An Roinn Caiteachais
Phoiblí agus Athchóirithe
Department of Public
Expenditure and Reform

Spending Review 2018

Trends in public Social Care Service Provision and Expenditure for Older Persons

JUDITH MEIRMANS

HEALTH VOTE

JULY 2018

IGEES
Irish Government Economic & Evaluation Service

Key points

Increased expenditure on Services for Older People has been in line with demographic changes.

- Demographic trends increase the need for efficient and effective social care for older persons.
- Expenditure on the HSE service area of Services for Older Persons (SfOP) amounted to over €788m in 2017. From 2012 to 2017, expenditure increased with 17.5%, while the elderly cohort increased with c. 18%

Home care service provision has increased beyond demographic trends over the last five years.

- Half of the total expenditure on SfOP is on home care, which consists of home help hours and home care packages (HCPs).
- While home help hours have remained relatively stable from 2012 to 2017, the number of HCPs has increased with close to 65% over the same period, compared to a growth in the elderly cohort (75+) over this period of only 18%.

While HCPs show a much larger increase than home help hours, it is unclear what the exact differences in service provision are.

- Analysis of the spread of provision of HCPs and home help hours suggest that these services are being delivered interchangeably.
- There is no data available on the services that have been delivered within HCPs.

The increased number of HCPs contrasts sharply with observed developments in demand for the Nursing Homes Support Scheme.

- The public scheme for State supported nursing home care only increased by 5% from 2012 to 2017 – far below the increase in HCPs and the demographic changes.
- Substantial cost sharing arrangements for residential care compared to the state as sole payer in publicly provided home care raises the question if the home care provision is sustainable from a cost perspective.

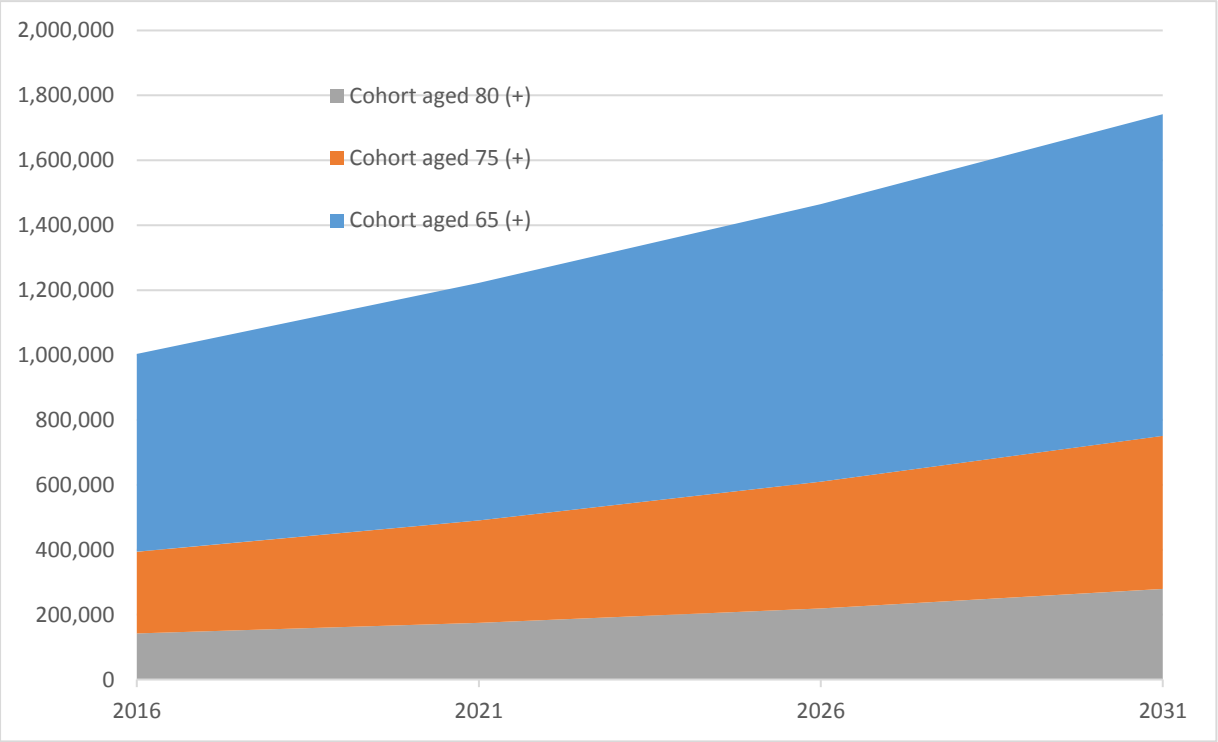
Improved data gathering and collation in this service area is required for a better understanding of the value for money that is being achieved.

- To understand the trends in home care services, additional information is required on HCPs and home help hours, including the average costs of HCPs, the quantity of services, and the age profile of clients.
- About half of the expenditure in SfOP is on other services than homecare, including short stay beds and day care. At present, there is few data available on these services.

1 Introduction

As the population ages, the pressure to create a sustainable system of care for older people is growing. CSO forecasts project an almost doubling of the population 65 or over in less than 20 years, while the general population is expected to grow by only 14% over this period. When considering people over the age of 80 a doubling is expected in less than 15 years. This means that by 2031, more than a quarter of a million inhabitants will be over 80 years of age (see table 1).

Table 1: CSO demographic projections up to 2046 (in thousands)



Source: CSO

This shift in the age profile of the population will have implications for the health system. For example, hospitals beds are disproportionally occupied by people over the age of 65 and at least 16% of the population over 80 years of age is in receipt of state-supported residential care.[1]

Continuing demographic change will inevitably lead to increased demand for health and social care. In a 2011 paper the OECD identified three developments that could increase pressure on long-term care systems in addition to demographic transformation (Colombo et al, 2011): a decline in the availability of family carers; higher expectations in terms of quality as people become wealthier; and technological changes that require a different approach to long-term care. Indeed, international data

[1] Estimate based on 2017 HSE data.

on long-term care expenditure suggests an increasing trend relative to the total growth in public expenditure (De la Maisonneuve & Martins, 2015).

In the context of increasing spending pressures it is not surprising that an OECD paper stemming from 2005 reported on the trend in developed countries to foster policies that explicitly aim for older people to stay at home longer (OECD observer, 2005). Homecare services allow the elderly to stay at home longer, which can benefits their own wellbeing as well as provide a more cost-efficient solution than residential care.

The HSE offers a number of services under the header of Services for Older Persons (SfOP). In addition to homecare, the range of services includes day care services, short stay beds and transitional care beds. In an evidence review of homecare service arrangements in four European countries – Germany, Sweden, the Netherlands and Scotland – the HRB identified that in each of the countries a formal home care scheme was in place (HRB, 2017). It also found that in these countries the regulatory bodies that provided home care were partly funded through contributions by recipients, via care insurance or through registration fees. This contrasts sharply with Ireland's case, where applicants are subject to a medical assessment, but no means-test. Moreover, in Ireland no flat-rate contributions are required for home care and most other targeted services.[2]

Services for older people naturally include long-term residential care. State support for residential care services is administered under a separate scheme, the Nursing Homes Support Scheme (NHSS). Previous analysis published as part of the spending review 2017 focused on trends in the NHSS (Meirmans, 2017). The present paper intends to add to that analysis by focusing on home care and other social care services that are targeted at older persons.

This paper finds that expenditure on SfOP has increased substantially, in line with demographic developments. It is observed that a large increase in home care packages (HCPs) has been achieved over the last five years, with an almost 65% increase since 2012. This increase exceeds the growth in the elderly cohort over this time period, which suggests that a growing part of the elderly population has acquired access to home care. In contrast to HCPs, home help hours have remained equal over the period from 2012 to 2017.

