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Towards Person-Centred Integrated Care? Facilitating Smart and Healthy Ageing in Ireland

by Emma McEvoy
Post-Doctoral Research
Maynooth University and ALL Institute

and Delia Ferri
Professor of Law
Maynooth University and ALL Institute

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Abstract [En]: This article discusses whether and to what extent the existing legal framework in Ireland enhances integrated care, thereby facilitating smart and healthy ageing. After having provided an overview of the functioning Irish healthcare system and of the current challenges it faces, the article moves onto examining the relevant legal framework. It then discusses the extent to which current legislation and policies have supported the move towards integrated care systems and the use of technology to facilitate independent living for older people. In that regard, this contribution supports the view that technology can act as a lever for integrated care, and highlights how technology has been used and promoted thus far. The analysis proposed in this contribution suggests that the current Irish legal framework does not actively promote smart and healthy ageing, but ensures a certain level of protection in terms of decision making and privacy rights. On the whole, this article contends that additional legislative and soft-law measures would facilitate innovative healthcare for older people.

Abstract [It]: Questo articolo spiega se e in che misura il quadro giuridico esistente in Irlanda favorisca l'assistenza integrata, facilitando così un invecchiamento equilibrato e sano. Dopo aver fornito una panoramica del funzionamento del sistema sanitario irlandese e delle sfide attuali che deve affrontare, l'articolo passa ad esaminare il quadro giuridico pertinente. Quindi, il contributo analizza la misura in cui la legislazione e le politiche attuali hanno supportato il passaggio verso sistemi di cura integrati e l'uso della tecnologia per facilitare la vita indipendente degli anziani. A questo proposito, questo contributo sostiene che la tecnologia può agire come una leva per l'assistenza integrata, e mette in evidenza come la tecnologia è stata usata e promossa finora. L'analisi proposta in questo contributo suggerisce che l'attuale quadro giuridico irlandese non promuove attivamente l'invecchiamento equilibrato e sano, ma garantisce un certo livello di protezione in termini di diritti decisionali e di privacy. Nel complesso, questo articolo sostiene che ulteriori misure legislative e di soft-law faciliterebbero l'assistenza sanitaria innovativa per gli anziani.

Keywords: Healthcare, Person-Centred Integrated Care, Technology, Ageing, Covid-19
Parole chiave: Assistenza sanitaria, Cura integrata incentrata sulla persona, Tecnologia, Invecchiamento, Covid-19

Summary: **1.** Introduction. **2.** The Healthcare System in Ireland: A Snapshot of Current Challenges. **2.1.** Inherent Inequality of the Two-Tier System. **2.2.** The Slow Move Towards Universal Access to Health-Care: A Policy Challenge. **2.3.** Ageing: A Challenge to be Addressed through Person-Centred Systems and Technology. **3.** The Relevant Legal Framework. **3.1.** Constitutional Rights. **3.2.** Decision Making and Health. **3.3.** Healthcare Legal Framework. **4.** Facilitating Smart and Healthy Ageing in Ireland: Is the Legal Framework Supportive of Integrated Care? **5.** Concluding Remarks.

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1. Introduction

The purpose of this short article is to discuss whether and to what extent the current legal framework in Ireland enhances integrated care also through the use of technology, thereby facilitating smart and healthy ageing. In that regard, this article supports the view that technology can act as a lever for integrated care. It is worth recalling that integrated care, as stated by the Health Service Executive (HSE) "aims to join up [Irish] health and social care services, improving quality and putting patient outcomes and experiences at the centre".[1] In a policy paper published by the Adelaide Health Foundation, integrated care is defined, in line with the conceptualization put forward by the World Health Organization (WHO), as the "the organisation and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money".[2] It is also suggested that "integrated health systems assume the responsibility to plan for, provide/purchase and coordinate all core services along the continuum of health for the population served".[3] Building on the latter definition, this article questions whether the current legal framework has the potential to support integrated care and promote person-centred innovative care to allow older people to live longer in their own dwellings and actively participate in local communities.

Previous interdisciplinary research has highlighted that, in Ireland, progress towards person-centred systems has been achieved, but much more remains to be done to foster integrated care.[4] It has also emphasised the need for a more collaborative relationship between services providers, caregivers and care recipients is essential to enhance the quality of services.[5] On foot of this research, this article suggests that the current Irish legal framework does not actively promote smart and healthy ageing, but ensures a certain level of protection in terms of decision making and privacy rights. In that connection, it contends that introducing additional soft-law measures would facilitate innovative healthcare for older people.

