless of the dependency level of the resident is likely to contribute to this situation, but any solution to this should focus on the relatively small number of people who have difficulty in finding a facility that can cater for their needs. A complete revamp of the pricing system, to one based on dependency categorisations could lead to upward pressure on pricing, and could give rise to considerable complexity in trying to adjust as residents move between dependency categories.

5.5. Future Pricing Model

It is considered that the NTPF have done an effective job in introducing and managing a pricing system for long-term residential care facilities, and this system should continue for the immediate future. However, in the medium term (within 18 months) the NTPF should review the present pricing system and submit proposals to the Minister for Health with a view to:-

- Ensuring that there is adequate residential capacity for those residents who require higher level or more complex care,
- Ensuring value and economy, with the lowest possible administrative cost for clients and the State and administrative burden for providers,
- Increasing the transparency of the pricing mechanism so that existing and potential investors can make as informed decisions as possible.

The review of the pricing system may require professional and independent costing and other technical and relevant expertise.

5.6. Voluntary Nursing Homes

Voluntary nursing homes are nursing homes which received funding for long-term residential care from the HSE under Section 39 of the Health Act 2004 prior to the commencement of the NHSS. There are nine such nursing homes providing approximately 450 long-term residential care beds, and they are operated by voluntary or community groups. These nursing homes are facing particular challenges arising from their inclusion within the NHSS. This is due primarily to inherited parity with HSE pay rates and staff conditions for which allowance is not made in the price-setting process. This has caused severe financial difficulties for some of these facilities and their long-term operation is challenged by the current pricing arrangements. In some cases the service provided by these facilities is very important to, and valued by, the local community, and it is therefore important that the position of voluntary facilities be secured for the future.

The consultants identified a number of options to secure the position of these facilities, but considered that the solution is likely to differ for each facility. Options proposed include:

- an increase to the current rate payable to them under the NHSS,
- proposed reduction in operating costs,
- a change from long-term residential care provision to alternative service models or to a mix of services, such as long-term residential care and respite care .

In considering voluntary nursing homes, and taking account of all relevant factors, the Department's conclusion is that:

- Voluntary facilities provide a small but important part of the overall long-term residential care provision,
- The cost structures of these facilities must, over time, be brought into line with good practice generally. A clear plan must be developed by the HSE to get the cost structures of voluntary facilities into line within a reasonable and specified timeframe,
- On the basis of the above, pricing for these facilities should allow for an adjustment for voluntary facilities for the factors particular to them. This would reduce over a clearly defined timeframe to allow cost and other adjustments to be implemented,
- However, even during this transitional period it would not be appropriate to give higher prices to voluntary facilities if this would distort normal competitive processes. Accordingly, this transitional arrangement could only be applied to voluntary facilities

where it has been confirmed that the facility provides an essential service which would not be provided by any public or private facility were the voluntary facility to close.

5.7. Additional Costs in Private Nursing Homes

Participants in the NHSS can still incur some costs in a nursing home, e.g. social programmes, newspapers or hairdressing. In recognition of this, anyone in receipt of financial support under the NHSS retains at least 20% of their income. The minimum amount that is retained is 20% of the State Pension (Non-Contributory). This currently amounts to about €43 per week.

Issues have arisen in relation to additional charges being levied on residents by some private operators, which may be presented as optional, but which residents and families see as mandatory in practice. For example, there is nothing in the NHSS to prevent a nursing home levying charges for certain “extras” which are additional to what is covered by the NHSS, but are in practice a non-optional part of the nursing home’s standard service and routine. There are cases where extra activities (e.g. social activities) incur a mandatory charge even though some residents are not in a position to avail of them because of their dependency levels. A very serious issue would arise if an operator were to seek payment from residents for items which are covered by the NHSS, the medical card or any other existing scheme.

To deal with the issue of additional charges it is recommended that nursing homes should have a published fee schedule showing all the costs associated with being a resident. Consideration should be given to introducing a new provision under the scheme to prohibit the levying of additional charges for any service or facility from which residents can not readily opt out without penalty while remaining as a resident of that facility, or in which they cannot participate because of the level of their dependency.

5.7.1. [Individual Contracts](#)

Part 7 of the Health Act 2013 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009, stipulates that the registered provider of the nursing home must agree a contract with each resident within one month of their admission. This contract must include details of the services to be provided to that resident and the fees to be charged. Residents should never be charged fees which are not set out in the contract.

The HSE is not party to such contracts which are concluded between each resident and their nursing home. However, consideration should be given to including in the Deed of Agreement with facilities, details of what additional charges are proposed, of the opt-out arrangements that exist for residents, and confirmation that residents will not be charged for extra services that they cannot participate in because of their dependency level or lack of capacity.

5.7.2. Additional Payments by the HSE

There are a growing number of applicants to the scheme, mainly with acquired brain injury or those with aggressive behaviour who require care above and beyond the majority of applicants, and therefore incur higher costs of care. Some of the people requiring top-up payments are younger, and the vast majority of these cases reside in acute hospital settings, accounting for considerable delayed discharge days, as nursing homes are unwilling to admit these persons at the current price rates. In the absence of a price setting mechanism based on dependency, it may continue to be necessary for the HSE to make top-up payments in circumstances where very specialist care is required. Engagement with acute, disability and other services is required to give a more comprehensive service for this cohort.

5.8. Process for Setting Prices for Public Nursing Homes

The NTPF has no role in setting or negotiating prices for public facilities. The maximum prices to be paid in public facilities, and referred to as the cost of care, are set by the HSE and are published on the HSE website. The cost for each public nursing home is determined using the definition of long-term residential care services underpinned by an agreed set of cost components which have been laid before the Houses of the Oireachtas. These include pay and non-pay goods and services. Pending the introduction of any new pricing model the HSE should be required to publish the cost of care on an annual basis.

The pay related services covered by the cost of care include the pay, overtime, allowances and employers PRSI contributions for the following:

- Management and administration staff,
- Nursing staff directly involved in managing and providing health and personal care services,
- Health care assistants, attendants and equivalent grades providing health and personal care services,
- Porters, laundry, housekeeping and catering staff,
- Maintenance and technical staff.

The non-pay related costs include:

- Basic clinical consumables,
- Oxygen,
- Catering,
- Heat, power and light,
- Cleaning/washing,
- Upkeep of furniture and equipment,
- Bedding and clothing,
- General maintenance,
- Education and training,
- Insurance,
- Audit,
- Office expenses.

5.8.1. [Issues Arising with Current Process for Setting Prices](#)

The current system of setting prices for public facilities is based on historic running costs. The price setting system has identified the cost within each facility and there are significant differences in price across facilities. The HSE Social Care Directorate is trying to achieve greater consistency in quality and cost and to reduce inappropriate costs across its facilities, but in doing this it faces structural, operational and HR challenges. Significant progress has been made since the scheme was introduced to ensure that only those costs proper to the NHSS are funded from the NHSS budget.

HSE long-term residential care facilities have the highest proportion of maximum dependent older people at just over 60% compared to that of private nursing homes with almost 35%. The most expensive of the HSE's public nursing homes generally accommodate a cohort of young chronic sick clients. These patients are complex cases with high dependency requiring significant nursing care. There are also nursing homes that specialise in the care of residents with Alzheimer's and who need a secure environment and others who care for residents with challenging behaviours. However, even allowing for the fact that residents in public facilities may have higher care needs, costs for public facilities appear to be in excess of what applies in private facilities.

The cost of public long-term residential care should be based on a pricing model that is objectively and consistently formulated, and which takes account of and accurately quantifies unavoidable price distortions. As a result, a Value For Money and Policy (VFM) review will be carried out by the Department of Health which will focus on the extent to which the existing cost differential can be attributed to inherent differences between public and private sector cost structures (e. g pay levels), and should identify and analyse the reasons for the existing differentials. The VFM review should also recommend actions and timelines to address any cost distorting factors that cannot be attributed to inherent differences between the public and the private sectors.

5.9. Recommendations on the Price of Long-Term Residential Care

Having examined the overall cost of long-term residential care in public and private nursing homes and the effectiveness of the current methods of negotiating and setting prices it is recommended that:

- 1) Nursing homes to consider offering access to a ‘house’ doctor in each facility.**
- 2) A person in a long-term residential care setting should receive the same level of other health services as they would if they remained in their own home and it is important that this policy is implemented consistently by the relevant HSE personnel.**
- 3) The existing system of agreeing prices facility by facility should continue for the immediate future.**
- 4) Within 18 months, the NTPF should review the present system and submit future pricing proposals to the Minister for Health with a view to:-**
 - i) Ensuring that there is adequate residential capacity for those residents who require higher level or more complex care;**
 - ii) Ensuring value and economy, with the lowest possible administrative cost for the State and administrative burden for providers;**
 - iii) Increasing the transparency of the pricing mechanism so that existing and potential investors can make as informed decisions as possible**
- 5) The cost of public long-term residential care should be based on a pricing model that is objectively and consistently formulated, and which takes account of and accurately quantifies unavoidable price distortions.**
- 6) It is important that the position of section 39 voluntary agencies be addressed. A clear plan must be developed by such facilities, supported by the HSE to agree their purpose and**

function and where necessary to get the cost structures into line within a reasonable and specified timeframe.

- 7) Nursing homes should have a published fee schedule showing all the costs associated with being a resident.
- 8) Consideration should be given to introducing a new provision under the scheme to prohibit the levying of additional charges for any service or facility from which residents can not readily opt out without penalty while remaining as residents of that facility, or in which they cannot participate because of the level of their dependency.
- 9) Consideration should be given to including in the price contracts with facilities, details of what additional charges are proposed, of the opt-out arrangements that exist for residents and confirmation that residents will not be charged for extra services that they cannot participate in because of their dependency or lack of capacity.
- 10) It may continue to be necessary for the HSE to make additional payments in circumstances where very specialist care is required. Engagement with acute, disability and other services is required to give a more comprehensive service for this cohort.
- 11) The HSE should publish the cost of care on an annual basis.
- 12) The HSE should continue to review the costs in its facilities to examine if facilities can be made more cost efficient. The review should start with the most expensive nursing homes and then cascade down.
- 13) A value for money and policy review will be undertaken of HSE public long-term residential care facilities to examine the extent to which cost differentials with care in private facilities can be attributed to patient dependency characteristics or other objective factors for which a higher level of cost is justified.

6. Re-orientation of the Social Care System

6.1. Background

A key element of this review is to consider how services for older people can be configured in a way to best meet their needs and that will be sustainable into the future in the light of projected demographic trends.

6.2. Current Community Service Provision

Most older people want to stay at home and in their communities for as long as possible and it is Government policy to facilitate this. Admission to long-term residential care should be seen as the last resort and should only be availed of when it is no longer feasible for people to remain in their own communities with appropriate support. Many older people can remain at home for longer if appropriate and adequate supports and services are made available to them. At present 90% of frail older people in Ireland live at home with 80% living well and independently (HSE National Clinical Care Programme). Those over 75 years and especially those over 85 years tend to have the highest care needs and the greatest level of disability.

Long-term care and support for older persons is provided in both a formal and informal way in Ireland, although social changes mean that there is uncertainty about the level of informal care that families and carers will be in a position to provide in the future. Currently, the majority of assistance provided to older people who need support with activities of daily living is done on an informal basis.