The findings suggests that home help provision has increasingly been labelled as *home care package*, while containing no or only a small component of additional services. However, the HSE does not have information available on the different services that were delivered in HCPs in the years prior to 2017.

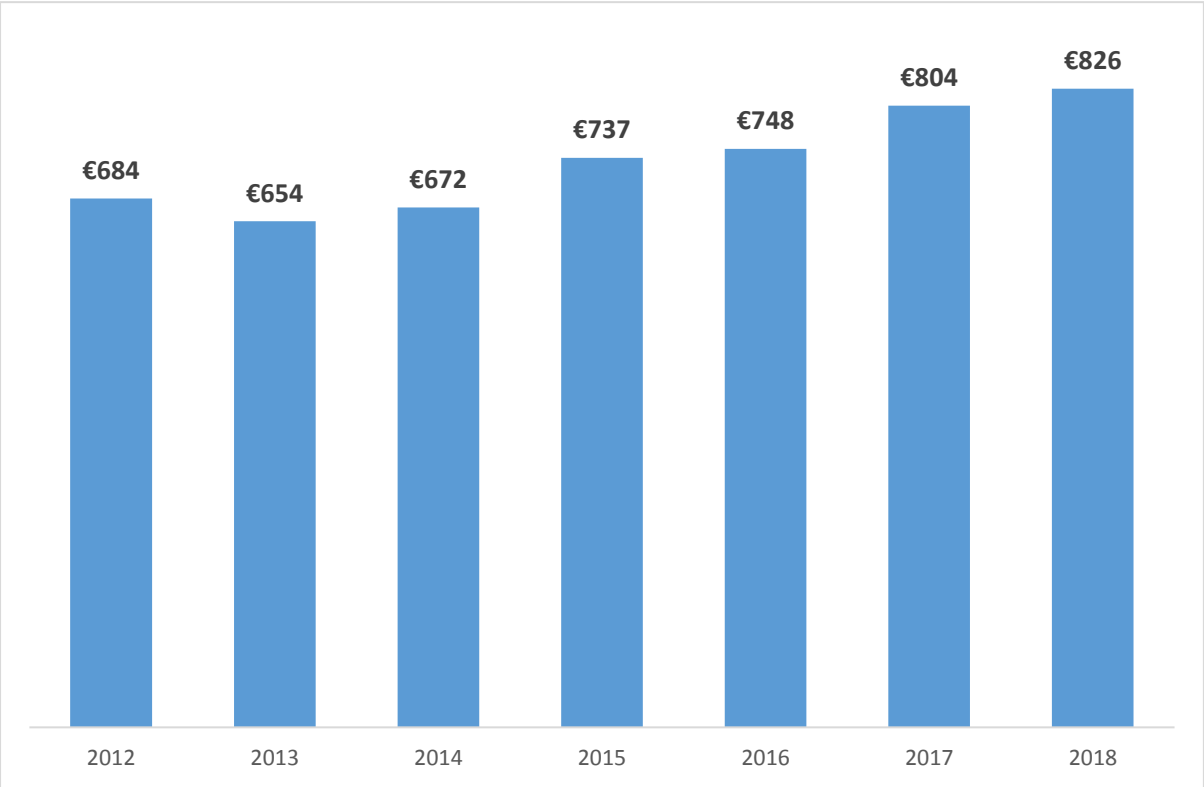
[2] There are some targeted services for which a client contribution is required. However, there is no data available on the level of these contributions.

The observed increase in HCPs of more than 60% over a five year period contrast sharply with the change in the number of clients in the NHSS, which has barely seen any increase over the same period. Under the NHSS people can avail of state support to meet the costs of their nursing home care. In addition to a medical assessment, one has to undergo a means-test to qualify for this scheme. This raises questions on the financial sustainability of the absence of cost-sharing arrangements for home care services.

The remainder of the paper is structured as follows. Section 2 discusses the expenditure on the SfOP service area. Section 3 zooms in on the trends in activity, with an emphasis on home care services. Section 4 focuses on the spread of home services over the community health organisations. Section 5 looks at the impact of demographics and the interaction with the NHSS scheme, and section 7 concludes with a discussion of the findings.

2 Expenditure

Figure 1: Funding of Services for Older Persons in millions, 2012-17



Source: HSE

Figure 1 shows the increase in expenditure on SfOP over the last five years to 2017 and the budgeted expenditure for 2018. After a moderate decrease in expenditure 2013 in the context of the fiscal consolidation measures, the expenditure on SfOP has increased with over 20%, from €654 to €804 in 2017. This is an increase of €150m over four year. Over the same time period, the cohort of elderly people increased with approximately 18% (age > 75) - for the cohort age > 80 this is 19%. This means that expenditure increases have been broadly in line with demographic changes.

Table 1 tabulates the expenditure on services for older people since 2012. It shows that by 2015, the expenditure had exceeded the 2012 expenditure level. In budget 2018 the service area has received an additional €22m on the 2017 outturn, which brings the total budget to €826m. This is an increase of almost 5.5% on the 2017 budget.

Table 1: Expenditure on Services for Older People, 2012-18

	2012	**2013**	**2014**	**2015**	**2016**	**2017**	***2018****	***2012-18***
Expenditure (millions)	€684	€654	€672	€737	€748	€804	€826	+ €146
Change	-	-4.3%	2.7%	9.6%	1.5%	7.5%	2.7%	21%

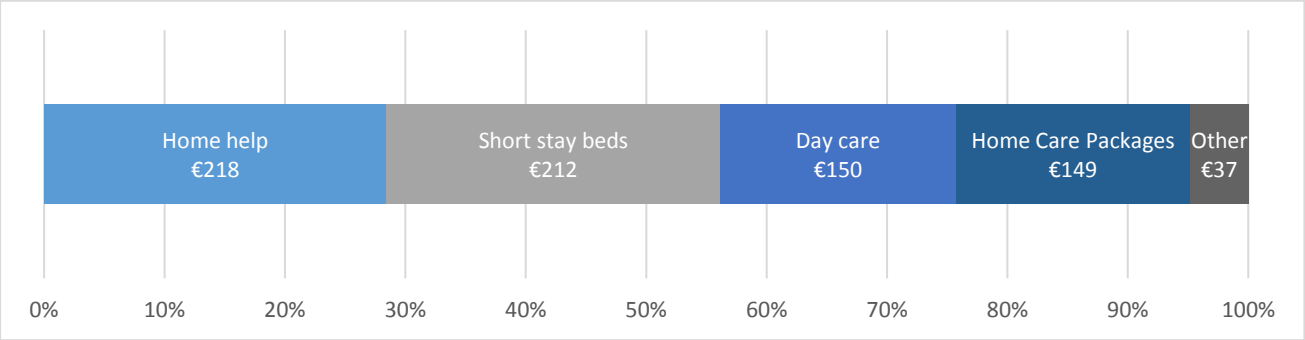
*2018 based on budgeted spend. Source: HSE

With a 21% increase in expenditure on SfOP over the period 2012 to 2018 expenditure growth in this area (17.5% when measured from 2012 – 2017) exceeds the increase in total government current health expenditure over the same period, which was less than 16%. However, this is still below the increase in expenditure on hospitals over the same period, which exceeded 20% from 2012 to 2017.

2.1 Breakdown of expenditure

Figure 2 reflects the breakdown of the expenditure as budgeted for 2017. It is clear that the largest amount of expenditure is on home help services with a €218m budget. The second largest expenditure block is on short stay beds (beds in community facilities) with €212m. Day care[3] and home care packages follow with an expenditure of €150m on each. The remaining €37m is for transitional care beds, complex care, and integrated care interventions.

Figure 2: Breakdown of 2017 budgeted expenditure



Source: HSE

2.2 Change in workforce

As of March 2018 the total number of WTE employed in the Services for Older People Division is 13,160. This number increased with less than 35% from 9,735 WTE in January 2017. Considering the substantial increase in activity over this period, this suggests either large efficiency gains or the increased use of agency staff for the delivery of the additional services.