Further to these introductory remarks, this article is divided into four main sections. Section 2 will offer a snapshot of the healthcare system in Ireland, and the challenges it faces. Section 3 will succinctly examine the relevant legal framework, paying attention to constitutional rights and the most relevant legislation. Section 4, further having appraised the use of technology to facilitate older people living at home independently and its role in an integrated care system, discusses the extent to which legislation

[1] See at https://www.hse.ie/eng/about/who/cspd/icp/.

[2] C. DARKER, *Integrated Healthcare in Ireland – A Critical Analysis and a Way Forward, An Adelaide Health Foundation Policy Paper*, at https://www.tcd.ie/medicine/public_health_primary_care/assets/pdf/Integrated-Care-Policy-LR.pdf, p. 17.

[3] Ibid. p. 24

[4] A. CARROLL *et al., Your Voice Matters, a pilot qualitative study of integrated care in Ireland*, in *International Journal of Integrated Care* 2018, Vol. 18(s2), p. 47.

[5] Ibid.

and policies have supported the move towards integrated care systems. Section 5 concludes by suggesting how legislation and soft-law measures can facilitate innovative integrated healthcare for older people.[6]

2. The Healthcare System in Ireland: A Snapshot of Current Challenges

Before engaging in an analysis of the relevant legal framework, this section offers an overview of the core features and inherent problematic issues of the two-tier healthcare system that operates in Ireland, with health and care services provided by both private and public providers.[7] It then recalls that plans have been put in place by the previous and current governments to dismantle this two-tier system, with the view of improving access to health and care services for all members of society, and creating a system where access to health services is based on medical need rather than wealth.[8] At the centre of the reform policies is a recognition that there is a change in the population demographics profile, which are placing increased challenges on the health and care systems.[9]

2.1. Inherent Inequality of the Two-Tier System

A two-tier healthcare system operates in Ireland, with health and care services provided by both public and private providers. While the government funds a comprehensive public healthcare system, nearly half of the population avail of private health insurance (PHI) to secure treatment by private health providers or hospitals, or private treatment in public hospitals.[10] Furthermore, currently, there are two main categories of entitlements to public health services in Ireland. Those that are full medical cardholders are entitled to free public health services (including inpatient and outpatient hospital care, General Practitioner (GP) care and other primary and community care services), but they must pay a co-payment of prescription item, up to a maximum of €25 per family per month.[11] Eligibility for a medical card is evaluated on the basis of an income means test. In substance, medical cards enable people on very low income, or with no income, to access a GP. There are then those who are entitled to subsidised public hospital services, but must pay the full cost of GP services, other primary and community care

[6] Health Service Executive, 'eHealth Strategy for Ireland' (2013) <https://www.ehealthireland.ie/Knowledge-Information-Plan/eHealth-Strategy-for-Ireland.pdf> Accessed 1 December 2020.
[7] P. HEAVEY, *The Irish healthcare system: A morality tale* (2019) 28(2) *Cambridge Quarterly of Healthcare Ethics* 276.
[8] Department of Health, 'Committee on the Future of Healthcare. Sláintecare Report' (2017) Houses of the Oireachtas.
[9] . In particular, it is estimated that 2021 will see a 17.3% increase (107.600) of additional people aged 65 years and over living in Ireland. Health Service Executive, 'Making a start in Integrated Care for Older Persons' (2017) <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/a-practical-guide-to-the-local-implementation-of-integrated-care-programmes-for-older-persons.pdf> Accessed 20 December 2020.
[10] OECD, 'Assessing Private Practice in Public Hospitals' (2018) OECD Better Policies for Better Lives.
[11] Y. MA and A. NOLAN, *Public Healthcare Entitlements and Healthcare Utilisation among the Older Population in Ireland* in *Health Economics*, 2017, vol. 26/no. 11, 1412.

and prescription medicines.[12] A study carried the European Observatory on Health Systems and Policies, released in 2015, contends that the "highest (formal) payments in the public system exist in Ireland, where patients without a medical card (over 60% of the population) pay €45–60 for each general practice visit, with no reimbursement".[13] More recent data suggest that those without a medical card are charged an average €52.50 per GP visit, a €100 charge for visiting an public hospital Emergency Department without a GP referral, and an €80 per night statutory bed charge for stays in public hospitals (up to a maximum of €800 in a continuous 12-month period).[14] They have a right to a monthly deductible of €124 for prescription medication under the Drug Payment Scheme.[15]

Currently, the Health Service Executive (HSE) has full operational and financial responsibility for managing the public health system. The HSE was established in 2005 by Ministerial order in compliance with the Health Act 2004, as amended by the Health Service Executive (Governance) Act 2013. Section 7(1) of the Health Act, 2004 (as amended) states that the main aim of the HSE is "to use the resources available in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public". Public health services are funded by the State. Separately, as part of this two-tier system, health care is provided by individual health professionals or private healthcare companies.

