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Funding Long-Term Care in Ireland

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The vast majority of older people in Ireland are active, healthy and live independently in their own homes. However, approximately 20 per cent of older people living at home have one or more disabilities and need the help and support of others at various times and to varying degrees. A further 4% of the older adult population live in long-stay residential care. While Ireland currently has a relatively young population in comparison to other European countries, demographic trends suggest that the country will experience an ageing of the population in the coming decades. There has been significant growth among people over the age of 60 in the past decade. This population group accounted for 15 per cent of the total population in 2006, reached 18 per cent in 2016 and is projected to rise further to 23 per cent by 2026. There has also been a significant increase in the number of people age 80 years and over. By 2026 there will be an estimated 104,000 people over the age of 80 years, suggesting a significant ageing of the older population in the coming decade.

Life expectancy for older men and women has increased significantly in Ireland in recent decades. A male aged 65 years in Ireland in 2014 will live, on average, for another 18 years while a female of the same age can expect to live for an additional 21 years. The life expectancy figures for 1994 were 14 years and 17 years respectively showing the average gains made over twenty years. These gains are a cause for celebration and reflect the economic and health benefits of living in Ireland now in comparison to previous periods of our history, but an older population means increased financial pressure on the exchequer arising from a more dependent older age cohort. Recent financial constraints have led to the HSE cutting back on spending for home support services in order to meet budgetary targets established in the austerity period. Table 1 shows that aggregate per capita spending on older people has been falling in recent years from €3,514 per person aged 65 years and over in 2009 to €2,612 in 2015. Not surprisingly, private consumer expenditure on home care has grown in recent years, as public spending has come under pressure. The market for private care was worth €20 million in 2014. The upward trend in private expenditure is likely to continue if public support for home care does not increase.

Table 1: Public Spending on the Care of Older People

Year	Spending on Care of Older People €m	As % of all HSE Gross Non-Capital Spending	Per Capita Spending on all People Aged 65 and Over
2009	1,738	12.4	3,514
2010	1,683	12.4	3,299
2011	1,433	11.0	2,720
2012	1,365	10.4	2,509
2013	1,366	10.5	2,429
2014	1,468	11.1	2,528
2015	1,569	11.3	2,612

When budgets are curtailed, as happened in recent times, there is limited scope as to where these cuts can fall, due to two major constraints: the need to continue providing services that are mandated or have a legislative basis (as you can be brought to account if they are not provided); and the high level of fixed pay costs in the system. The only statutory scheme we have in place at present to care for older people is the Nursing Homes Support Scheme (NHSS) (commonly referred to as the Fair Deal scheme), so there is an element of protection in the residential sector compared to home care provision, where there is no statutory protection. Fixed staff costs also affects decision-making in relation to cuts. Pay costs are significant, given the labour intensive nature of care provision, making it difficult to effect savings in this area should they be required. These constraints mean that if cuts are necessary, they tend to fall on what is termed 'discretionary' spending e.g. services which do not have a legislative underpinning. This is why home care is often one of the first targets in times of adversity, even though managers know that this is counter-productive in the long-term.

Recent coverage in the media, for example the RTE documentary *We Need To Talk About Dad* in January 2017 featuring Brendan Courtney, have highlighted imbalances and inequities in the structure of care for dependent older people in Ireland. Although policy purports to favour community-based care, the funding system is biased in favour of residential care. That bias reflects the legislative underpinning for Fair Deal,

but there are also other related factors at play. The public may believe that residential care is less risky than community-based care. Residential care is associated with continuity of care compared to home care, which is seen as uncertain, mainly due to the perceived vagaries and oscillations of the social care budgetary system. There is a lot of uncertainty associated with home care provision. Admission to residential care means that people do not need to worry about home care services being cut at some time in the future, should public resources become scarcer. Residential care can provide confidence for families that their loved one will continue to be looked after, even if their needs change in the future. The risk is even higher if patient support needs are complex and require a level of integrated care that is difficult to organise and deliver in community care settings.