There is no information on the number of staff in services for older people prior to 2017. Available information is confined to staff numbers in the social care area, which also includes social care services for people with Disabilities. Assuming a constant ratio of staff in Disabilities Services and Services for Older Persons, it appears that from 2014 to 2017 there was a more than 10% increase in the number of people working in this area. Taking into account pay increases, this seems to be in line with the increase in expenditure over this period.

[3] Day care services include some community services.

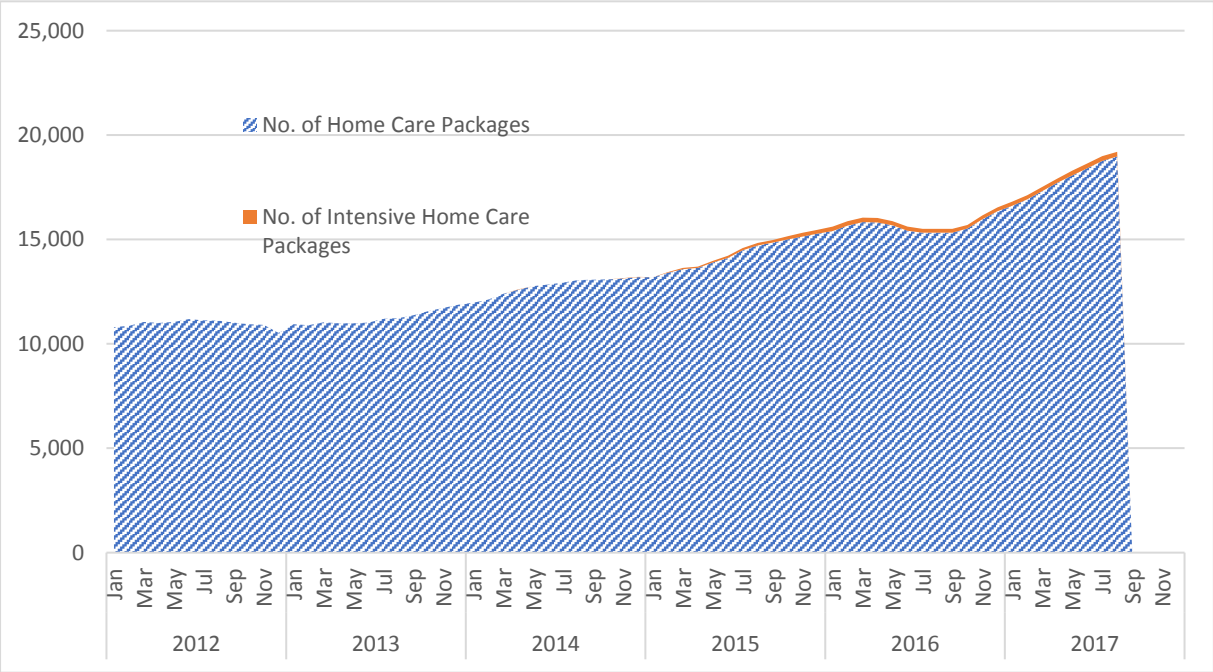
3 Activity

Homecare services are provided by the HSE, voluntary service providers and for-profit companies. The services are aimed to maximise independence of the client and support them staying in their own home, in contrast to going into residential care.

3.1 Homecare packages

Homecare packages are a set of services that are provided by the HSE or ancillary providers that support an elderly persons to be cared for in their own home. Services include home help hours, nursing care, respite care, physiotherapy and other supports.[4] The packages are provided on the basis of needs, meaning that the level of care that will be delivered is determined in a care assessment. There is neither a means test involved, nor a flat rate contribution from the client.

Figure 3: trend in Homecare Packages, 2012-17



Source: HSE

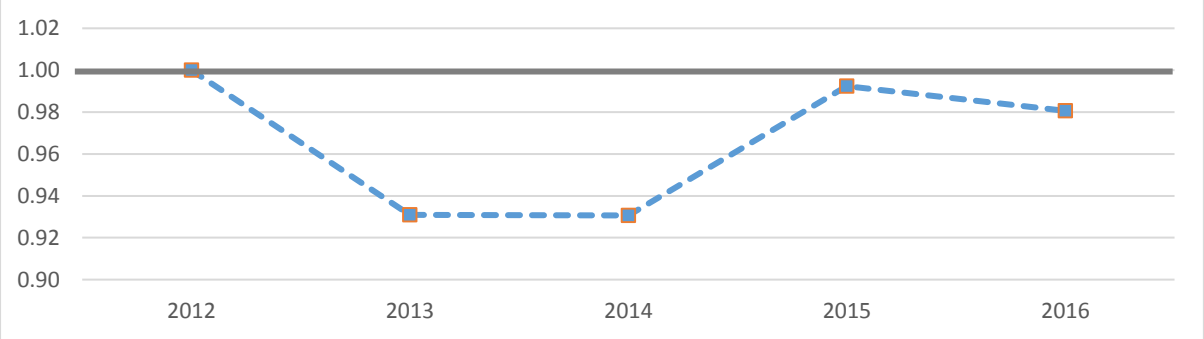
The number of Home Care Packages (HCPs) has increased from close to 11,000 in 2012 to almost 18,000 in 2017 (see figure 3 above and table 1 in the appendix). This is an increase of close to 65%. In 2014 the HSE introduced Intensive Home Care Packages. These packages include more nursing and home help hours than standard home care packages, although it is unclear what the exact threshold of service intensity is for a HCP to be labelled as an intensive HCP. The number of such packages increased to over 200 since. The total number of homecare packages has increased with 65% since 2012 – an average of 7,098 packages per annum. As of 2016, the average expenditure per package is around €700 per month.

[4] http://www.hse.ie/eng/services/list/4/olderpeople/homecarepackages/

Ratio of HCP to the number of elderly people

Between 2012 and 2016, the ratio of HCPs to the 75+ cohort has increased slightly from 0.05 to 0.06 packages per person, which means that approximately 1 in every 20 people above the age 75 receives a home care package[5]. The ratio of home help hours has remained equal. The ratio of total annual expenditure on older people services to the number of persons aged over 75 has decreased in the years 2013 and 2014 from over €3,000 per capita to €2,800. In 2015 per capita cost approached the 2012 level of close to €3,000. This is evident from figure 4, which shows the per capita expenditure of the age cohort over 75 from 2013 to 2015, relative to 2012.

Figure 4: Expenditure per person over 75, 2012 - 16 (2012 set equal to 1)



Source: HSE

[5] We assume most packages would be received by the age cohort over 75

3.2 Home Help Hours

Home help hours are provided to elderly people in need of support for personal care and essential domestic tasks. This support allows them to stay in their own homes longer. Home help hours are provided by home helps and do not include any nursing care.