6.3. Informal Care

The Census in 2011 showed that over 187,000 people were providing unpaid assistance to a family member or friend with a long term illness, disability or a level of need.¹³ The Census however does not break this number down by age group, but TILDA data shows that approximately 90% of older people, who required assistance with daily living, received support from unpaid family or friends.¹⁴ There are currently two State payments to support this type of care i.e. carer's benefit up to €332.50 per week and a respite grant of €1,375 which is also available to those in receipt of carer's benefit.

¹³ http://www.cso.ie/en/media/csoie/census/documents/census2011profile8/Profile_8_Full_document.pdf

¹⁴ <http://tilda.tcd.ie/assets/pdf/Carer%20Report.pdf>

The *National Carers' Strategy* signals the Government's commitment to recognising carers as key care partners and it is critical that carers are taken account of in developing future care models and that they are supported in the way that care services are delivered.¹⁵

6.4. Formal Care

Formal care is provided and funded by the State through either direct service provision or through private or voluntary agencies who receive funding from the State to carry out this role.

Approximately 4% of older people in Ireland are supported by the State in long-term residential care, and the vast majority of these are in receipt of financial support from the Nursing Homes Support Scheme.

For those who need support to continue living at home, the HSE provides home help, home care and day care services. These services are allocated on the basis of need, insofar as resources allow. Service users do not currently make any contribution towards the cost of these services, regardless of their means.

6.5. Social Care Services-Community Based Supports

Reducing the proportion of older people in residential care will require the expansion of community and home based services and perhaps, the development of alternative models of care.

In considering the balance of funding between long-term residential care and community based services it is worth noting that over 60% of the current budget for the provision of services for older people goes towards support for long-term residential care. Since the late 1990s there is growing evidence that home care support can be a cost-effective alternative to long-term residential care for some older people. However, there will always be a significant requirement for long-term residential care. There is consensus that projected increases in the numbers needing long-term residential care can be mitigated by developing and strengthening community-based alternatives but the extent to which this is possible will only become clearer as new approaches are tested and evaluated.

¹⁵ http://health.gov.ie/wp-content/uploads/2014/03/National_Carers_Strategy_en.pdf

Currently the main community supports specifically available to older people in their own homes or local community are home help services, home care packages, day care services and short-stay beds.

[6.5.1. Home Help Service](#)

Home help services traditionally consisted of domestic assistance, such as help with cleaning, cooking and personal hygiene. However, since 2012, there has been more emphasis on assisting with personal care services (bathing, dressing, etc.). In 2014, the HSE provided approximately 47,500 older people with home help services and provided approximately 10.3 million home help hours to older people. 70% of this service is provided directly by the HSE and the remaining 30% by voluntary organisations on behalf of the HSE.

Nationally, approximately 8% of the population over 65 years are in receipt of some type of home help services. The average number of home help hours is 5 hours per week. Allocation of hours is based on need and availability of resources rather than ability to pay. Currently there is no charge, although section 61 of the Health Act, 1970 appears to allow the HSE to charge for such services, subject to any directions given by the Minister.

[6.5.2. Home Care Packages](#)

In addition to home help services, the HSE arranges the provision of home care packages. A home care package will normally assist with personal care such as bathing and dressing as well as nursing and services such as physiotherapy etc. These packages support older people with a medium to high dependency requirement and are aimed at facilitating these people to remain at home for longer than would otherwise be the case.

At end 2014, 13,057 older people were in receipt of a home care package. Over 18,500 home care packages were provided throughout the year benefitting approximately 3% of the population over 65 years. A further 190 older people benefited from more intensive home care packages.

60% of home care packages are provided by private providers. This service was successfully tendered out by the HSE in 2013, and a number of private providers were approved to provide this service on behalf of the HSE. This service will continue to be tendered into the future. The remaining 40% of home care packages are provided by the HSE directly and through voluntary organisations on behalf of the HSE.

Like home help services, allocation of home care packages is based on need and availability of resources rather than ability to pay and there is no charge for the service.

6.5.3. [Day Care Services](#)

Day care centres can vary from social centres where clients attend a couple of times of week for social activities and meals to comprehensive nurse-led day care centres where clients with high-end needs have access to a range of medical services including nursing, chiropody, physiotherapy, dietetic services, occupational therapy, speech and language therapy etc. For those caring full-time for an older person with high-end needs, these centres act as a major support and offer a form of respite that is of great value to carers. Day care centres can either be HSE run or in a lot of cases are run by voluntary bodies with funding from the HSE (Section 39). Table 4 shows the numbers attending some type of day care service.

Table 4: Number of Day Care Centres that are in operation

Day Care Survey 2011							
	No of places	Total No of Units	Social Day Care units	Social Day Care places	HSE Dementia Day Care units	HSE Dementia Day Care places	No of units not Recorded
Total	29,879	413	208	10,960	191	18,919	14

6.5.4. [Community Hospitals](#)

Local community or district hospitals are non-acute hospitals that provide a range of health services and resources to the local community outside of the acute hospital environment. They are traditionally nurse-led and supported by the primary care team, particularly the GP, although this can vary depending on the local situation. They can provide long-term and short-term residential care, and in a lot of cases, they also have a day care service attached to them. To date the community hospitals have been mainly located in areas other than Dublin, although the acquisition and commissioning of the old Mount Carmel Hospital in 2015 is a significant first step in expanding this service in Dublin.

[6.5.5. Short -Stay Beds](#)

Short-stay beds are traditionally run and operated by the HSE. They can be attached to a community hospital, community nursing homes or in some cases are stand-alone units, and traditionally include respite, convalescent, rehabilitation, assessment and palliative care beds.

In the past three years, more intermediate type care beds (i.e. transitional care beds and more intensive rehabilitation beds) have been made available in areas where acute hospitals are experiencing service pressures with delayed discharges and waiting lists. These beds have proved to be extremely effective for easing pressures on the acute hospital services and facilitating the planning and management of older peoples' health needs in a more appropriate environment. Rehabilitation beds in particular have been extremely successful and a high number of older people have been able to return home after a period of rehabilitation. Transitional care beds allow an assessment of long-term need to be made in a setting that is more appropriate and conducive to a considered outcome than can happen in an acute bed and also directly allows more acute beds to be made available to those who really need them.

6.6. Other Services

In addition to the home and community based services outlined above, older people depend heavily on healthcare services generally. Whilst such services are outside the remit of the review of the NHSS, it is important that the range of care services is acknowledged.

[6.6.1. Primary Care Teams](#)

The majority of healthcare services should be delivered through the primary care setting. Government policy on healthcare envisages that the first point of contact for a person needing healthcare should be primary care, which it is estimated should meet 90-95% of people's health and personal social care needs. The development of primary care teams has been a priority for the HSE over the past number of years and primary care teams play a key role in managing the healthcare requirements of the whole community, including the older person population, at the primary care level.

[6.6.2. Medical Cards](#)

Older people with medical cards are eligible for a range of healthcare services free of charge including GP Visits, prescription medicines (for a small fee), certain dental, ophthalmic and aural services, and in-patient and out-patient acute hospital care. In addition, primary care services

including public health nursing, occupational and physiotherapy services, social work services and other community care services based on client need, are available.

Medical cards for the over 70s are provided based on a means test with the majority of older people entitled to a 'full' medical card and those with higher incomes entitled to a 'GP Only' medical card. The provision of GP visit medical cards to all over 70s is a stated priority of the Government.

[6.6.3. Community Intervention Teams](#)

The purpose of a community intervention team (CIT) service is to facilitate the avoidance of an unnecessary acute hospital admission or attendance and to facilitate/enable discharge from the acute hospital of patients appropriate for CIT care. The CIT is very much about rapid response through its fast-tracked provision of enhanced services. CITs facilitate the mainstream primary care and the acute hospital services in arranging follow up care for patients as required. The ultimate aim is to enable patients to access all the care they need swiftly, and with minimum inconvenience. The team typically consists of a CIT manager, nurses, home helps and care attendants. The teams are contactable by GPs and by local emergency departments of the acute hospitals. At end 2014, there were 8 CITs in place with almost 14,700 patients being seen by the service throughout the year.

[6.6.4. Acute Hospital Services](#)

It is widely recognised that the management of the frail elderly patient is currently a major challenge for the acute hospital system due to a significant number of delayed discharges (those remaining in acute hospitals after clinical discharge) who include older people awaiting long-term residential care, a home care package, or in some cases some home adaptations etc. These patients are concentrated in hospitals in Dublin and other urban areas. Research shows that acute hospitals are extremely unsuitable environments for older people, as well as increasing the risk of exposing them to hospital acquired infections.

6.7. Future Service Models

[6.7.1. Analysis of Current Services](#)

With a view to identifying the mix of services that can best meet the needs and preferences of older people into the future, the HSE profiled and analysed in detail services in four of the seventeen HSE

Integrated Service Areas (ISAs) compared with their referral rates for long-term residential care. This analysis looked at what is currently in place, what appears to be working well, and what elements or models of services need to be developed to facilitate a more community focused service. Each area was profiled for the degree of correlation between the availability of community and acute hospital supports and referral rates to long-term residential care.

Two urban areas in Dublin (one north-side, one south-side) with similar population bases and acute hospitals and two rural areas with similar population bases, one in the North and one in the South of the country were analysed. The two Dublin areas were selected as they have major acute hospitals that have considerable pressures with delayed discharges, waiting lists and emergency department trolley waits and experience some of the largest pressures on services in the country. Both have also received a high proportion of the funding provided by the Special Delivery Unit for initiatives targeting the needs of the frail elderly.

- Dublin North covers Balbriggan, The Naul, Skerries, Garristown, Oldtown, Lusk, Donabate, Rush, Ballyboghill, Swords, Malahide, Portmarnock, Darndale, Baldoyle, Coolock, Artane and Howth. The main acute hospital is Beaumont Hospital.
- Dublin South Central covers Dublin 8, 10 and 22 together with, Rathfarnham, Rathgar, Terenure and Irishtown. The main acute hospital is St. James' Hospital

The two rural areas, (Donegal and Kerry) were selected because Donegal has the lowest percentage of people over 65 years in long-term residential care. The main acute hospital is Letterkenny General Hospital. Kerry has a good spread of both urban and rural based locations. Kerry is considered to have a good range of both community supports and long and short-stay beds. The main acute hospital is Tralee General Hospital.

In addition to residential services, both long-term and short-term, a number of other areas of service provision were examined across the four ISA areas including:

- Homecare,
- Primary care teams,
- Community management and governance structures,
- Acute hospital services for older persons,
- Role of voluntary organisations,

- Alternative services and models of care specific to a particular ISA area,
- Services that ISA areas themselves felt worked well in supporting older people in their communities,
- Views of the ISA areas on what is needed to support older people in their communities.

Each of the ISA areas surveyed were asked what services and initiatives would facilitate assisting older people with healthcare needs to remain in their own homes for longer. The responses were in keeping with the services currently in place in each of the ISA areas. However, it is important to note that this exercise was carried out at a particular point in time and due to the nature of services for older people, services and processes continually change to meet demand and changing need. The profiles and the services available in each of the selected ISA areas selected for review are set out in Table 5. All figures refer to the population over 65 years.