Home care provision is currently weak relative to need and distributed unevenly across the country. The result is that family carers bear most of the care burden and financial cost of providing care to older people living at home in the community. For example, of the €2 billion costs associated with dementia in the country, almost half are borne directly by informal carers. If families stopped caring, the care system would collapse. While this will not happen, increasing numbers of older people, allied to a reduction in the number of potential carers, due to population changes and the increased labour force participation of women, will place greater pressure on the State in the care of older people in the future. All the evidence is that families want to care, but they also want recognition for what they do and mutuality in relation to care provision. Shared responsibility is what carers tend to value, but the State has been slow in recognising the need for complementarity in care provision, leading to unnecessary conflict in this space.

Ireland has a well-stablished funding system for residential care in the country. The so-called Fair Deal scheme was introduced in October 2009, after a protracted gestation period, to address care and funding issues in residential care in the country. The current Fair Deal budget is €940 million, supporting over 23,000 residents, averaging approximately €41,000 per resident. For those who choose to avail of the Scheme, there is significant assessment of care needs and economic means as part of the qualification process. Under Fair Deal, older people in residential care pay up to 80 per cent of their disposable income towards the cost of their care. They also pay up

to 22.5 per cent of the value of their home, if their assets are over a certain limit, for the first three years of their care – 7.5 per cent annual contribution. The payment can be deferred and collected posthumously.

Cost sharing plays a significant role in the Fair Deal funding system for residential care. This is not surprising given the long-term budgetary implications of universal provision for long-stay care. There is recent survey evidence which indicates public support in Ireland for a co-responsibility approach to funding whereby individuals and the State combine to jointly finance long-term care. For farmers, however, there is concern that current cost sharing arrangements within Fair Deal are too severe and that there needs to be changes to protect the viability of family farms and placement decision-making in relation to residential care. The value of farm assets is taken into account in the Fair Deal financial assessment but, unlike other assets, the three year limit does not apply, except in limited circumstances such as sudden illness or disability Moreover, if a farm asset was transferred less than five years before entering the scheme, it is included in the financial assessment, meaning the new owner is liable for nursing home costs. Plans are afoot to introduce legislative changes to reduce farmer (and small business) liabilities for care, including a lower charge on farm assets, standard limits and reduction in transfer time.

Before looking at the advantages and disadvantages of the Fair Deal scheme it is important to remember briefly some of the shortcomings of the previous model. The old system suffered from horizontal and vertical inequity. There were different levels of financial aid for care in public and private settings and availing of maximum public support owed everything to gaming the system or luck and little, if anything, to care needs or financial circumstances. One of the difficulties was that as public beds became scarcer, partly as a result of disinvestment in public infrastructure, private facilities expanded, mostly as a result of generous tax breaks for private development. Care in a public bed became highly valued because the incumbent paid much less there than for care in a private bed – only a percentage of their pension, as against paying close to the full economic cost in a private nursing home setting.

Residents in similar financial circumstances, with similar care needs, were treated differently between public and private settings. There was no means testing for public

beds, while there was stringent testing to determine eligibility for a public subvention for care in private facilities. Sometimes enhanced subvention was available for private care, sometimes not, depending on where you lived and how loud you shouted. In most cases, subvention was never sufficient, resulting in considerable financial hardship on older people and their families, including people forced to sell their houses to fund care, and significant wasted effort by people trying to manipulate an admissions system that many could not understand in the first place. It is not surprising that some people chose to initiate legal proceedings against the State in relation to their right to care and support under the legislation, or that the Office of the Ombudsman became involved over a long period trying to resolve differences and difficulties in this area.

There are clear benefits associated with the Fair Deal scheme, even if all issues have not been resolved. Certainty and transparency are important advantages, relative to what existed before the introduction of the Scheme. Individuals know that they have to contribute 80% of assessable income on an ongoing basis, which for most people is four fifths of their old age pension. Asset-related cost sharing can be deferred until after the death of the resident and further if there is a partner or certain dependents living in the principal residence. In general, people know that the State will cover approximately two thirds of the cost of long-stay care should they need it. The pressure on older people and their families to come up with the money to pay weekly payment rates of up to €1,000 has been considerably reduced. People do not face the prospect of having to sell their home to pay for care. The new arrangements has also reduced the potential of bad debts for private nursing homes, as there is now much less risk of default on payment, or of people being denied appropriate care as a result of default.