Table 2: Home Help hours and Home Help Beneficiaries, 2012-17

	2012	2017*	Change 2012-17
No. of Home Help Hours (000)	9,467	10,214	+7.9%
No. of Home Help Beneficiaries (average)	49,016	46,559	-5.0%
No. Hours per client p/a	193	219	+13.6%

Source: HSE

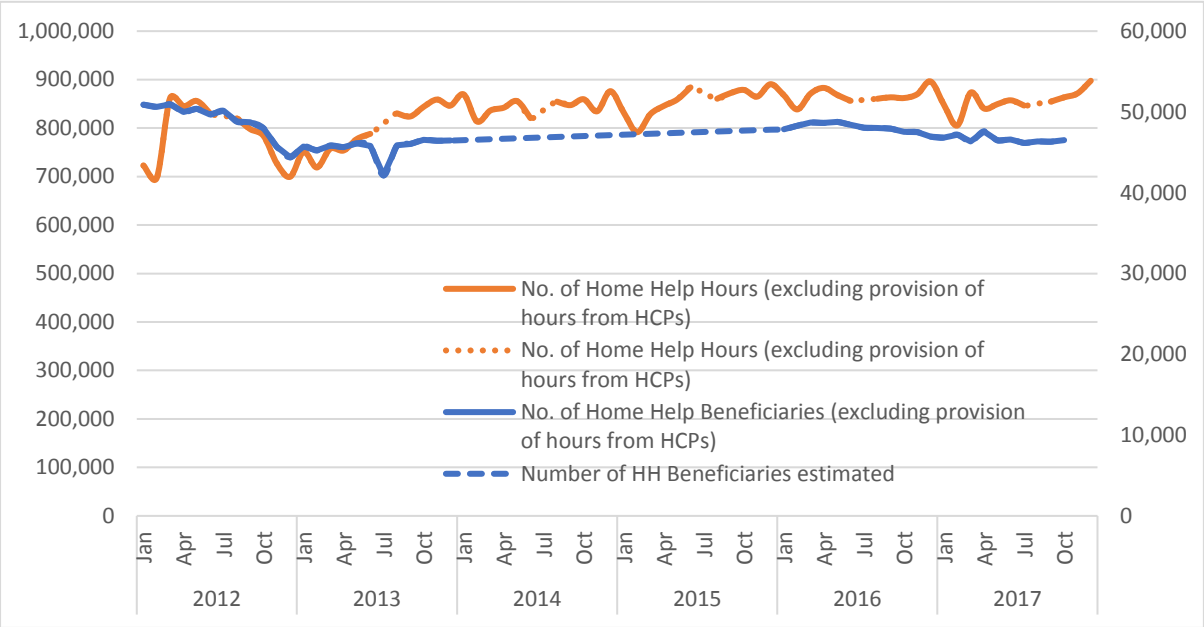
Table 2 shows the number of home help hours and home help beneficiaries in 2012 and 2017 (for the increase by year, see table 2 in the Appendix). The number of supplied home help hours has increased with 8% since 2012. However, with increases of on average 1.6%, the investment in home help hours seems to be lower than the investment in home care packages. The number of beneficiaries has also decreased. The average number of hours help per beneficiary has steadily increased from 193 hours per year in 2012 to 219 hours in 2017. The costs of home help were roughly €21 per hour in 2017.

Figure 5 depicts the trend in home help hours and beneficiaries between 2012 and 2017. Data for one month in each summer is missing, as the data for that month is incorrect due to an administrative particularity in the reporting of the hours. For this analysis these data points were omitted. Also the number of beneficiaries in 2014 and 2015 is estimated, as there is no data available for these years.

Examining the trend in home help hours, it stands out that there is a lot of month-to-month variability. The underlying trend seems to be stable from the end of 2013 onwards. With regards to the home help beneficiaries, this number is relatively stable over time, apart from a drop in July 2013. It is unclear why this drop occurs, and this might well be related to a reporting error. After a decrease in beneficiaries in 2012, the trend seems to be slightly upwards from 2013 to start 2016, with a slight decline over 2016 and 2017.

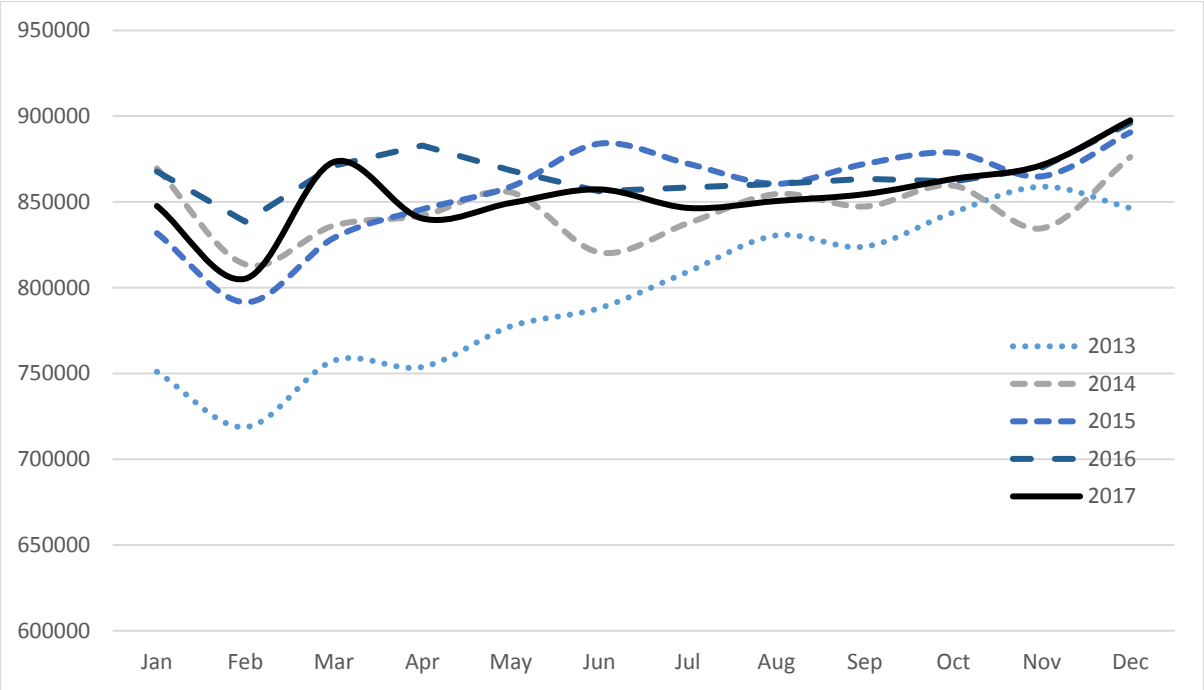
Figure 6 zooms in on the seasonal trend in home help hours. When layering the years, there appears to be a seasonal trend in the provision of home help hours, with more hours provided in the winter months. The graph shows that after an increasing trend in 2013, the provision of home help hours has remained relatively stable, with the lines for the years 2014 to 2017 overlapping.

Figure 5: Trend in home help hours (LHS) and beneficiaries (RHS), 2012 to 2017



Source: HSE

Figure 6: Number of Home Help hours per month, 2013 - 2017



Source: HSE

3.2 Comparing Home Help Hours and Home Care Packages

It is likely that the number of home help hour provision has been supressed by the increase in HCPs over the last five years. This would explain the observed decrease in both home help hours and beneficiaries.

Average monthly expenditure per home help beneficiary in 2016 was approximately €360. In 2017, this went up to an average of around €380 due to an increased per-hour costs of home help. This means that the average monthly expenditure on home help is almost half the average expenditure per HCP. In addition, from 2016 to 2017 the average costs of per home help beneficiary has been increasing, while the average costs of HCPs have remained equal (see table 3).

The costs of home help hours per beneficiary and HCP differ by close to 50%. Without data on the services that are being delivered within homecare packages, we can only guess what the source of this difference is: more expensive services in HCPs, more home help hours in the average HCP than the average number of hours per home help beneficiary, or a combination of both.

Table 3: Average costs per beneficiary, change from 2016 to 2017

	2016	2017	Change
Average cost per HH beneficiary	€360	€380	5.6%
Average cost per HCP	€701	€699	-0.3%

* 2017 figures based on data up to July Source: HSE

3.4 Other services

There are a number of other services provided within the service area for older persons, including short stay residential care, transitional care, complex care and day care. The expenditure on services was budgeted to be €373m in 2017 – this is over half of the total budgeted spending in the service area (see table 5 in the appendix). Figure 7a and 7b reflect the breakdown of the 2017 budget into the different services. From figure 7a it is clear that almost half of the expenditure on SfOP is going to home care; the other services make up 51% of the expenditure. Figure 7b shows that from all 'other' services short stay beds consume most of the budget, followed by day care. Transitional care and integrated care make up only small parts of the budget.