Table 5: Profile of 4 ISA Areas

2013	Dublin North	Dublin South	Kerry	Donegal
Population of over 65 years¹⁶	26,860	25,283	20,988	21,851
No. of long-term residential care beds/per 1,000	42.3	43.7	47.4	38
Number of short-stay beds /1,000	2.9	3.4	5.1	10.6
No. of community hospitals	0 ¹⁷	1	6	8
No. in Long-term residential care	1,236	1,214	881	612
	4.6%	4.8%	4.2%	2.8%
No. in receipt of home care package	1,182	556	462	153
	4.4%	2.2%	2.1%	0.7%
No. of enhanced home care packages value €500-€800/week	30	15	6	0
No. of enhanced home care packages value >€800/week	6	1	1	66
Total hours enhanced home care packages	1,076	324	174	1,282
Average hours per enhanced home care package	29.9	20.2	24.8	19.4
Total home help hours	33,339	20,887	41,309	49,483
Average home help hours per recipient	1.24	0.83	1.96	2.26
No. in receipt of home help	1,197	1,999	2,331	1,866
	4.45%	7.9%	11.1%	8.53%

¹⁶ Population figures are based on the 2011 Census

¹⁷ St. Joseph's Hospital in Raheny is a 100 bed unit run by Beaumont Hospital. However, it is not deemed a Community Hospital as it is managed by the Acute Hospital Sector.

6.7.2. [Findings from Analysis](#)

As can be seen from table 5 the numbers being supported in long-term residential care differ greatly across the 4 ISA areas. The areas where there is a shortage of long-term residential care beds rely more on the provision of home help and home care packages. The shortage of long-term residential care beds in Dublin North is causing significant difficulties, and the ISA area is using a combination of home care packages, enhanced home care packages, short-term and rehabilitation beds to deal with the lack of long-term residential care capacity.

Home help hours and home care packages are being allocated and delivered in very different quantities in the 4 ISA areas. Kerry is providing a high level of service to its older people with a high level of home help, home care, community hospitals and long term residential care being offered in the county.

Donegal has in place a very comprehensive and co-ordinated admissions and discharge policy which involves all relevant healthcare providers in the delivery of services to older people. The majority of service is delivered in the community setting with a strong network of community hospitals, community beds and home help hours being delivered.

Short-stay community beds play an essential role in the management of healthcare for older people.

There is strong evidence from the data analysed that a well-developed, co-ordinated and integrated approach to the management of older people helps to reduce referrals to long-term residential care.

The analysis identified that the future model of care needs to include:

- Sufficient home help and home care packages,
- Intensive home care packages,
- Access to short-stay community beds, providing respite and rehabilitation so as to reduce acute hospital or long-term residential care requirements,
- Integration and communication links between the acute and community services,
- Access to the expertise of the consultant geriatrician team when required with additional supports from the voluntary sector.

[6.7.3. Home Care](#)

The availability of effective supports in the ISA areas analysed helps to keep older people supported in their communities. Uneven availability needs to be addressed. Clear and effective linkages and co-ordination between acute hospitals and home care services must be developed as a priority. Procedures for assessing, approving and procuring home supports should be reviewed and simplified, and they should be standardised across the system.

[6.7.4. Short-Stay Care](#)

Short-stay beds are an extremely valuable resource for individuals and the health service in that:

- they allow short-term difficulties to be addressed without admission to acute hospital, with all of the issues that go with such admission,
- they are very flexible, and can be focused to provide relief where need is greatest at any given time, for example, where particular hospitals have unsustainable numbers of delayed discharges,
- They allow future care needs (e.g. residential, home care, etc.) to be assessed outside of the acute hospital setting. Apart from relieving the pressure on the acute hospital, this can facilitate a less pressured and more balanced assessment of needs, and can help reduce the extent to which long-term residential care is seen as the default option.

The provision of additional short-stay beds, particularly in areas that are most relevant to major acute hospitals, should be prioritised. It is important that such beds are ring-fenced for short-stay purposes and that the governance and management arrangements ensure the availability of appropriate input from health professionals and linkage across the continuum of care.

[6.7.5. Day Care](#)

Day care should be appropriately included in the service mix in planning for future services.

[6.7.6. Information Management](#)

The development of an IT system accessible by both acute hospitals and community based health and social care services would enable the management of the older person and their healthcare needs to be met in a more streamlined and integrated manner.

6.8. Alternative Initiatives to Enable Older People to Remain in their Communities

In addition to the current services analysed in detail in the 4 ISA areas, and the future model of services recommended, a number of alternative initiatives were considered in the present review of the NHSS that could assist in re-orientating the services towards the community.

6.8.1. [Telecare and Technology](#)

Telecare services and the use of technology have been developing for some years now and may facilitate and support new approaches to care. A range of technologies and services are available, such as mobility aids, sensors and alarms. Applications and services for falls prevention, wandering and self-management are currently being developed. Remote monitoring of health indicators, particularly when effectively linked with appropriate healthcare professionals and supported by more direct intervention when necessary, can allow various conditions to be effectively and safely managed in new ways.

An audit of hospital in-patients awaiting discharge to long-term residential care, conducted in St James' Hospital, found that 24% had low physical dependency with moderate cognitive impairment and were generally referred to long-term residential care because it was deemed unsafe for them to live alone. Such older people could potentially benefit from greater use of technology including where such technology is used by family member and/or carers. The potential of assistive technology should be proactively assessed by the HSE and possible collaboration with researchers and industry should be considered in this context.

6.8.2. [Supported Housing](#)

Supported housing schemes which are linked to appropriate community care services can offer an alternative option to support older people. Although dependency levels of those availing of financial support under the Nursing Homes Support Scheme are not centrally recorded, the *Long-Stay Activity Statistics 2013* prepared by the Department of Health indicate that 12.8% of those in long-term residential care are low dependency. The NHI survey 2015 found 13% of residents were low dependency. Low dependency refers to the more independent residents in nursing homes who require little nursing care, but who do need some level of support. In addition, as mentioned above, the audit of St James Hospital found that 24% of those referred to long-term residential care had low dependency and therefore could potentially benefit from supported living arrangements.

For those with some diminished capacity, who may need some support, but do not yet need 24 hour nursing home care, a lower level of support might serve their needs, while preserving their independence and capacity better and for longer.

In broad terms sheltered housing is developed by the Department of the Environment, Community and Local Government through various funding mechanisms. The 2010 Irish Council for Social Housing (ICSH) report on 'The provision of housing and supports for the elderly' highlights the role of sheltered housing and how it can prevent older people entering long-term residential care prematurely, provided the appropriate supports are in place. Whilst the role of volunteers is pivotal, so also are the supports provided by the HSE. In the current climate, the ability to provide value for money, alongside quality housing and appropriate support services, should be developed.

The role of sheltered housing, appropriately supported by community health and social services, should be considered in the context of future service planning as an integral component of long-term care. The Departments of Health and Environment, Community and Local Government, the HSE, and possibly NAMA should explore the potential for developing sheltered or supported living arrangements.

6.8.2.1. Danish Example

In Denmark when legislation was passed to prohibit municipalities from building nursing homes, there was almost a 50% reduction in the number of nursing home beds, and instead assisted living arrangements, where assistance or specialised care is provided, were developed by local municipalities. These facilities can also provide rehabilitative care to older people following a hospital stay. People with dementia live in assisted living facilities which are designed to meet their needs. In Denmark, there were 49,000 nursing home beds in 1985 and 2,307 assisted dwellings. By 2002 there were 25,800 nursing home beds and 43,700 assisted dwellings¹⁸. However, this model has not been developed in Ireland to any degree.

6.8.3. Boarding Out Service

The Meath area operates a 'boarding out' model of care whereby older people live with families other than their own, who provide care somewhat like the children's foster care model. *The Boarding Out Regulations 1993* provide for the boarding out of adults (excluding the boarding out of persons

¹⁸"Rescaling Social Welfare Policies in Denmark" Thorgaard & Vinther, 2007 at: <http://www.sfi.dk/publications-4844.aspx?Action=1&NewsId=119&PID=10056>

under the Mental Treatment Act 1945) and contain provisions to ensure that adequate and suitable maintenance, care, accommodation and food are provided for persons while they are being boarded out. The Regulations also provide for the regular inspection of boarding out dwellings.¹⁹ There is potential to explore the extension of the boarding out model, particularly in light of the results from the St James' audit.

6.8.4. Voluntary Sector

There are a myriad of voluntary organisations throughout the country working in preventative and supportive roles for older people. The voluntary sector plays a large part in supplementing formal HSE services and also plays an advocacy role in providing a voice for older people. In addition, the sector is particularly important in providing services to older people who would otherwise be isolated, which has been shown to have a negative impact on both physical and mental health of older people. Links and partnerships with the voluntary sector, which have been shown to assist with supporting older people to remain in their own communities, should continue to be fostered.

6.8.5. Volunteers (older people, unemployed)

Volunteers play a significant role in the overall provision of services for older people. Many of these volunteers are themselves older people. The potential of volunteers and the contribution that they can make in facilitating older people to remain in their own homes or communities is recognized and should continue to be supported and developed.

The option of harnessing the potential of those seeking employment in relation to volunteering should be further considered.

6.8.6. Integrated Services

Given the range of alternative services and supports that are available to older people, it is important that more is done to consolidate all of these efforts and initiatives. An integrated approach to service developments, involving all relevant stakeholders, will provide a more comprehensive model of care for older people and will facilitate co-ordinated and integrated planning for the provision and delivery of services across home and community care, transitional care, acute hospital care and long-term residential care. The HSE is developing an integrated care programme for older people which will outline the requirements for the provision of integrated care

¹⁹ <http://www.irishstatutebook.ie/1993/en/si/0225.html>

across acute hospital and community services. This should result in the integration of existing services, so as to maximise the outcomes for older people, leading to a full continuum of care, which is easily accessed and appropriate to the older persons' level of dependency. Developing an integrated model of care for older people should be a priority, particularly based on demand for long-term and other services for older people in general into the future.

To be effective, social care should be part of a wider care and support system which includes the health service, housing support and other public services. In this regard the approach taken by the Older People Remaining at Home (OPRAH) pilot project which co-ordinates local health and public services and voluntary organisations in five areas across Ireland should be fully evaluated, with a view to applying learning from the project to other areas.

6.8.7. [Budget Allocations](#)

If community based services are to be developed and strengthened, consideration should be given to rationalising and centralising budget provisions for these services. The budget allocations for many of the community based services are not centralised in the same way as NHSS funding, which has its own distinct budget. The NHSS allocation is clear from the start of the year enabling the HSE to plan service levels and to manage the budget.

6.9. Recommendations for Future Service Provision

In conclusion, a range of initiatives and actions should be progressed to ensure the ongoing sustainability of services for older people and to facilitate the re-balancing of funding between long-term residential care and community based services. These include:

- 1) Development of a community based model of care that includes:**
 - a) access to short-stay community beds,**
 - b) sufficient home help and home care packages,**
 - c) Intensive home care packages,**
 - d) Integration and communication links between the acute hospital and community services,**
 - e) Access to the expertise of the consultant geriatrician team when required with additional supports from the voluntary sector.**
- 2) Addressing the uneven availability of home care.**
- 3) Developing clear and effective linkages and co-ordination between acute hospitals and home care services, including the development of an IT System.**

- 4) Reviewing, simplifying and standardising procedures for assessing, approving and procuring home supports across the system.
- 5) Providing additional short-stay beds, particularly in areas that are most relevant to major acute hospitals.
- 6) Including day care beds as appropriate in planning future services.
- 7) Explore the potential of assistive technology in possible collaboration with researchers and industry.
- 8) Exploring the potential of a collaborative approach across the Departments of Health, Environment, Community and Local Government to provide appropriately supported sheltered housing.
- 9) Considering the extension of the boarding out model where appropriate.
- 10) Maintaining and fostering links with the voluntary sector which can make an important contribution in supporting older people to remain in their own communities.
- 11) Evaluating the *Older People Remaining at Home (OPRAH)* project with a view to applying learning from the project to other areas.
- 12) Considering ways to bring greater clarity and consolidation to budgets for older person's community services.