Byers has described the Irish healthcare system as "a complicated mix of public and public providers, with inequitable and unclear routes for health service users to access and navigate the system".[16] In particular, the two-tier public and private healthcare system has been harshly criticised for creating inequities in access to hospital care.[17] Darker *et al.* highlight that those who do not possess a PHI often face long waiting lists for acute care, minor operations and diagnostics.

[12] At present, people who do not qualify for a full medical card, can obtain a GP visit card allows to visit GP for free. The GP visit card does not cover hospital charges. See at <https://www.citizensinformation.ie/en/health/medical_cards_and_gp_visit_cards/gp_visit_cards.html > Accessed 1 January 2021

[13] D. KRINGOS et al. *Building primary care in a changing Europe*, European Observatory on Health Systems and Policies, 2015, p. 74 at <https://www.euro.who.int/__data/assets/pdf_file/0018/271170/BuildingPrimaryCareChangingEurope.pdf>

[14] A. MURPHY, J BOURKE, & B TURNER, *A two-tiered public-private health system: Who stays in (private) hospitals in Ireland?* In (2020) *Health Policy*, 124(7), 765-771. doi:10.1016/j.healthpol.2020.04.003.

[15] Ibid.

[16] V. BYERS, *Health care for all in Ireland? The consequences of politics for health policy* (2017) 9(1) *World Medical & Health Policy* 138.

[17] S.A. BURKE, C. NORMAND, S. BARRY, S. THOMAS, *From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis* (2016) 120(3) *Health Policy* 235.

2.2. The Slow Move Towards Universal Access to Health-Care: A Policy Challenge

Connolly and Wren, in their article entitled *Universal Health Care in Ireland—What are the Prospects for Reform?*,[18] highlight that, while several European countries moved toward universal health care in the period after World War II, "the powerful positions of the Catholic Church and the medical profession in Ireland were instrumental in impeding reform through the first half of the 20th century". In another contribution, those Authors summarise the several attempts that have been made to reform the inequitable two-tier healthcare system, with an ambitious policy goal, put forward in 2011, to introduce universal health care.[19] The aim was to stop private health insurance holders receiving preferential healthcare in public hospitals,[20] exacerbating inequalities. Given that "Ireland has a relatively low provision of hospital beds – 3.0 per 1,000 population in 2017, compared with an OECD average of 4.7 – and the highest bed occupancy rate in the OECD, at 94.9% in 2017, well above the OECD average of 75.2%",[21] Keegan *et al.* note that "public hospitals in Ireland are currently operating at close to full capacity".[22]

While several initiatives have been introduced, providing access to free healthcare services for children, the government have not yet dismantled the two-tier healthcare system.[23] In fact, the 2011 reform proposal was abandoned due to concerns regarding the proposed Universal Health Insurance (UHI) potential costs.[24]. Furthermore, while specialist medical and psychiatric services for older people have developed consistently in Ireland, the same level of progression has yet to be witnessed in community and long-term services.[25] Darker *et al.* also report that, over recent years, funding for the health service in Ireland has decreased,[26] and significant resource cuts led to "reduced home care hours, increased wait-

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[18] S. CONNOLLY and MA WREN, *Universal Health Care in Ireland—What are the Prospects for Reform?*', Health Systems and Reform, vol. 5/no. 2, (2019), 94.

[19] M. WREN and S. CONNOLLY, *A European late starter: lessons from the history of reform in Irish health care* (2019) 14(3) Health *Economics, Policy and Law* 355. See also S. CONNOLLY and M.A. WREN, *The 2011 proposal for universal health Insurance in Ireland: potential implications for healthcare expenditure* (2016) 120(7) *Health Policy* 790.

[20] S. CONNOLLY and M.A. WREN, *The 2011 proposal for universal health Insurance in Ireland: potential implications for healthcare expenditure* (2016) 120(7) *Health Policy* 790.

[21] A. MURPHY, J BOURKE, & B TURNER, *A two-tiered public-private health system: Who stays in (private) hospitals in Ireland? Health Policy* (2020), 124(7), 765.