Figure 7a: SfOP broken down

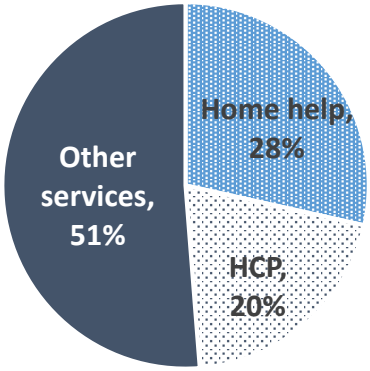
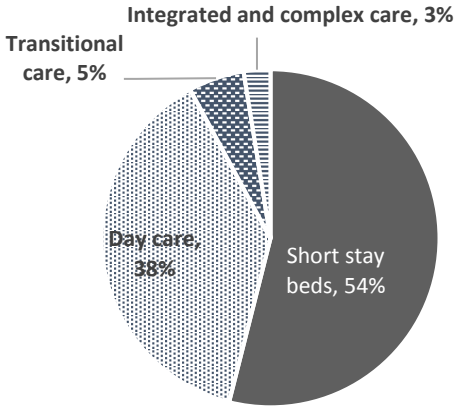


Figure 7b: SfOP 'Other services' broken down



Source: HSE

Apart from the budgeted expenditure, there is very few data available on services. There are targets set in terms of service delivery, but it is unclear if targets were met. Little information is available on the data gathering processes, which raises the question if service delivery is recorded in a consistent manner. The following sections shortly discuss short stay beds, day care, and transitional care.

Short Stay beds

Short stay beds are beds in the community that are used in a flexible manner to meet local needs. This includes intermediate, respite and rehabilitation care for older persons. It was reported by the HSE that in December 2017 1,998 of such beds were in operation spread over 130 public care centres.

The 2017 allocation for rehabilitation and short stay beds was €212m. More information is needed on the services that were delivered with this funding, including the number of people that availed of short stay beds, the spread of the beds over the country and the per-bed costs.

Day Care

Day care arrangements are directly provided by the HSE or provided through voluntary organisations and include a wide range of support activities. Day care services provided by the HSE include nursing and therapy supports, social activities, chiropody, personal care and care in the community.

The funding for day care in 2017 amounted to €150m. This should fund 560,000 day service attendances in over 100 community care centres. Although covering a large part of the total funding for expenditure for older persons, there is no information available on the services that were delivered in the last number of years.

Transitional Care

Transitional care beds are beds in private nursing homes that are fully funded by the HSE to serve people who are in need of nursing home care, but are awaiting their application for the Nursing Homes

Support Scheme (NHSS) to be processed, or for supports to be put in place to allow a person to return home. The availability of such beds prevents hospital beds being occupied by people whose care needs could be met in a social care setting. Transitional care beds are generally less costly than the costs of a hospital bed, and contribute to a better hospital throughput.

From 2015 to 2017 the number of approvals increased with more than 57% to 8,930, while the budgeted spend increased by 10% to €21m (see table 3 in the appendix). The average time in a transitional care bed is currently 3 -4 weeks.[6]

[6] Source: HSE

4 Spread of activity and expenditure

The HSE provides its community services through nine Community Health Organisations (CHOs). In this section we consider the spread of expenditure and activity over these CHOs, and compare it with what activity would be expected based on demographics.

We use 2016 census data to approach the spread of the elderly population over the CHOs.[7] In order to make the data comparable, we combine the activity and expenditure in CHO 6, 7, and 9, as these CHOs cover parts of Dublin for which no separate information on the population is available (see table 6 in the Appendix for an overview of the counties that are covered by each CHO).

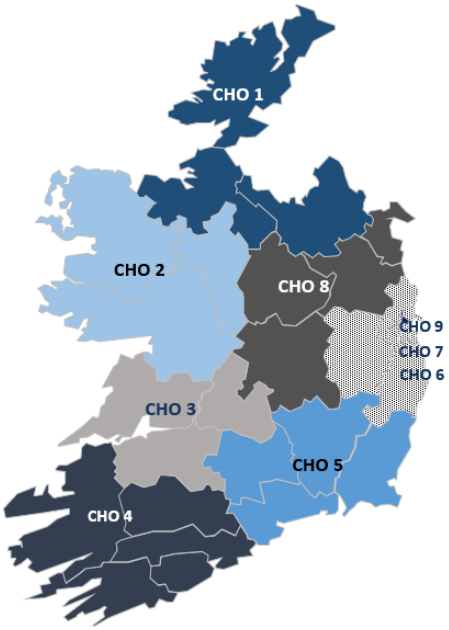
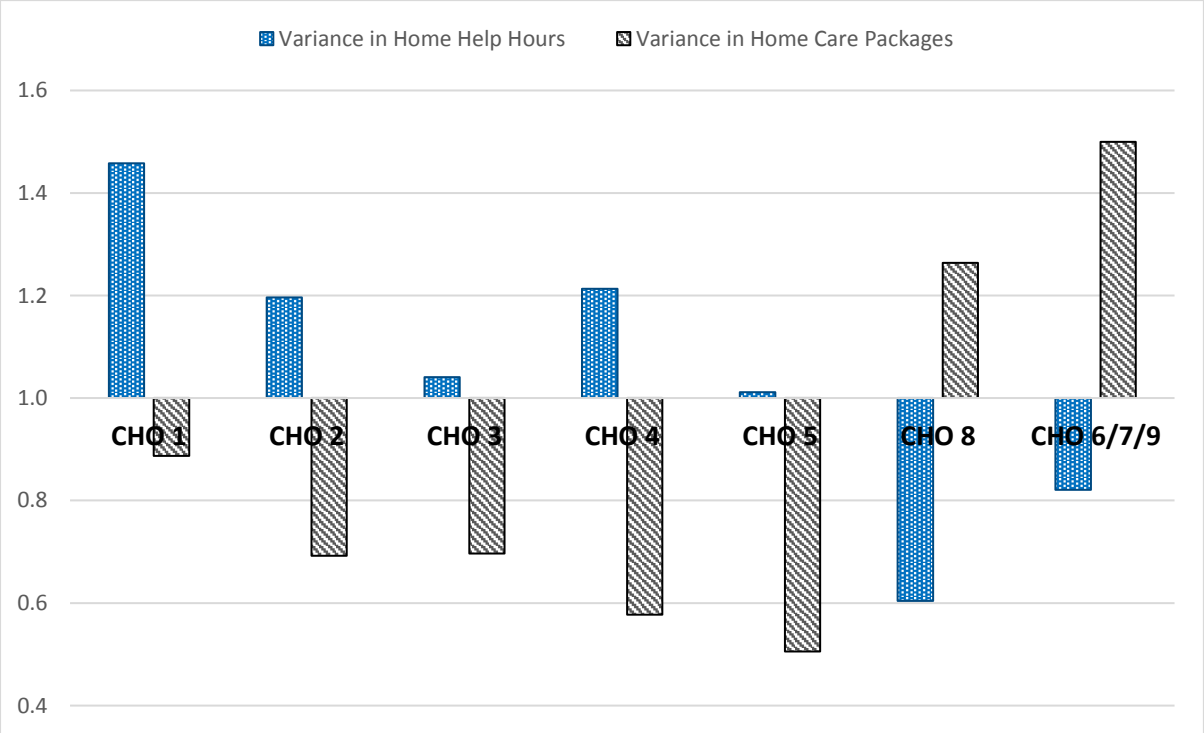


Figure 8: Ratio of the percentage HHH and HCP and the percentage population over 75



Source: Department of Health

The spread of the elderly population over CHOs gives an indication of the number of home help service hours or number of HCPs that we expect to be provided in each CHO. We compute the variation from