7. Residential Care Capacity and Demand

7.1. Introduction

Government policy aims to support older people to remain in their own homes and communities for as long as possible and, where this is not possible, to support access to high quality nursing home care. This requires planning ahead to ensure an adequate supply of long-term nursing home care beds to meet the needs of our ageing population.

This chapter considers future requirements for long-term nursing home care, the capacity of the current long-term residential care sector to meet those requirements and possible approaches to ensuring adequate future capacity.

7.2. Future Need for Long-Term Nursing Home Care

The vast majority of long-term nursing home beds are utilised by people over 65 years of age, with only 5% of residents aged under 65 years.

The over 65 population is set to increase from 585,700 in 2014 to 732,000 by 2021 and to 803,000 by 2024. Based on current utilisation rates, this suggests a requirement to have over 36,000 long-stay beds in the system by 2024. By 2021, the population over the age of 80 years will have increased by 37 % since 2011. Those over 80 years of age accounted for 71% of NHSS residents at end 2014, with over 50% being over 85 years of age. Thus, even in the context of strengthened community and home-based models of care, it is clear that there will be an absolute requirement for additional long-term residential care capacity.

Within the overall long-stay population, it is anticipated that 23,965 people will be in receipt of support under the Nursing Homes Support Scheme by end 2015. This is estimated to grow to 33,070 by 2024.

Table 6 shows the percentage of the general population, and the actual numbers supported by the scheme from 2012-2014, for each age cohort. It also shows the percentage of the total NHSS population in each age cohort.

Table 6. Utilisation rates for NHSS scheme

	2012	2012	2012	2013	2013	2013	2014	2014	2014
Age	No. in NHSS	% of total NHSS	% of general population in age group	No. in NHSS	% of total NHSS	% of general population in age group	No. in NHSS	% of total NHSS	% of general population in age group
< 65 years	1,306	5.92%	0.03%	1,271	5.53%	0.03%	1,110	4.96%	0.03%
65-69 years	978	4.43%	0.54%	1,006	4.37%	0.53%	931	4.16%	0.48%
70-74 years	1,759	7.97%	1.33%	1,782	7.75%	1.30%	1,597	7.14%	1.12%
75-79 years	3,321	15.05%	3.21%	3,482	15.14%	3.30%	2,848	12.74%	2.65%
80-84 years	5,216	23.64%	7.34%	5,249	22.81%	7.22%	4,629	20.70%	6.19%
> 85 years	9,486	42.99%	15.65%	10,217	44.41%	16.36%	11,247	50.30%	17.40%
Total	22,065	100%	*0.0048%	23,007	100%	*0.0050%	22,362	100%	*0.0048%

Source: Nursing Homes Support Scheme, HSE/CSO

*The % figures give the % of the total population in Ireland supported by the NHSS

Table 7 sets out the medium-term projected requirements for long-term residential care beds. The end 2015 target NHSS population has been broken down by age group, and long-term residential bed utilisation for each age group in the scheme, and has been expressed as a % of the current total national population in that age group in the scheme. Future projected bed utilisation has then been projected by relating these age-related bed utilisation rates to national population projections for these age cohorts out to 2024.

Table7: Medium-term projected numbers for NHSS.

Year	Total NHSS Numbers
2019	27,419
2024	33,070

Source CSO/DoH

While every effort should be made to maximise the number of older people who can be supported in their own homes, by strengthening home and community supports, and developing alternative models of care, it is not yet clear how many older people will avoid or delay the need for long-term

residential care under this approach. However, even under the most optimistic scenario, absolute numbers needing residential care will increase over the coming years and we need to plan for that. It is clear that net additional long-term and short-term residential beds will be needed in light of the forecast increase in the number of older people.

7.3. Current Long-Term Nursing Home Capacity

Long-term nursing home care in Ireland is provided through a mix of public and private provision, with the public sector providing about 20% of all beds and the private sector delivering the remaining 80%. At the end of 2014, the Health Information and Quality Authority (HIQA) advised that there were approximately 29,000 long-stay beds in 565 designated centres registered with the Authority. A breakdown of these is set out in table 8.

Table 8 HIQA register of providers of long-term residential care end 2014

Designated Centre	No. of residents who can be accommodated
Private	21,900
Health Act, 2004 Section 38 arrangement*	780
Health Act, 2004 Section 39 assistance**	332
Health Service Executive	6,030
Total	29,050

Source: Health Information and Quality Authority.

*Health Act, 2004 arrangement refers to a voluntary agency providing services on behalf of the HSE under Section 38 of the Health, Act 2004.

**Health Act, 2004 Section 39 assistance refers to a voluntary agency grant aided by the HSE under to provide services under Section 39 of the Health Act, 2004

7.3.1 Public Nursing Home Capacity

An immediate issue facing the public system is the fact that a notable number of facilities do not meet HIQA infrastructural standards. Currently there are 5,290 long-term residential care beds available in the public system. While some progress has been made in maintaining and upgrading existing public bed stock so that it is HIQA compliant, further work is required which will entail significant capital costs. Moreover, the re-development of public facilities in line with HIQA standards is likely to involve further reductions in current public bed numbers within affected facilities. The impact of such reductions may be particularly marked for high-needs residents given

the role of the public sector in catering to those with complex care needs. Indeed, an analysis of delayed discharge data highlights that approximately 3% of those awaiting discharge from acute hospitals encounter difficulties securing an appropriate placement due to complex care needs, particularly in areas where there is a general shortage of long-term residential care services.

In addition to the pressing need to upgrade and maintain existing public capacity, there is also a need for additional public sector capacity, if the Government wishes the public sector to maintain its current presence within the nursing home market. There may be important policy reasons for maintaining a strategic presence such as the need to ensure that the State is not wholly dependent on private operators or, as noted above, to ensure the availability of services for the most highly dependent, complex cases. If Government policy is for the public sector to continue to provide circa 20% of all nursing home capacity, this will require public nursing home beds to increase by approximately 1,200 beds by 2024, with an associated capital cost for the provision of these beds.

[7.3.2 Private Nursing Home Capacity](#)

Based on the end 2014 data from HIQA, there are currently 450 private nursing homes, i.e. private and voluntary (Section 39) operators. These facilities can provide accommodation for 22,232 residents.

Given projected demographic trends and continuing public expenditure constraints, it appears probable that there will be an expanded role for the private sector in the future nursing home market. However, Nursing Homes Ireland has indicated that, while there is an appetite to invest in delivering extra capacity including short stay/intermediate type care, there may be merit in stimulating the sector via a series of measures, including:

- guarantees of future NHSS funding,
- advance price agreements,
- extensions to the length of contracts,
- tax incentives to encourage targeted development.

This issue of future private capacity was considered by Deloitte and Touche Consultants. It was their view that, given the relationship between current and projected demand and supply, and prices available, lenders and developers are likely to continue to see the nursing home sector as a viable

investment, provided they have certainty about the bed price rate they would be paid for a number of years. However, the fact that lenders now require developers to provide upfront capital of approximately 30% of the total development costs is a limiting factor. There may not be sufficient ready capital available from existing nursing home operators to co-finance the levels of additional capacity needed over the coming years, resulting in private development only by larger operators. Lenders have expressed concern about this as it concentrates their lending risk more than they would wish.

7.4 Measures to Encourage Provision of Future Nursing Home Capacity

The provision of additional capacity must be planned to ensure adequate supply throughout the country. Trends in the provision of new residential capacity by the private sector should be carefully monitored over the coming months and years, and if required replacement ratios and levels of new capacity fall significantly behind projected population demand, all available responses should be considered.

As an important starting point for this planning work, the Department of Health is currently undertaking a project to identify and assess the various options available to Government to encourage the provision, including the upgrading and refurbishment, of long-term residential care facilities for older people, in areas where they are needed. This will consider whether it is preferable for the Government to meet future nursing home needs by means of direct build, public private partnership, tax incentives or other initiatives.

The work involves:

- detailed forecasting of the demand for, and supply of, nursing home care,
- extensive stakeholder consultation to identify both the market failures which may be inhibiting optimal supply of nursing home care and the potential measures for addressing those failures, and
- full cost benefit analysis of a suite of policy options to encourage the provision of necessary nursing home facilities.

The work is at an advanced stage and is expected to culminate in a report to the Minister in the coming months.

In addition to the above analysis, the Ireland Strategic Investment Fund has identified the nursing home sector as one that could provide a rate of return and an outcome that is compatible with the Fund's mandate. The Fund would offer loan finance on fully commercial terms (this is not

preferential funding), but it could still be a valuable stimulus to increasing private investment activity.

7.5 New Public Private Collaboration

In addition to the analysis outlined in section 7.4, detailed consideration should be given to potential new models of collaboration between the public and private sectors. Such new models might provide for a private operator to finance, build, and operate a facility. However, the allocation of beds and the level of care provided would remain within the remit of the HSE. These arrangements could apply to both short-stay and long-term residential care beds.

7.6 Sheltered Housing

In line with Government policy to support older people in their own homes and communities, it is important to consider the need to build capacity in areas other than long-term residential care. To this end, the potential of sheltered housing and assisted housing models should be considered in consultation with the Department of Environment, Community and Local Government.

Current initiatives include the Sue Ryder model or the Great Northern Haven housing development in County Louth, which is an integrated, community orientated housing model that incorporates health and community supports. Such initiatives can provide an alternative to long-term residential care, delivering homes which are 'lifetime adaptable' and designed to meet the changing needs of residents over time.

While sheltered housing appears to offer significant benefits over the longer term, it is currently under-developed in Ireland. In developing this sector, it is important that scarce health sector funds remain effectively focused on healthcare requirements. For example, the creation of an intermediate care model which falls between care at home and long-term residential care is as likely to attract people who may otherwise remain at home, though socially isolated, as it would those in long-term residential care. Those who would shift up from home care may, in many cases, have social housing issues rather than healthcare issues.