The new Scheme also allows older people much greater choice in respect of residential long-stay care. The same financial arrangements now apply equally to residents in both public and private care facilities, although that distinction is a lot less relevant nowadays than in the past. The private nursing home sector now dominates the residential care market in Ireland, mainly because public sector provision has been run down through a failure of successive governments to invest in new public infrastructure and significant tax breaks for nursing homes have facilitated their

growth and development. One of the positive implications of the rapid growth of nursing homes is that people are now able to live closer to their own communities.

Criticisms of the Fair Deal scheme have been both practical and philosophical. On the practical side there were always going to be teething problems in changing from one system to another. This has been exacerbated by the bureaucratic and burdensome nature of the application process and the need for considerable information on both dependency and assets. There are a lot of forms to be filled and information to be gathered. But maybe this is understandable, given the importance of existing Constitutional protection in relation to the family home and property in this country. A recent review of the Scheme by Deloitte in 2014 has recommended administrative changes to make the application process less burdensome on applicants and their families, but there will always be residual inertia given that decisions have to be made on each applicant's eligibility for public support. Means testing arrangements generate administration costs that do not arise in universal systems of provision.

There have also been philosophical objections to the Fair Deal scheme. At its simplest, this case rests on the view that care for older people should be free and universal, notwithstanding economic arguments that population ageing will impose significant pressures on the public finances. The core argument is that older people in residential care are being discriminated against since health care for the general population in acute care is paid for out of general taxation, with minimal cost sharing. Critics point out that the Fair Deal especially discriminates against older people with stroke who receive free care within the acute system, but are subject to significant cost-sharing if they move to residential care under current financing arrangements. Their question is why should people be treated differently simply because of their age, condition or care setting? Opponents of this view point to the significantly longer length of stays in residential care and the difficulty of sustaining public funding for chronic conditions across many different patient groups in the longer-term.

A more fundamental consideration in relation to the Fair Deal has nothing to do with its operation, but with overall priority-setting within the long-stay care system. The scheme has probably drawn additional resources into residential care at the expense of community care. I say 'probably' because it is impossible to tell how priorities are determined and implemented in health and social care in Ireland. However, we are

currently spending almost three times more on residential care than we are on home care. Spending on home care services and supports was €345 million in 2014 compared to almost 1 billion on residential care. Thirty years ago, The Years Ahead: A Policy for the Elderly report highlighted the need for the development and practice of home based care for older people and recommended greater state involvement to support community-based care. The report called for the development of a social model that maintained older people in their own homes rather than be admitted to long-stay residential care. Back in 2005, the National Economic and Social Forum called on the then government to spend an additional €500 million to bring long-term care expenditure up to the OECD average. That did not happen and there was no significant increase in resources for home care in Ireland. It remains the official policy of the current government to prioritise and support community-based care. But it is not doing so sufficiently.

Community care services for older people remain under-developed and concentrated on public health nursing and home help provision. Public health nurses provide front line support for dependent older people living at home, though it is acknowledged that provision relative to need is not satisfactory given the multiple demands on the service. Home help is also critical in allowing older people to remain in their own homes, but the service is not statutorily provided. In 2016, 49,000 people were in receipt of HSE funded home help services receiving just over 10.57 million hours of care over the full year. The average weekly hours for home help recipients was just over 4 hours. In 2009, the ESRI argued that in order to develop care in the community to the levels of other Western European states, the current level of home help provision will also have to increase substantially (Wren, 2009). Instead, in the ensuing years, partly in response to austerity requirements, home help hours were reduced.