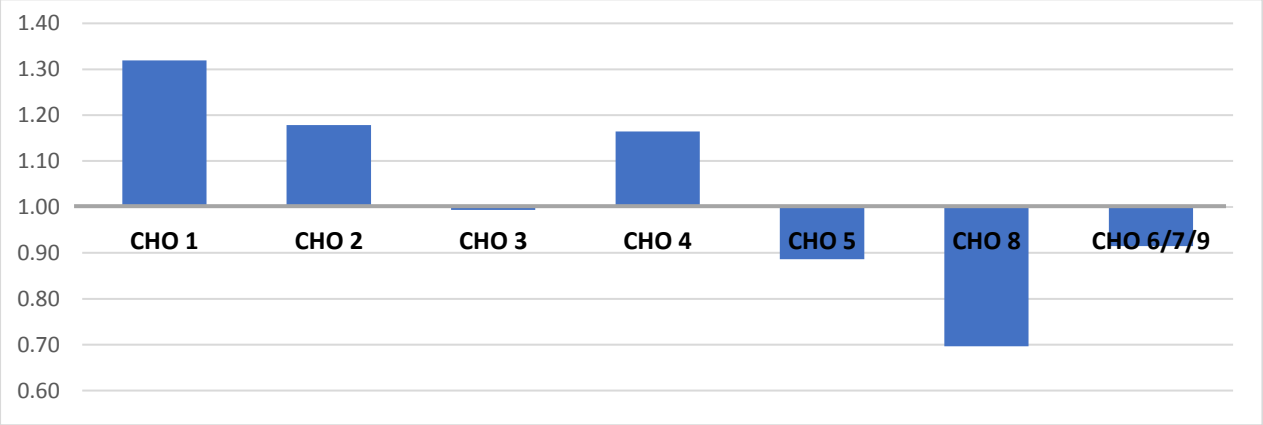
[7] We assume that the population of Tipperary is evenly divided over CHO 3 and 5.

this number for each CHO by dividing the percentage of the total number of home care services that are provided by the percentage of people of the cohort over age 75 that are residing in the area covered by that CHO. When this ratio is 1 this indicates that there is no variation from the expected number for that CHO. When the indicator is between 0 and 1, the CHO provides less services than what would be expected based on its demographics. A ratio greater than 1 suggests that the CHO is providing more services than expected.

Figure 8 above reflects the described ratio for each CHO based on 2016 data. From the graph it appears that CHO 1, 2 and 4 are providing more home help hours than would be expected on the bases of their population, but less HCPs. CHO 8 and the combined CHOs 6/7/9 show the opposite pattern, as they provide more HCPs than expected, but less home help hours. CHO 3 and 5 fall outside of this pattern, as they provide exactly the amount of home help hours that would be expected and less HCPs. In other words, CHO 3 and 5 seem to do more for less.

The general pattern that appears suggests that HCPs and home help hours are being provided interchangeably. This support the hypothesis that HCPs are mainly another way of providing more home help hours, and contain relatively small amount of additional services, such as nursing care. Indeed, in the start of 2018 less than 2% of the total allocation to CHOs is used for nursing or therapy hours. Data on the composition of HCPs before 2018 is not available.

Figure 9: Ratio of home care expenditure and percentage population over 75 (2016)



Source: Department of Health

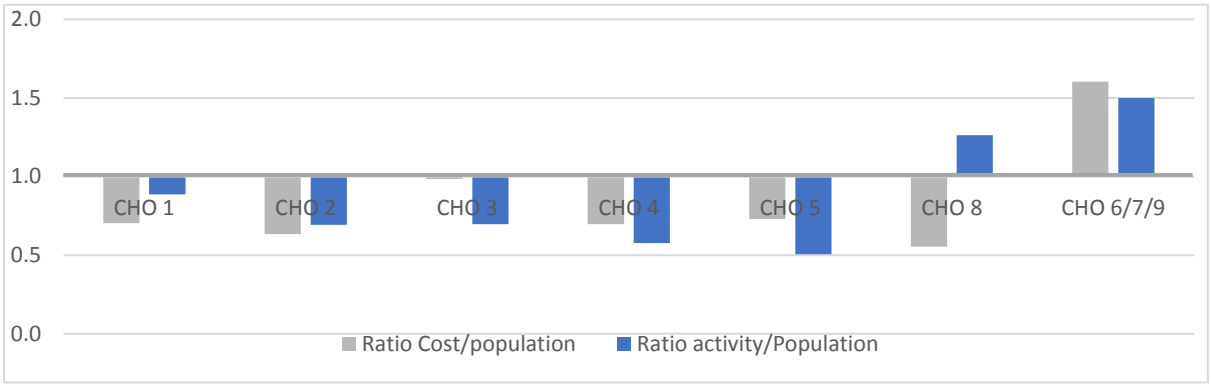
Figure 9 above shows the variation of the expenditure on home care services from the expenditure that would be expected on the basis of the elderly population in each CHO.[8] Expenditure in CHO 1 appears to be 30% higher than expected, and expenditure in CHO 8 seems 30% lower.

[8] We assume the same availability of residential/long stay beds in nursing homes in each county.

Figure 10 and 11 below reflect the cost/population and activity/population ratios for HCPs and home help hours respectively. The graphs mirror each other, with CHOs that provide a lower than expected number of HCPs, provide a higher than expected number of home help hours. The cost ratios follow the activity ratios closely, indicating that costs and activity are generally aligned. CHO 8 - covering counties Laois, Offaly, Longford, Westmeath, Louth and Meath – proves an exception to this, providing more HCPs than expected, but for a smaller percentage of the expected costs. This could indicate a lower average care need in the CHO, or a more cost efficient way of delivering care, or both.

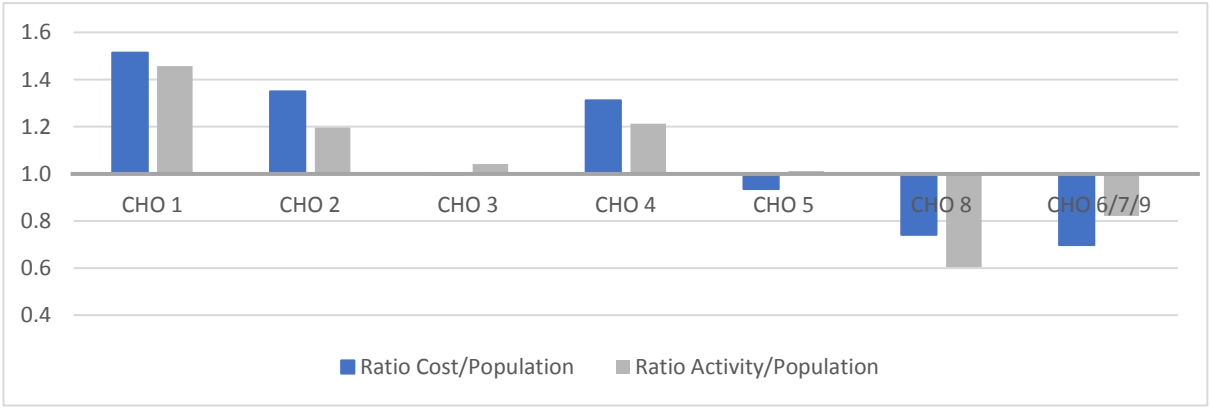
It should be noted that although this analysis is based on the elderly cohort over age 80, changing the cohort to over 70s or over 65s does not impact the findings much. In both instances the pattern as discussed above arises.