7.7 Recommendations on Residential Care Capacity

In order to ensure that there is sufficient capacity in the residential care setting to meet the needs of the increasing numbers of older people it is recommended that:

- 1) The Department of Health continues to progress the project to identify and assess the various options available to encourage the provision, including the upgrading and refurbishment, of long-term residential care facilities for older people.**
- 2) The implications for HSE residential facilities of the relevant standards should be clarified with a view to agreeing an approach that achieves the best achievable outcome for residents.**
- 3) Detailed consideration should be given to whether there is potential for new models of collaboration between the public and private sectors.**
- 4) The potential of sheltered housing and assisted housing models should be considered in consultation with the Department of Environment, Community and Local Government.**

8. Future Financing of Services for Older People

8.1. Background

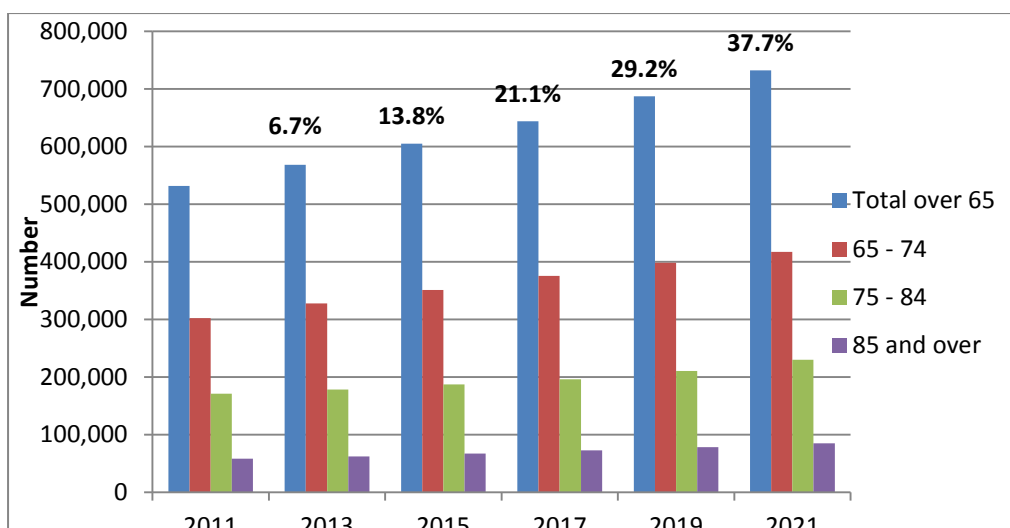
Based on the projected demographics it is clear that a significantly greater volume of service will be required to cater for older people in Ireland in the future years and that this will inevitably mean that the costs of providing these services will significantly increase. In planning for services and future models of care for older people it is therefore critical to consider how the needs and preferences of older people can be met in the most effective, efficient and economical way, and how the provision of services and supports can be sustainably financed.

8.2. Demographic Overview

Demographic projections show that our older population is expected to increase significantly in the coming years with the number of people over the age of 65 years expected to more than double (106% increase) by 2035. The population aged over 65 years, is projected to rise from just under 600,000 to almost 800,000 over the next 10 years. The projected growth rate is nearly double the EU average. By 2021, the population over the age of 65 will have increased by close to 40% since 2011.

Ireland's over 65 years population is currently increasing by approximately 20,000 per year. By 2021, the population over the age of 80, which tends to be the cohort with the highest health and social care needs, will have increased by 37 % since 2011. The number of people aged over 80 years will rise by approximately 3% per year over the next 5 years until 2021, and by approximately 5% annually from 2021 until 2031.

The projected increase in the number of people over the age of 65 from 2011 to 2021 is shown in the chart below.



Source CSO –Population Estimates and ‘Population and Labour Force Projections 2016-2046’

Note: The increases quoted are cumulative percentage increases in the numbers aged 65 and over from 2011.

Future models of care for older people must meet the demands of a growing older population at a cost that can be afforded. Approximately, 104,500 or 17.8% of older people were in receipt of some kind of service for older people in 2014, including residential care, home care and day care. While initiatives to increase healthy life expectancy will have some impact on utilisation of services, if services were to continue to be provided to the same proportion of older people as in 2014, by 2016 approximately 111,000 older people would be receiving these services. This would increase to 130,000 by 2021 and to 143,000 by 2024 and the increase could be even higher if informal carers were unable to provide the same rate of care that they currently provide. Table 9 shows the projected numbers availing of some type of service over the next ten years based on current usage.

Table 9: Projected number of older people needing services.

Year	Estimated Population Over 65 Years	Estimated Population Over 85 Years	Total Population in receipt of Services for Older People (17.8%)
2015	604,825	67,100	107,659
2016	624,183	69,800	111,204
2017	643,985	72,500	114,629
2018	665,800	75,100	118,512
2019	686,924	78,300	122,272
2020	709,500	81,600	126,291
2021	731,863	85,000	130,271
2022	755,222	88,600	134,429
2023	779,076	91,900	138,676
2024	802,885	95,900	142,914

Source: Public Health Information System. Data for 2015-2024 derived from the CSO's Population and Labour Force Projections: 2016-2046. Data for projected numbers in receipt of services from HSE.

8.3. Projected Costs of Providing Long-Term Residential Care Services

A number of factors may impact on future demand for long-term residential care services, including social changes, possible new models of care for older people, and changes in population health status. Accurate long-term forecasts are accordingly difficult. However, high-level projections are possible, and an analysis of the current NHSS population by age cohort, projected forward in line with CSO demographic projections, indicates that approximately 33,000 people will require support under the scheme by 2024, as set out at table 6 in chapter 7.

More detailed projections for the period 2016-2018 are set out in table 10. These are based on strict assumptions over the projection period of three years. It is assumed the average length of stay of participants in the scheme does not change, the approval rate of applicants remains constant and that the population aged over 65 increases linearly each month. In 2015, HSE figures for the expected number of scheme participants are used. It is assumed that the end of year target for the NHSS population will be reached. This assumption also impacts on the number of NHSS participants during 2015. Projections on this basis, taking account of applications to the scheme and departures from the scheme since 2011, are set out in table 10. Departures from the scheme are influenced by the average length of stay (currently 35 months) and the point at which people entered the scheme. By tracking entry to the scheme by month since 2011, and projecting based upon existing average length of stay information, a forecast of departures from the scheme can be made over the next three years. Projection of potential scheme entrants is derived from existing trends adjusted for the overall increase in the over 65 population over the period.

Using this methodology and assumptions it is projected that during 2018, up to 25,086 people will require support from the scheme. It is acknowledged that these projections will need to be tracked carefully over the period to monitor any changes in key variables such as average length of stay and levels of applications and approvals under the scheme.

Costing of the projected increase in scheme participants over this period has been calculated based upon the average weighted cost of care and the reduction in the number of residents who were in nursing homes prior to the commencement of the scheme. Projected costs also take account of the reducing numbers of residents who pay a 5% asset contribution (as opposed to the higher rate of 7.5%) It is assumed that the increase in the number of residents to be supported by the scheme in the short-term will be accommodated in private nursing homes.

However, it is similarly acknowledged that monitoring of actual costs against projections will be required. Variations could arise depending on the actual distribution of new residents across facilities with a range of costs, and the average contribution of individuals towards the cost of their care.

Finally, it should be noted that the headline figures overstate the actual net cost to the State of the scheme. This is because the personal contributions collected by the Revenue Commissioners from those availing of the loan element of the scheme are currently not restored to the NHSS provision but are absorbed as general receipts by the Exchequer and do not go as income to the scheme or the health services.

Table 10: Projected Number of People to be Supported under the NHSS and the Associated Costs 2016-2018

	2016	2016	2017	2017	2018	2018
	Numbers	Cost € million	Numbers	Cost € million	Numbers	Cost € million
Jan	23,938	€83.6	24,009	€83.5	24,948	€85.9
Feb	23,949	€83.6	24,083	€83.7	25,086	€86.3
Mar	24,128	€84.0	24,348	€84.5	24,315	€84.2
Apr	23,996	€83.6	24,407	€84.6	24,286	€84.0
May	24,116	€83.9	24,589	€85.1	24,257	€84.0
Jun	24,017	€83.6	24,614	€85.1	24,172	€83.7
Jul	23,986	€83.5	24,672	€85.3	24,090	€83.5
Aug	24,026	€83.6	24,721	€85.4	24,080	€83.4
Sep	23,956	€83.4	24,690	€85.3	23,838	€82.8
Oct	24,010	€83.6	24,700	€85.3	23,709	€82.4
Nov	24,144	€83.9	24,879	€85.8	23,707	€82.4
Dec	23,930	€83.3	24,735	€85.4	23,807	€82.7
Total		€1,003.6		€1,018.9		€1,005.30

Source DoH

The above calculations indicate a requirement for additional funding in 2016 and 2017 (€10.6 million and €25.9 million respectively compared to the 2015 provision). The reduction in 2018 is attributable to a significant intake of applicants in 2015 who, based upon projected length of stay may exit the scheme in 2018

8.4. Projected costs of Providing Home Based Services

A range of home based services are provided to older people as set out below, but unlike the Nursing Homes Support Scheme there is considerable variation in arrangements across the country. Waiting times for home based services vary by location, but are an established feature of the service. Furthermore, the level of service (in terms of hours) that can be provided to each applicant often falls short of what is ideally required.

8.4.1. Home Help Services

The level of home help service has reduced from a high of 11.98 million hours delivered to 55,000 people in 2008, to a level of 10.3 million hours delivered to 47,500 people in 2014. This represents a reduction of 14% in the number of people being supported by the service. The funding level was reduced from €211 million to €185 million over this period. The average cost per person of home help in 2014 was €3,900. Table 11 sets out the numbers in receipt of home help services and the budget allocation since 2009.

Table 11: Home help hours delivered 2009-2014

Home Help Hours	2009	2010	2011	2012	2013	2014
Number of hours	11.97m	11.68m	11.09m	9.89m	9.74m	10.3m
Budget allocation	€211m	€211m	€211m	€185m	€185m	€185m
Clients in receipt	53,791	54,011	50,986	45,705	46,249	47,500

Source HSE

8.4.2 Home Care Packages

While the numbers being supported by home care packages have increased year on year between 2009 and 2014, the average value of each home care package has fallen. This reflects the fact that available funding has remained relatively static since 2009. The average cost of a home care package in 2014 was €7,000. Table 12 sets out the numbers in receipt of home care packages and the budget allocation since 2009.

Table 12: Home Care Packages – Number of people in receipt 2009– 2014

Home Care Packages	2009	2010	2011	2012	2013	2014
Clients in Receipt 31 st Dec	8,959	9,941	10,968	11,023	11,873	13,057*
Clients benefitting - full year	12,000	14,285	15,681	16,443	16,877	18,573
Budget Allocation	€120m	€130m	€138m	€130m	€130m	€130m*

Source HSE

*In addition in 2014 a sum of €10m was provided from NHSS which was utilised for care packages and additional intermediate & short-stay bed capacity to support acute hospital discharges.

An additional allocation of €5 million was made for home care in 2015, and this is expected to deliver an additional 400 home care packages to 600 clients. However, the HSE estimates that, even with this extra provision, home care services, i.e. home care packages and the traditional home help service, fall short of the required level by about 10%. Therefore, the 2015 baseline figures in table 13 are adjusted to reflect this estimate of unmet need.

Table 13: Projected cost of providing Home Care Services (Home Help & Home Care Packages)

Year	Estimated Population Over 65 Years	% increase	Budget Required €m
2015	604,825		€352.00
2016	624,183	3.20	€363.25
2017	643,985	3.17	€374.78
2018	665,800	3.39	€387.48
2019	686,924	3.17	€399.77
2020	709,500	3.29	€412.92
2021	731,863	3.15	€425.93
2022	755,222	3.20	€439.56
2023	779,076	3.16	€453.45
2024	802,885	3.05	€467.28

Source CSO/DoH

8.5. Current Financing of Services

At present long-term residential care is financed via a combination of direct State support and a contribution from residents based on their means. The average contribution amounts to approximately 25% of the cost of care.

Short-stay beds, with an average weekly cost of €1,200 are substantially financed by the State with patients subject to a charge only where in-patient services in excess of 30 days have been provided over the previous 12 month period. Regulations currently provide for a maximum charge of €175 per week where care is provided in a setting with 24-hour nursing care.

Home care and other community based services are currently provided by the State based on need and there is no means test or personal contribution, although some families do directly finance care provided by private providers.