Recent innovations in community care in Ireland have focused on the introduction of designated home care packages (HCP’s) for older people living at home. The latter are additional support measures over and above existing community based services and are designed to maintain an older person at home through home supports and rehabilitation services. They are targeted towards people on the margin of residential long-stay care or who need additional supports following discharge from an acute care bed. The most recent data suggests that 16,450 people benefited from a home care package during 2016. The average weekly hours for HCPs are 6.5 hours at a cost of

€165 per week. There were also 182 intensive home care packages provided by the HSE in 2016, the majority of which were provided to people with dementia through funding received under the National Dementia Strategy. The latter are designed to keep people with dementia living at home for longer, even those with significant dependency. These packages are expensive, usually equal to or above the cost of residential care, requiring significant co-ordination and integration of care from a variety of sources.

Notwithstanding such welcome innovation, community care service provision is based on a budget constrained, supply-driven model, partly due to the absence of a legal basis for many services, with provision determined more by the needs of the provider than the needs of the older person. The paradox is that the more successful Fair Deal is in funding highly dependent older people, the more important it is that community care services are expanded to meet the needs of those who remain living in their own homes. The most important part of the care jigsaw, therefore, is investment in community care, which remains low by international standards. It is no surprise, therefore, that the Government are now taking steps to develop a statutory response to deficiencies in this area, through a new Home Care funding scheme similar to the NHSS.

When older people are asked what they want in relation to home care, their answer typically is a system that allows them to live well in their own familiar environment. They want better and timely information, choice, personalised care, integrated care and more practical supports for family carers. So what needs to change to deliver the community-based system of care that people want? The first thing to acknowledge is that the development of a new system is not going to be cheap. Providing good quality care that is tailored to the individual needs of older people will be expensive, requiring complex co-ordination and regulation. Home carers will also have to be better trained and paid more to attract people into the profession. So solving the problem is going to cost money.

Funding long-term care through general taxation has not delivered the funds necessary to support an optimal community-based response for dependent older people. General taxation has many advantages in that it is democratically accountable, universal, yields large amounts of money and it tends to be progressive, which means

that the rich pay proportionately more than the less well off in society. However, older people seem to continually lose out in the allocation of scarce public resources collected through general taxation, particularly when it comes to funding community-based care. And even when resources do trickle down to older people, automatic entitlement is unusual and cost sharing is the rule rather than the exception. Co-payment is a feature of general taxation systems all over the world.

An alternative option is long-term care social insurance. Under a social insurance system individuals pay into a fund over the life cycle, in return for automatic entitlement should they need benefits at some time in the future. Government can pay the premiums of those not in the labour market and inability to pay would not deny access to any new national scheme. A designated social insurance fund would allow for a more protected, community-based funding model than currently exists. It would also encourage transparency in priority-setting and service delivery. It would likely be more consumer oriented and consumer responsive than a general taxation system. Social insurance organised through the labour market would, however, draw from a smaller contributory pool than the general taxation system.

Back in 2002, when this was last examined in detail for Ireland, Mercer favoured a social insurance approach to funding long-stay care in Ireland arguing that it would generate additional resources and would establish a clear link between contribution and benefit. Their calculations suggested a one percentage point increase in both employer and employee PRSI contributions would, for example, yield approximately €725 million, not an inconsiderable amount, then or now. The key advantages of introducing a long-term care social insurance contribution noted by Mercer were: the ability of social insurance to support a standardised needs assessment; the creation of a bias in favour of home care; the separation of financing and service delivery; the end to the welfare stigma associated with means tests; and the provision of long-term stability to the financing regime. Cost would obviously be an issue and they acknowledged that there could be potential adverse effects on competitiveness from raising PRSI rates.

The inter-departmental *Report of the Long-term Care Working Group* (2006) subsequently shied away from a social insurance model, concluding that a co-payment

scheme by nursing home residents based on ability to pay, taking both income and assets into account, was the optimal approach to funding residential care. The question of whether social insurance is an option to support an enhanced statutory-based home care system for older people in this country, or, more broadly could be used to support both home care and residential care, remains an interesting and important policy question for Ireland. The cost of any new and enhanced system of care for older people is likely to be high, requiring new sources of funding. General taxation has never generated sufficient resources for home care, where demand continues to exceed supply. The problem will get worse as population ageing increases. Agreeing an optimal funding model for long-term care in Ireland is important if we really want to change the care system, thereby improving the lives of older people.