Figure 10: Home Care Packages (2016)



Source: Department of Health

Figure 11: Home Help Hours (2016)



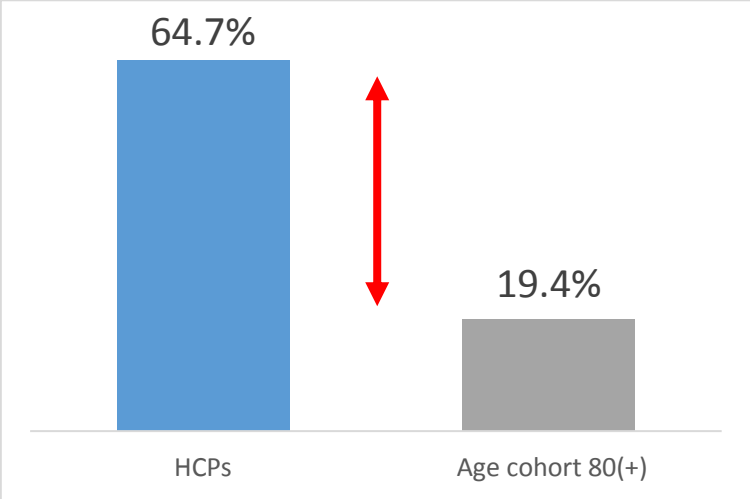
Source: Department of Health

4 Explaining Trends in Home Care

5.1 Demographic developments

With the elderly age cohort growing an increase in demand for social care services is no surprise. The question is whether the increase in the elderly cohort over the last three years explains the observed increase in home care services.

Figure 12: Increase in HCPs and growth in 80+ cohort, 2012 - 2017



Source: HSE and CSO

Based on the census 2011 and 2016, the estimated increase in the elderly cohort age 80+ has been 3% per year on average, and a total 19.4% over the three year period from 2012 to 2016 (this is 19.6% for the 85+ cohort, and 17.7% for 75+ cohort – see table 4 in the Appendix). Although this is a significant increase, it is much lower than the increase in HCPs over this period, which is close to 65%. Demographic developments alone cannot fully explain the observed increase in HCP provision.

5.2 Home Care in the Context of the Provision of Residential Care

Ideally, an elderly person in need of social care would receive these services at the most appropriate level: at home when care needs are moderate, and in a nursing home when needs become more intense. Apart from personal preferences, there is a pivotal point after which the provision of services at home is less cost-effective than care provision within a nursing home. Therefore it is important to consider home care in conjunction with residential nursing care.

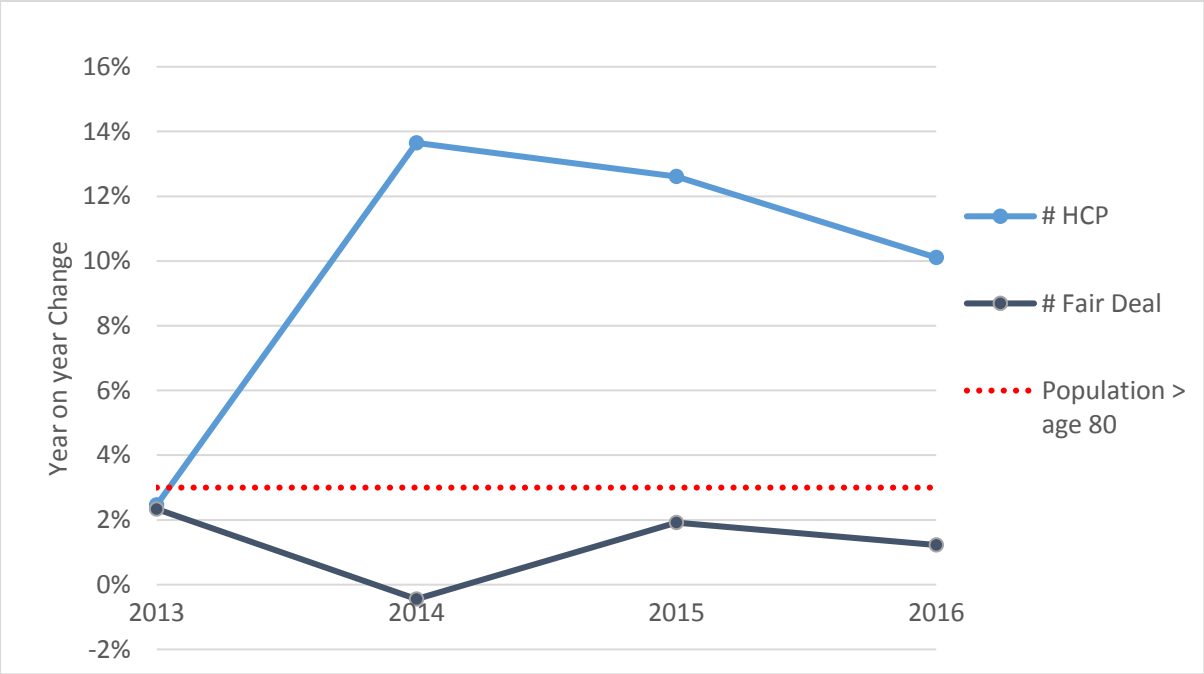
Unlike home care, residential nursing care is not provided free of charge by the State. People that are assessed to be in need of residential nursing care can apply for State support under the Nursing Homes Support Scheme (NHSS), which is a statutory scheme. Once a person is assessed to be in need of

nursing home care, an income analysis is carried out. A person is required to pay up to 80% of his or her income (7.5% for assets) towards the own costs of care, with the balance payed for by the State.

The paper 'The NHSS – Trends and figures' (Meirmans, 2017) presents an analysis of the trends in the Fair Deal scheme. The paper found that over the five year period starting in 2012, the number of clients in the Fair Deal scheme increased with only 5% (see table 7 in the Appendix). The trend contrasts sharply with the over 60% increase in the number of HCPs over this period. The average length of stay in the NHSS as of the end of 2017 is less than three years, and this measure has been decreasing continuously over the life of the scheme. This trend might indicate increased pressure on formal and informal home care.

Figure 13 shows the year-on-year change in the number of HCPs and the number of people receiving state supported residential care from 2012 to 2016. The dotted line represent the estimated year-on-year change in the elderly cohort aged over 80. The graph shows an increase in HCPs far above the increase in the elderly cohort. The number of people receiving residential care, in contrast, has been systematically below the increase in the elderly cohort.

Figure 13: Number of people in NHSS and number of HCPs – Year on year change



Source: HSE and CSO

The large discrepancy between changes in demand for home care and residential care is remarkable and raises the question why this occurs. Possible answers include changing preferences of elderly people and better health into later age. Beyond preferences, there might also exist financial incentives for elderly people and their families to delay any move to a nursing home. Home care services are

non-means tested, meaning that there are no contributions required from the client. This contrasts sharply with the Fair Deal scheme, which is means tested and requires clients to contribute a substantial part of their income and assets – including their home – to the costs of their own nursing care.

6 Discussion

It can be concluded that there is a significant increase in both expenditure and activity in the service area for older people. Reported increases in activity are well beyond the growth in the elderly cohort. This raises the questions not only about both the quality of the reporting, but also the sustainability of the current arrangements. Home care services do not require any contribution from the client, while the scheme for residential nursing care requires the client to make a significant contribution in proportion to their income and assets. In 2005 the OECD recognized that one of the ways in which the costs of public long term health system can be controlled is by substantial cost sharing based on a means test (OECD Observer, 2015). This advice might be even more relevant to Ireland today than it was back then. A 2011 OECD paper states that although public coverage of long-term care decreases the costs of care for users, such schemes inevitably reduce costs incurred by users who could afford to fully or partially pay for their own care (Colombo et al, 2011).

The question of sustainability of the current structures becomes even more stringent when one considers the expected demographic developments. Although it is clear that demographics will impact on the level of social care services, there is a lot of uncertainty around the about the level of public expenditure this will require (Comas-Herrera et al, 2006).

The observations in this paper seem to suggest that HCPs are used interchangeably with home help hours. A recent once-off data gathering exercise by the HSE in 2017 suggests that almost all of the service hours delivered in HCPs consist of home help hours, which confirms the hypothesis postulated in this paper. This is an example of the lack of transparent data in the sector, leading to a misrepresentation of the services that are actually being delivered.