8.6. Changing Model of Care

The decision to adjust the model of care provision to increase emphasis on community based services and supports has already been taken in principle and reflects the wishes of most older people. Elements of this approach include more flexible and responsive home care, more integration of primary care services with home supports, using the potential of technology insofar as this is possible, and developing respite, re-ablement and convalescent beds. These areas have been covered in more detail in chapter 6.

8.7. Sources of Finance

Broadly speaking there are three possible approaches to financing long-term residential and community based care:

- Public tax based finance,
- Insurance either private or social,
- Individual contributions based on income and assets.

Decisions on financing should support Government policy in relation to the care model of supporting older people to remain at home.

8.7.1. [Tax Based](#)

Tax based financing is dependent on available revenues. Tax based financing systems have the advantage of being more flexible as budgets can be adapted to changing economic and demographic circumstances.

The forecasted increases in the over 65 population from 11% of the total population in 2011 to 25% by 2041 will affect the old age dependency ratio which measures the number of people over the age of 65 years supported per 100 people in the age bracket 15-64 years. In 2013, this ratio was 18.8%, and it will increase to almost 24% by 2021 and 30% by 2031 (CSO).

8.7.2. [Insurance](#)

Issues of uncertainty for individuals, particularly younger individuals, as to whether they will need long-term care and affordability are likely to limit the contribution of private insurance to addressing

the financing of long-term care. Substantial difficulties arise in voluntary private insurance markets such as the United States, where long-term care insurance is sold but often with limited take up in practice. For consumers the costs are high but the benefits can often fall short of need. It is also difficult to get younger people to voluntarily insure themselves against something which they feel may never happen or which seems too far removed for them to worry about. The key to competitive insurance pricing is the pooling of risk amongst as wide a group as possible rather than leaving those unlucky enough to require care with the full cost. In practice, it has been hard to attract a wide pool of insured into purchasing long-term care private insurance. The fact that in countries where private insurance is offered for long-term care the uptake is generally low contributes to lack of affordability. In addition, unlike insurance for acute care, long-term care insurance is written over a long time horizon. This means that the risk to the insurance company depends on any change in the average cost of care over time. This risk cannot be pooled as it is common to all those insured. Faced with higher risk, insurance companies demand a higher rate of return, increasing the premiums charged.

A mandatory social insurance model of financing would have many of the features of the current tax-based system, although long-term care would be funded from a dedicated fund rather than from general taxation. Some additional issues that would require consideration would be the interaction with other health and social care services financed by other means, the financing of care for those outside of the workforce without social insurance and the implications of this model for payroll costs and competitiveness.

[8.7.3. Individual Contributions](#)

The historic situation prior to the introduction of the NHSS was that the cost of nursing home care outside of public facilities was generally met by residents or families, with comparatively modest State support provided through a subvention scheme. This situation was widely regarded as inequitable and in need of reform. The NHSS was introduced to ensure that all those who require nursing home care would have access to it, with a contribution based upon their means, regardless of their choice of nursing home.

The Nursing Homes Support Scheme is a progressive scheme with residents' contributions based on their means. There are extensive exclusions from the property or asset based contributions, including a substantial portion of the value of the principal private residence. There is very significant expenditure incurred by the State, costing €993 million in 2015. The objective for the future is to

ensure that long-term residential care continues to be available to all who need it, and that the State can afford to pay its share of the cost of such care.

8.8. Future Financing of Services

This section attempts to identify from a technical perspective the options that may be considered when reviewing rates of personal contributions in the future. The options set out below would require amendments to the NHSS Act, 2009 and could only apply to residents who join the scheme after the date of enactment of legislation providing for any such options.

8.8.1. [Reduce Asset Disregard](#)

Currently, the first €36,000 of a person's assets (or €72,000 for a couple), including savings are not taken into account during the financial assessment. By abolishing this disregard altogether, additional contributions of up to €50 per week would be payable by those with assets or savings. By reducing it to €20,000 (or €40,000 for a couple), additional contributions of €23 per week could be payable, yielding an additional €13.1 million in a full year. As with any measure this could apply only to new residents, so the rollout would take place over about 3 years.

8.8.2. [Increase the Asset Contribution](#)

Currently the asset contribution based on cash, investments, property and other assets is set at 7.5%. This was increased from 5% to 7.5% in July 2013. It is estimated that an increase in the rate of contributions based on cash and other relevant assets would yield the following additional full year revenues:

- 7.5% to 9.5% - €6.7m
- 7.5% to 11.5% - €13.4m
- 7.5% to 13.5% - €19.9m
- 7.5% to 15.59% - €26.7m

These estimates take account of the effect of the maximum percentage contribution on the principal private residence as explained below.

8.8.3. [Increase the Asset Contribution based on the Principal Private Residence](#)

The existing rules provide that the principal private residence (PPR) is not assessable after three years in care. This effectively means that a maximum of 22.5% of the value of the PPR can be absorbed by way of asset contribution.

Further consideration could be given to the maximum percentage cap applied to the value of the PPR. The effect of various caps would require further investigation

Currently 36% of nursing home residents have reached the three year cap. If the PPR is subsequently sold, the proceeds of the sale are assessed as cash assets as long as the person remains in long-term residential care. This anomaly has created a perverse incentive not to sell homes, leading to properties being left vacant. Removing or extending the 3 year cap would remove the current disincentive to sell vacant homes. It would, however, lead to the fuller dissipation of the value of the PPR (i.e. for inheritance and other purposes) in over one-third of cases.

8.8.4. Farms and Small Businesses

Further consideration will be given to the application of the asset-based contribution to family farms or other family businesses where the relevant asset generates a household's income, and where the asset would in the normal course pass on to the next generation as a primary income source. Such consideration should involve input of a wider range of expertise relevant to such matters including the Revenue Commissioners. At present both the income generated and the capital value are used as a basis for contributions. The resultant dilution of equity in the capital asset, particularly in circumstances where the three year cap does not apply, can cause real difficulties for farming and other families.

8.8.5. Increase the Income Contribution

It is generally acknowledged that a contribution of 80% of income is fair, if the only source of income is the State (Non-Contributory) pension. However, for those with higher incomes increasing the rate to e.g. 85% for other income sources could be considered, subject to safeguards providing residents with a minimum amount of income.

Since the scheme commenced, there are some residents who refuse to pay their contribution. An amendment to the Act to allow for charges to be either attached to a person's earnings, placed against their property, or deducted at source for those in receipt of State pensions could be considered.

8.8.6. [Financial profile of NHSS Participants.](#)

It is worth noting that:

- 83% of those supported by the NHSS scheme are single;
- 34% of single residents have income at maximum Non-Contributory Old Age Pension rate (€229 per week) or less and
- 76% of single residents have income below €300 per week.

The income distribution for those currently being supported under the scheme is set out in table 14.

Table 14: Income Distribution

Weekly Income	Single assessment clients	Joint assessment clients (couple)	Total	Percentage %
€0-€229	5,330	46	5,376	28%
€230-€300	6,697	55	6,752	35%
€300-€400	1,956	241	2,197	12%
€400-€500	1,078	1,368	2,446	13%
€500-€600	557	697	1,254	7%
€600-€700	250	370	620	3%
€700-€800	73	242	315	2%
€800-€900		142	142	1%
€900-€1000			0	0%
>€1000				28%
Total	15,941	3,161	19,102	100%

*The slight difference in the total numbers in tables 14,15 and 16 on the financial profile are due to data being gathered on different dates throughout the month of April 2015.

The level of cash assets are set out in table 15. It is worth noting that:

- 18% of all residents supported under the scheme have no cash assets,
- 55% of all residents have cash assets between €1 and €20,000.

Table 15: Distribution of Cash Assets

Value	Number with cash assets	Percentage with cash assets
0	3,509	18%
€1-€10k	4,567	24%
€10k-€20k	2,510	13%
€20k-€30k	1,620	8%
€30k-€40k	1,268	7%
€40k-€50k	824	4%
€50k-€60k	687	4%

€60k-€70k	528	3%
€70k-€80k	430	2%
€80k-€100k	707	4%
€100k-€200k	1,541	8%
€200k-€300k	603	3%
€300k-€400k	243	1%
€400k-€500k	114	1%
Total	19,151	

The level of other declared assets are set out in table 16. Again, it is worth noting that

- 15% of all residents supported by the scheme have no relevant assets,
- 48% of all residents have relevant assets between €1 and €20,000 value.

Table 16: Distribution of Relevant Assets

Value	Number with relevant assets	% with relevant assets
€1-€10k	9,143	48%
€10k-€20k	165	1%
€20k-€30k	238	1%
€30k-€40k	293	2%
€40k-€50k	418	2%
€50k-€100k	2,805	15%
€100k-€200k	3,296	17%
€200k-€300k	1,567	8%
€300k-€400k	651	3%
€400k-€500k	300	2%
€500k-€600k	133	1%
€600k-€700k	73	0%
€700k-€800k	27	0%
€800k-€900k	13	0%
€900k-€1m	6	0%
>€1m	20	0%
Total	19,148	

8.8.7. [Effective Application of Current Conditions of Scheme.](#)

Those supported under the Nursing Homes Support Scheme currently contribute an average of 25% of the cost of their care, with the balance being met by the State.

However, before any increase in such contributions is considered, it is essential that the existing conditions of the scheme be implemented as effectively as possible. This review has identified a number of issues with regard to the validation and verification of financial declarations that should be addressed as a priority.

8.8.8. [Nursing Home Loan](#)

A key feature of the scheme is the nursing home loan. Currently if a person entering a nursing home avails of the loan, it becomes repayable from their estate after their death. This money is repaid to the Revenue Commissioners and goes directly back to the Exchequer. Since the scheme commenced to end 2014 almost 10% of applicants who received support under the scheme have availed of the loan. The HSE has advised Revenue that to end 2014 €34.9m fell to be recouped from estates, of which Revenue has recouped €20.2m.

When considering future financing of the scheme, consideration should be given to allocating the amount of the nursing home loan availed of (or repaid) in any given year to the scheme by way of income (or Appropriations-in-Aid) to the Health Vote. This would more accurately represent the cost to the Exchequer of the scheme and it would allow the financing of the scheme to benefit from what, due to demographic factors, can be expected to be a growing source of revenue which was specifically provided for in the design of the scheme's financing.

8.9. [Short-Stay Beds](#)

Having a dedicated ear-marked source of funding for short-stay beds is a key step in implementing a 'money follows the patient' model of financing services, and arguably for supporting the most effective use of more expensive acute hospital capacity. As such this should be considered.

8.10. [Community Services](#)

Home based and community services are currently fully funded from general taxation. Most community services, e.g. meals on wheels, home help services, home care packages and day care, are provided based on need but are subject to resource constraints.

Although section 61 of the Health Act, 1970 may enable charges to be levied for home help, in line with any directions given by the Minister, user charges do not currently apply. It is Government policy to increase the part played by community services in supporting older people in line with the preferences of older people themselves. The question arises as to whether some level of user contribution by those who could afford it would allow the provision of a better level of services overall, and allow available resources to be focussed where need is greatest. It should be recognised that those living in the community have different costs associated with daily living and it would, therefore, not be appropriate to apply a rate of contribution based on current NHSS arrangements to those who are living at home. In reality, some individuals and families with the means to do so

already contribute financially by procuring additional home supports privately. Tax relief is available in such instances.