Need for reliable and complete data

Reliable and complete data will allow for better understanding of current trends, the value for money that is being achieved, areas for improvements and future needs. In a 2016 institutional paper on long-term care, the European Commission points out that "[m]onitoring and controlling expenditure with specific budgetary tools, using to a wider extent performance-based budgeting and spending reviews to improve the quality of spending, introducing spending targets and spending ceilings, as well as budget buffers and early-warning mechanisms, can give the fiscal and health authorities more steering tools to prevent blunt cost-cutting that does not serve health system objectives. " (European Commission, 2016)

This paper identifies a number of areas in services for older persons where data collection is incomplete, inconsistent or non-existent. For example, we found that there is no information available

on the services provided in home care packages, client profiles and a breakdown of expenditure. These data gaps prevent a complete expenditure review of the service area and make it impossible to examine the value for money that is being achieved.

Recently, there has been some improvement in the data reporting in the service area. In 2018 the HSE will no longer report on HCPs, but only on home help hours delivered and the number of beneficiaries, including the home help hours that were previously labelled as home care packages. This will give more clarity on the value for money that is being achieved with the growing number of HCPs. Further areas of improvement as highlighted by this paper are:

- The HSE should start collecting and collating data on service provision, resource utilisation and expenditure in day care, short-stay bed, transitional care beds, and other services provided by the HSE (or through HSE funding) that are targeted to older people. Such data collection at a central level should allow, at minimum, for identification of average costs of services and the change in provision and costs over time.
- The HSE should register who receives home care or other services for older people: the average age, what combination of services is being received, how long recipients enjoy services, and what percentage of move from home care into residential care. Such data on client profiles would allow for analysis of how demographic changes and other developments are impacting demand for services. Such analysis is necessary to inform adequate planning of care provision going forwards.

A 2016-report by Mazers, commissioned by the HSE, recommended immediate implementation of a national client database in the area of services for older persons to support coherent data collection amongst CHOs (Mazers, 2016). This paper underlines the importance of the creation of such a database to make data reporting in the services area for Older Persons consistent and reliable.

References

Colombo, F. et al. (2011) “Help Wanted? Providing and Paying for Long-Term Care.” Chapter 2. OECD Health Paper Studies, OECD Publishing. URL: http://www.oecd.org/els/health-systems/47884543.pdf

Comas-Herrera, A. et al. (2006) "Future long-term care expenditure in Germany, Spain, Italy and the United Kingdom." Ageing & Society 26.2: 285-302. URL: https://www.cambridge.org/core/journals/ageing-and-society/article/future-longterm-care-expenditure-in-germany-spain-italy-and-the-united-kingdom/2D645494B4A46A82800F464158649AC7

European Commission (2016), Joint Report on Health Care and Long Term Care Systems & Fiscal Sustainability, Institutional Paper, Volume 1. URL: https://ec.europa.eu/info/sites/info/files/file_import/ip037_vol1_en_2.pdf

HRB (2017), “Approaches to the regulation and financing of home care services in four European countries – an evidence review”. URL: http://health.gov.ie/wp-content/uploads/2017/04/FINAL-HRB-Evidence-Review-7-4-17.pdf

De la Maisonneuve, C., & Martins, J. O. (2015). “The future of health and long-term care spending.” OECD Journal: Economic Studies (1), 61-96. URL: https://www.oecd.org/eco/growth/The-future-of-health-and-long-term-care-spending-OECD-Journal-Economic-Studies-2014.pdf

Mazers (2016), Health Service Executive – Services for Older People; Activity & resource review. URL: http://www.lenus.ie/hse/bitstream/10147/621444/1/Activity.pdf

Meirmans (2017), “NHSS: Trends and Figures”. Part of Public Spending Review 2017. URL: http://budget.gov.ie/Budgets/2018/Documents/7.Nursing%20Homes%20Support%20Scheme%20%E2%80%93%20Trends%20and%20Figures.pdf

OECD Observer (2005), Ensuring quality long-term care for older people, Policy brief. URL: https://www.oecd.org/els/health-systems/Ensuring-quality-long-term-care-for-older-people.pdf

Appendix

Table 1: Home Care Packages (annual average), 2012-17

	2012	2013	2014	2015	2016	2017*	2012 – 17
Standard HCPs	10,964	11,233	12,765	14,272	15,637	17,847	
Intensive HCPs			2	105	194	215	
Total HCPs	10,964	11,233	12,767	14,377	15,831	18,062	**+7098**
Y-on-y change		2.5%	13.6%	12.6%	10.1%	14.1%	**64.7%**

*2017 figures based on data up to August. Source: HSE, Data Management Reports

Table 2: Home Help hours and Home Help Beneficiaries (annual average), 2012 -17

	2012	2013	2014*	2015*	2016	2017**	2012-17
No. of Home Help Hours (000)	9,611	9,715	10,317	10,457	10,552	10,428	817
Y-on-y change		1.1%	6.2%	1.4%	0.9%	-1.2%	8.5%
No. of Home Help Clients	49,016	45,654	-	-	48,054	46,691	-2,382
No. Hours per client	196	213	-	-	220	224	28

*No data available on help beneficiaries in 2014 and 2015. Source: HSE, Data Management Reports

** Figures for 2017 based on data up to October. Hours for November and December based on estimations.

Table 3: Transitional care beds approvals, 2015 - 17

	2015	2016	2017	2015 -17
Approvals	5,696	7,342	8,930	**+3,234**
Y-on-y change		29%	22%	**57%**
Funding (millions)	€20	€21	€22	**+ €2**
Y-on-y change		5%	5%	**10%**

Source: HSE

Table 4: Increase in HCPs relative to growth in cohort of people age 80(+)

	2012 - 17
Increase HCPs	64.7%
Increase in 85(+) cohort*	19.6%
Increase in 80(+) cohort *	19.4%
Increase in 75(+) cohort*	17.7%
Increase in 70(+) cohort*	21.4%

Source: HSE; CSO census 2011 and 2016

Table 4: Budgeted expenditure for services, 2017

Area	Budget	Percentage
Home Care		
Total Home Care	**€373**	**48.7%**
Home help	€218	28.5%
HCP	€149	19.5%
Intensive HCP	€6	0.8%
Other Services		
Total Other services	**€392**	**51.3%**
Short stay	€212	27.7%
Day care	€150	19.6%
Transitional care beds	€21	2.7%
Integrated care	€4	0.5%
Complex care	€6	0.7%

Source: HSE

Table 5: Area/county covered by each Community Health Organisation (CHO)

CHO	Counties/ area covered
CHO 1	Donegal; Sligo; Leitrim; Cavan; Monaghan
CHO 2	Galway; Roscommon; Mayo
CHO 3	Clare; Limerick; Tipperary (North)
CHO 4	Kerry; Cork
CHO 5	Tipperary (South); Carlow; Kilkenny; Waterford; Wexford
CHO 6	Wicklow; Dun Laoghaire; Dublin South East
CHO 7	Kildare; West Wicklow; Dublin West; Dublin South City; Dublin South West
CHO 8	Laois; Offaly; Longford; Westmeath; Louth; Meath
CHO 9	Dublin North; Dublin North Central; Dublin North West

Table 6: Increase in the Fair Deal Scheme, 2012 - 2017

	2012	2013	2014	2015	2016	2017	2012-17
Supported	21,884	22,396	22,296	22,724	23,002	23,021	**+1,137**
Percentage	1.7%	2.3%	-0.4%	1.9%	1.2%	0.1%	**5.2%**

Source: HSE

Quality assurance process

To ensure accuracy and methodological rigour, the author engaged in the following quality assurance process.

✓ **Internal/Departmental**

- ✓ Line management
- ✓ Spending Review Steering group
- ✓ Peer review (IGEES network)

✓ **External**

- ✓ Other Government Department