Alternatively, means testing could be used to determine the provision of services without charge to qualifying individuals, or a sliding means test could be applied with personal contributions increasing in line with means. Other options would include providing for a charge on the estates of community service recipients for collection after their deaths or earmarking a portion of inheritance tax for the provision of services received by the person prior to their death.

[8.10.1. Review of Home Care](#)

The HSE is currently conducting a review of home care packages. This review should proceed as a matter of priority, with consideration being given to the following issues which emerged from the analysis of the four selected geographic areas as part of the present review of the NHSS:

- Uneven distribution of applications to NHSS;
- Uneven distribution of home help/home care packages;
- Role of enhanced home care package;
- Provision of home care at night/weekends,
- Provision of flexible respite, including respite in the home,
- Enhanced support for carers managing people with dementia,
- Domestic assistance and the importance of this for persons living on their own with no family support.

[8.10.2. Standard Assessment of Needs](#)

The introduction of a standardised assessment of need should be a priority for community services. The roll-out of the single assessment tool should facilitate the targeting of services to where need is greatest and the identification of services most appropriate to a person's needs.

8.11. Carers

Informal care is a major part of the care provided to older people. It is important that the role played by carers is fully supported so as to protect and sustain this invaluable resource. Support for the implementation of The National Carers' Strategy is key in this regard. Carers' entitlements under the social protection system play an important role in supporting carers in their vital work.

8.12. Tax Relief

Currently tax relief can be claimed at the higher and marginal tax rate for fees paid to approved nursing homes. Tax relief is also available for those employing carers in their own homes. The level of tax relief that can be claimed by employing a carer was raised from €50,000 to €75,000 per annum in Budget 2015.

8.13. International Models of Long-Term Care Support

A summary of financing approaches and service provision in a number of other countries is included in appendix A for comparison purposes.

8.14. Technical Policy Options on the Financial Sustainability of the Scheme

In summary the following menu of options merit consideration:

- 1) Increase the level of State support to cover the effect of demographic change.**
- 2) Address the issues with regard to the validation and verification of financial declarations as a priority.**
- 3) On an ongoing basis, allocate additional amounts to the NHSS equivalent to the amounts recouped by Revenue in respect of the nursing home loan (ancillary State support). This can be done by means of an Appropriation-in- Aid in the Health Vote.**
- 4) Put in place a management information system to track and update on an on-going basis the key variables used in deriving the utilisation and cost projections presented in this review.**
- 5) The application of the asset-based contribution to farm and business assets which generate the primary income source for the household should be the subject of further examination drawing on wider expertise including that of the Revenue Commissioners.**
- 6) Consideration could be given to whether the charges for short term beds, which operate outside of the scheme, should be revised. The contribution by users to the cost of short-term beds could be based upon means.**
- 7) The introduction of a standardised assessment of need should be a priority for community services. The roll-out of a single assessment tool should facilitate better targeting of services to areas of greatest need and more appropriate design of those services.**
- 8) Given the scale of costs arising in properly meeting the long-term care needs of older people in the community and the objective of equity of treatment, the absence of contribution towards the costs of publicly funded community based care should be reviewed as improvement in availability and consistency is brought to the level of State supports available. Such**

consideration would need to recognise the additional expenses incurred by people who are living at home.

9) The HSE review of home care should proceed as a priority.

10) Continue to support for the implementation and monitoring of The National Carers' Strategy is important including continuing support through the social protection system.

Introduction

This section gives an overview of long term care services in a number of OECD countries. It should be noted that there are significant variations in both data and interpretation, and as such the material compiled on service provision and funding is for information rather than comparative purposes. There is growing recognition in developed countries worldwide that many patients in hospital do not require the intensity of care of an acute care hospital but cannot be cared for safely in the community and therefore need a level of care that is between acute hospital care and community care. This level of short stay care is often referred to as “Transitional Care” and is included in the data below as it is an integral part of the continuum of care for older people.

Although this report does not go into too much detail on home based services, pending the conclusion of the review currently being conducted by the HSE, some key features of systems providing more support to home care rather than residential care have been identified. Included among these are that support for home care is generally non means tested, with highest levels of support being provided to those with the highest dependency levels, and that there is a greater use of both short stay care and supported housing arrangements.

1. England²⁰

Access to publicly funded services is mainly through an assessment of care needs coordinated by local authorities, leading to a great variability within a national framework of eligibility criteria. Those that have been assessed as eligible are then subject to a means test. In terms of financial eligibility for residential care, for example, currently an individual must have assets worth less than £23,250 (approx. €28,000) in England to qualify for local authority placement into a care home. In most localities only people with the highest care needs and lowest means are eligible for services.

The UK Parliament is enacting legislation to reform the long-term care system in England. It will be implemented over the next couple of years. The legislation includes the following:

- A cap on individual care costs will be introduced from April 2016;
- If someone is assessed by a local authority as having eligible care needs, they will be informed how much it will cost the local authority to meet those needs;

²⁰ <http://www.nhs.uk>

- These costs will count towards the cap;
- However great a person's costs become, once they have reached the cap the State will step in and provide financial support;
- The Government is introducing a cap that is equivalent to around £61,000 (approx. €73,800) in 2010/2011 prices and £75,000 (approx. €91,000) in 2017/2018 prices;
- It is expected up to 16% of older people will face costs of £75,000 or more;
- People of working age who develop care needs before retirement age will benefit from a cap that's lower than £75,000;
- People who have care needs before they turn 18 will effectively have their cap set at zero;
- These legislative changes will mean that those with property value and savings of £100,000²¹ (approx. €120,000) or less will start to receive financial support with the Government paying a proportion of their residential care costs on a sliding scale.

Short-Stay beds

In the United Kingdom, transitional sub-acute services are called "Intermediate Care" and have been widely introduced as part of the National Health Service's – National Service Framework for Older People (2001) with the goal to provide lower cost, more appropriate health care for older adults. Intermediate care is a range of needs led, transitional and integrated services that are intended to maximise health gain and prevent unnecessary admission to an acute hospital bed, support timely discharge, reduce avoidable use of long-term care and maximise independent living. These services are delivered in partnership between primary and secondary health care providers, local government services (social care) and the private sector. This comprehensive strategy aims to promote and maintain independence of older people while reducing hospital and long-term care use. The NHS estimates that one quarter of acute admissions would be appropriate for intermediate care following the acute phase of their admission.

2. Scotland²²

As in the rest of the UK, access to services is based on an assessment of care needs. Free personal care is available for everyone aged 65 and over in Scotland who have been assessed by the local authority as needing it. Free nursing care is available for people of any age who have been assessed as requiring nursing care services.

²¹ £100,000 was the amount recommended by Andrew Dilnot, who chaired a commission on long-term care reform (Dilnot Commission), and is equivalent to around £123,000 in 2017/18 prices

²² <http://www.scotland.gov.uk>

If a person has been assessed as needing personal and nursing care they will receive this regardless of income, capital assets, or marital or civil partner status. If a person lives in a care home and the local authority agrees that these services should be provided, the local authority will pay £166 per week for personal care and £75 per week for nursing care directly to the person's care provider.

If a person lives in a residential care home they need to contribute towards the remaining accommodation costs. Those with personal capital assets (and half of any jointly held assessable assets) exceeding only £25,250 (approx. €30,500) have to pay for all of their accommodation costs. Only those with assets currently below £15,500 (approx. €18,700) qualify for the maximum Local Authority budget of £580.11 (approx. €700) with nursing care, or £499.38 (approx. €600) without nursing care.

Those whose capital falls in between the upper and lower capital thresholds will have the value of any capital exceeding the lower limits theoretically converted into "income" at a rate of £1 (approx. €1.20) extra "notional income" for every £250 (approx. €300) worth of capital exceeding the lower limit.

Deferred payments were introduced in July 2002 under the Community Care and Health (Scotland) Act 2002. These allow people to avoid selling their homes up-front to meet their care home fees by entering into a legal agreement to have part of their fees paid by their local authority and the balance settled from their estate.

The Personal Expenses Allowance (PEA) is the weekly allowance that publically funded residents in care homes are allowed to retain from their income for personal expenses. The current rate from April 8th 2013 is £23.90 (approx. €29) per week and is increased annually in line with average earnings. This allowance is intended for personal items such as:

- Personal toiletries;
- Gifts for family and friends;
- Stationery;
- Other minor items.

Short-Stay Care

Though there is no simple definition for all services within the scope of intermediate care, it has been defined in Scotland as 'a range of integrated services to promote faster recovery from illness,

prevent unnecessary acute hospital admission, support timely discharge and maximise independent living.’

Intermediate care enables people to improve their independence by providing a range of enabling, rehabilitative and treatment services in community and residential settings. Better integrated approaches through intermediate care not only help to prevent unnecessary admission to hospital, or help facilitate early discharge, but they are also central to the priorities from the Reshaping Care programme and the need to ensure improved joint working between local authorities and the NHS in community care.

3. [Sweden](#)²³

The majority of long-term care services are financed through local municipal taxes (85% of total long-term care spending in 2010), the remainder is from user fees (3-4%) and grants from the national government (11-12%). The level of user co-payment is based on income, minus the cost for housing and basic necessities. There is a maximum contribution amount for home help services. The rules are designed to strengthen safeguards for the individual against excessively high charges. They set out how incomes are to be computed, the level of the reserved amount and the highest charge that can be made for home help services (in both ordinary housing and special housing accommodation), daytime activities and certain outpatient health care. The reserved amount is intended to cover the individual’s normal living expenses and actual housing cost and the individual is entitled to retain this amount before any charge is levied for home care services.

Short-Stay Care

Although Home Care gives older people the possibility to live an independent life for as long as possible, it has also made it difficult for those in need of more attention to receive the sort of care only provided in an institutional setting. Because of problems like increasing waiting times for placement in institutional care, and growing concern about the mismanagement of care for the elderly in institutions owing to economic retrenchment, Swedish policy makers have recently been more favourably inclined towards the restoration of institutional care. Demographic changes and cost awareness have also made policy-makers progressively turn their attention to informal care, as it is not only a cheaper care solution than any service provided by the government, but it is only considered to require fewer human resources.

²³ OECD (2011); Help Wanted? Providing and Paying for Long-Term Care

4. [France](#)²⁴

Support for the provision of long-term care, either at home or in an institution, is mainly provided through the public health insurance system and through the 'allowance for autonomy' (allocation personnalisée d'autonomie - APA). While support provided to elderly for activities of daily living (ADL) or instrumental activities of daily living (IADL) is viewed as a social risk, the public health insurance system continues to play a major role in financing ADL-support services. Consideration is currently being given to changing to the existing long-term care system in France.

Generally, the public health insurance system covers health services provided to a patient who requires long-term care due to a chronic or acute medical condition. These include health services provided in institutions and home nursing care (services de soins infirmiers à domicile (Ssiad)). Home nursing care (e.g., Ssiad services) includes support for ADLs such as personal hygiene, and eating. Prescribed home nursing care is fully covered by the public health insurance system.

The cost of nursing and residential care facilities is split in three components, the health cost, the dependence cost and hotel cost. Residents are responsible for hotel costs. Those who cannot afford to pay the full-cost of long term residential care may be eligible for public social assistance for housing.

As a complement to the support provided by public health insurance, APA provides individuals with ADL restrictions additional cash support towards the cost they incur as a result of their dependence. APA is available for people aged 60 or older, who are dependent (assessed according to four levels) and live either at home or in a retirement centre. APA is administered by local Departments, which leads to some differences in the level of APA benefits provided across beneficiaries.

For those living at home, APA provides support towards any expenses incurred in line with a personalised support plan identified by a social-medical team. Plans generally include support for both ADL and IADL services through the employment of a caregiver (except for their spouse or partner). For those living in a retirement centre, APA offset a portion of the dependence cost while the remaining is paid by the resident (about 33% of the dependence costs on average).

²⁴ OECD (2011); Help Wanted? Providing and Paying for Long-Term Care

The monthly cash allowance varies according to the assessed level of dependence and is limited to national ceilings (in 2010 ranging from €530-€1,235). Depending on their level of income beneficiaries are required to forego a certain percentage of the assessed level of APA down to a prescribed floor (up to a 90 per cent reduction).

France is one of the two leading markets in terms of the share of its population covered by private long-term care insurance. In 2010, the equivalent of 15% of the population aged over 40 years had private long-term care coverage.

Short-Stay Care

Depending on a patient's condition after acute treatment, rehabilitation care can be delivered in an inpatient or an outpatient setting.

Following a hospital stay for acute care, a patient would typically be transferred to an inpatient follow-up and rehabilitation unit (SSR) as soon as daily monitoring by acute care specialists is no longer necessary. The SSR unit might be a follow-up and rehabilitation unit or a specialized one (for example, in cardiology, neurology or orthopaedics), depending on patient needs.

The private non-profit making sector is historically the main sector in SSR, owning one third of full time and half of part time SSR beds. The public sector represents 40% of full time and 25% of part-time capacity.

5. The Netherlands²⁵

The financing arrangements for long-term care consist of three main pillars:

- The first pillar is the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten- AWBZ) which funds most of long-term care. The AWBZ, which is in place since 1968, is a national mandatory, contribution based insurance scheme, which covers personal care, nursing care, counselling, medical treatment in a residential setting and accommodation. Clients are required to co-pay. The size of the co-payment is related to income, age, family situation and stage of care. In 2012 a recipient co-paid on average €6,400 a year for residential care. Since 2013, 8% of a person's private savings and assets above a state-set threshold (€21,000) are accounted for in calculation of the co-payment.

²⁵ Draft EU Social Protection Committee report on Long Term Care – Country Profile The Netherlands

- The second pillar is the Social Support Act (Wet Maatschappelijke Ondersteuning) which is in place since 2007. It is a tax-funded scheme run by municipalities. The WMO pays, among others, for household (domiciliary) services. Before its introduction, these services were covered by the AWBZ. The transition of these services from the AWBZ to the WMO meant that a rights-based scheme was converted into a provision-based scheme which gives recipients fewer rights. Municipalities have substantial discretionary power in the implementation of the WMO.
- The personal budget (persoonsgebonden budget) constitutes the third pillar. This benefit-in-cash arrangement was introduced in the mid-1990's to give recipients an alternative for in kind services. The personal budget enables clients to organise their own tailor-made care arrangements.

Means testing is not used under the AWBZ. If after a need-assessment procedure a person is considered eligible for long-term care, his/her personal financial situation is only relevant for the calculation of co-payment. The AWBZ gives him/her a legal right to care.

This is different under the WMO, where municipalities may take the financial situation of the applicant into consideration in deciding on whether he/she is eligible for publicly funded care. Means-testing is likely to be applied by the municipalities.

Short-Stay Care

The general trend is that the number of persons in residential care has been declining since the early 1980's. The percentage of persons aged 80+ living in a residential home or nursing facility dropped from 63% in 1980 to 24% in 2010. Various programmes are in place to make independent living possible. For example, sheltered accommodation in the proximity of a care home. Residents can make use of the services (e.g. meal) of the care home (assisted living) and the accommodation has a direct alarm line with the care home. Ever more nursing homes participate in integrated networks (care chains) to shorten the length of stay in a hospital and facilitate a smooth transition to a residential setting for what is termed as geriatric rehabilitation (e.g. in cases of strokes, hip replacement, fractures).

6. Norway²⁶

Norway has a tax-based, universal public long-term care scheme. All long-term care services are delivered in kind. The system is funded by national taxes but carried out at local level, and may require co-payments depending on the care required.

Services cover home practical care, home medical care, institutional day and night care, daytime relief for informal carers, provision of assistive devices and technology, economical support to informal carers, social contact assistance, and personal assistance for disabled (user-organised).

Eligibility is assessed by municipalities (local government) agencies. Municipalities are free to organise the services as they find appropriate in order to fulfil their obligations according to medical and social rights determined by law. With funding tax-based, there is no clear “right” to care.

Furthermore, there is no absolute “criterion” that makes people eligible for care. However, there must be a need for “required health care” beyond immediate help, and health care should be “properly” secured by the municipality. In order to receive social services (personal and practical assistance at home, short-term stay in nursing homes, residence in elderly home or discretionary cash benefits), the client must have a special need for help due to factors such as sickness or disability. The client must be dependent on practical or personal help to manage ordinary activities of daily living. Normally, qualified staff will assess the need for care but variation exists.

Co-payments are required for home care and nursing homes. However for home nursing and medical care no co-payments are required.

For long-term nursing home care the patient must pay 75% of income above NOK 6,600 (€850) and up to the Basic Amount (Grunnbeløpet) of NOK 75,641 (€9,800), plus 85% of any exceeding income up to the full cost of a nursing home place (as calculated for the municipality in question). Property and capital assets are left untouched.

Short-Stay Care

Provision of rehabilitative/transitional care has a long tradition in Norway. Rehabilitation is provided at both the primary (physiotherapy, occupational therapy etc.) and secondary (specialised

²⁶ OECD (2011); Help Wanted? Providing and Paying for Long-Term Care

rehabilitation) levels. As in other countries, Norway has in the last two decades also developed some intermediate rehabilitation services based on shared care between specialised and primary health care (Johansen, et al., 2012).

Primary care rehabilitation is provided in the community – in patient’s homes, schools and institutions run by the municipalities (e.g. nursing homes). Services are provided by medical doctors, physiotherapists and nurses. Primary rehabilitation is available for somatic as well a psychiatric patients and can be accessed through a referral from a primary care physician.

Secondary rehabilitation services are provided in hospitals – in dedicated rehabilitation departments or other units, such as rheumatological or neurological departments. Rehabilitation, especially post-operative rehabilitation, may also be provided in private rehabilitation institutions contracted by the RHAs; this is free of charge if the patient is referred by a GP or a hospital.

7. Australia²⁷

Home Care Packages

From the 1st July 2014, new fee arrangements for Home Care Packages will introduce a consistent approach to the way that older Australians contribute to the cost of the care they receive in their own homes. This arrangement ensures that people with similar income pay similar fees, regardless of where they live, with safeguards for those who can least afford to pay.

From the 1st July 2014, individuals can be asked to pay a basic daily care fee as a contribution towards the cost of their care, as is currently the case. Consumers with higher incomes may also be asked to pay an income tested care fee.

From the 1st July 2014:

- No full pensioner will pay an income tested care fee,
- No part pensioner will pay an income tested care fee greater than \$5,000 (approx. €3,300) per annum,
- People with an income of more than \$43,186 (approx. €28,300) will pay an income tested care fee on a sliding scale up to a total of \$10,000 (approx. €6,600) per annum, and

²⁷ <http://www.livinglongerlivingbetter.gov.au>

- No one will pay more than \$60,000 (approx. €39,300) in an income tested care fee over their lifetime.

If paying home care fees would cause hardship, from 1 July 2014, a consumer will be able to apply to the Department for relief from paying some or all of their fees.

Residential Care

In order to ensure the sustainability of the aged care system so that all Australians get the care that they need, the Government will strengthen the means testing arrangements for people entering residential care from the 1st July 2014. It will combine the current income and asset tests to ensure a consistent fees policy. This will address the issue of asset-rich, income-poor residents paying for all of their accommodation and nothing for care, and the income-rich, asset-poor residents paying for their care but not for accommodation.

The treatment of the family home will not change. It will continue to be exempt from the aged care assets test if occupied by a spouse or other protected person. An annual cap of \$25,000 (approx. €16,400) will apply to a resident's mean tested contribution to their care costs, together with a lifetime cap of \$60,000 (approx. €40,000). These amounts will be indexed.

There will be safeguards to ensure access to care for those who cannot afford to contribute to the cost of their care and accommodation.

Short-Stay Care

In Australia, Transitional Care / sub-acute care encompasses palliative care, rehabilitation medicine, psycho-geriatrics and geriatric evaluation and management but not convalescent, respite or long-term care. Australia has also developed a category called “non-acute” care which is described as “maintenance care” and provides respite and interim long term care. Australia’s sub-acute care service was developed in response to increasing demands for acute care beds and overcrowded emergency departments. Services were initially offered in acute care inpatient units but with the introduction of “Aged Care Packages”, sub-acute care is increasingly being offered in ambulatory and community settings.

8. New Zealand

Residential Care

Eligibility for tax-funded subsidised care is based on need and the person's ability to pay over an annually increasing asset threshold. For those whose assets are less than the threshold²⁸ there is the tax-funded Residential Care Subsidy (RCS).

The Residential Care Subsidy is a subsidy provided by the Ministry of Health funded through local District Health Boards. Generally, the amount of subsidy is the difference between the cost of contracted care and the amount a person is required to contribute for that care. To be eligible for Residential Care Subsidy, the person must be eligible for publicly-funded health and disability services and be aged 65 years or over, or between 50 and 64 and be single with no dependent children. They must also have been needs assessed as requiring long-term residential care in a hospital or rest home indefinitely and be financially eligible as determined by a financial means assessment. The asset threshold is set in legislation to increase each year until 2026. People aged 50-64 who are single and have no dependent children are deemed to automatically meet the asset test but must undergo an income test. People aged 65 and over must submit to an asset test for eligibility but do not need to take any income test.

People aged 65 and older who are receiving New Zealand Superannuation or Veteran's Pension must contribute to the cost of their care from their entitlement if they meet the means test for assets and are eligible for the Residential Care Subsidy. They keep a specified amount of their entitlement as a Personal Allowance while the rest goes to payment of services. Older people who do not qualify for the Residential Care Subsidy pay the full cost of their residential contracted care services up to a maximum that is set at the lowest cost of care which is known as the "rest home level". District Health Boards fund any higher levels of contracted care services above rest home level for both those who qualify for the Residential Care Subsidy and those who pay for their own care.

²⁸ From 1st July 2013, a) people who do not have a spouse/partner or have a spouse/partner who is also in long-term residential care must have combined total assets valued at \$215,132 (approx. €141,000) or less to qualify for Residential Care Subsidy and b) People who have a spouse/partner who is not in care, can choose a threshold of combined total assets of \$117,811 (approx. €77,200) not including the value of their house (the house is only exempt from the financial means assessment when it is the principal place of residence of the spouse/partner who is not in care or a dependent child) and car or combined total assets of \$215,132 (approx. €141,000) which will include the value of their house and car.

Short-Stay care

Hospitals in New Zealand now mainly treat people for conditions that require short-term and intensive treatment, with long-stay treatment and care being shifted to the private sector and to nursing homes. Between 1988 and 2001, the number of private hospital beds grew by 45% and the number of public beds dropped by the same amount. The growth in the number of private hospitals occurred largely as a result of the move away from the public provision of long-term geriatric care, with patients shifting into either nursing homes or to treatment or care in the community.