[22] C. KEEGAN *et al., How many beds? capacity implications of hospital care demand projections in the irish hospital system, 2015-2030* (2019) *The International Journal of Health Planning and Management*, 34(1), 569.

[23] P. MALONE AND M. MILLAR, *The only equality is the pain: An exploration of the Irish policy sphere's approach to "access" and "entitlement" in health care* (2020) 54(1) *Social Policy & Administration* 163.

[24] Ibid.

[25] D. O'NEILL AND S. O'KEEFFE, *Health care for older people in Ireland* (2003) 51(9) *Journal of the American Geriatrics Society* 1280.

[26] C.D. DARKER et al. *Demographic Factors and Attitudes that Influence the Support of the General Public for the Introduction of Universal Healthcare in Ireland: A National Survey* (2018) *Health Policy*, vol. 122/no. 2, 147.

times, expensive agency staffing and accentuated inequities of access for patients within the health system".[27]

In 2016, the government decided to investigate more efficient ways to implement universal healthcare. The *Oireachtas* (Parliamentary) Committee on the Future of Healthcare was tasked with developing cross-party political agreement on a reform for the health and social care system. A year later, in May 2017, adopted a cross-political party agreement on a single, "long-term vision for health and social care and the direction of health policy in Ireland": *Sláintecare*. That Report's primary aim is to implement a more equitable universal single-tier health and social care system, based on need, and "not ability to pay".[28] The *Sláintecare* Report further attempts to embed an integrated approach to healthcare in Ireland, recognising that integrated care requires:

Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients' needs come first in driving safety, quality and the coordination of care. [29]

Sláintecare has also the ostensible goal of lowering the cost of healthcare. Integrated care seems, in that connection, a means to reduce public expenditure, by decreasing hospitalisation, and enhancing a greater management of chronic diseases at primary care rather than hospital level.[30] Research has, however, shown "that substantial investment will be required to bring Irish acute hospital bed capacity in line with projected demand by 2030",[31] and this aspect does not seem to be tackled by *Sláintecare*. Keegan *et al.* suggest that current investment in primary care might reduce acute care demand, but additional resources and an increase in hospital capacity will still be needed.

2.3. Ageing: A Challenge to be Addressed through Person-Centred Systems and Technology

The *Sláintecare* Report recognises the ageing population will place great pressure on limited resources, and, in that vein, it aims to deliver integrated care as a tool to increase the efficiency of the Irish healthcare system. In fact, while Ireland has a young population base, the demographics is changing and there is an increase in the number of older people, in line with most European countries. At present, Ireland has a

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[27] Ibid.
[28] Department of Health, *Committee on the Future of Healthcare. Sláintecare Report* (2017) Houses of the Oireachtas.
[29] Ibid. p. 75
[30] A. MURPHY, J BOURKE, & B TURNER, *A two-tiered public-private health system: Who stays in (private) hospitals in Ireland? Health Policy* (2020), 124(7), 765.
[31] C. KEEGAN *et al., How many beds? capacity implications of hospital care demand projections in the irish hospital system, 2015-2030* (2019) *The International Journal of Health Planning and Management*, 34(1), 569.

population of 4.9 million,[32] and people aged 65 years and over represent 12.7% of the population, and people aged 85 and over represent 1.4% of the population.[33] Combined, these two groups tend to use 66.5% of inpatient hospital beds.[34] Data reported by the Royal College of Physician state that, in 2014, the average age of care recipients on the island of Ireland was 76 years.[35] Ma and Nolan report that "[b]y 2046, approximately 21% of the Irish population will be aged 65 years or older, and approximately 7% will be aged 80 years or older (the corresponding figures for 2011 were 11.6% and 2.8%, respectively)".[36] As the population is ageing, new challenges for the national health and social care systems arise. Some of the pressing problems relate to an increased need for Emergency Departments and home care assistance. Patients aged 75 years and over spend three times longer availing of Emergency Department hospital services than those aged 65 or younger.[37] Furthermore, it is appraised that for patients aged 85 years and older, 600 acute hospital presentations per 1,000 population are needed.[38] Approximately 50% of these inpatients require further nursing or home care assistance when released from hospital.[39] Increased need for home support care is, hence, a growing challenge for society. Presently, 4.1% of the population provide unpaid care for older people, primarily providing care for older family members.[40]

In this context, the HSE is attempting to reinforce its "Home Care Package". This includes the provision of community care and home care supports at a local level. In practice, older people receive care to support them in continuing to live independently in their own homes.[41] This service is available to people aged 65 years or over who require support to live independently or for those released from hospital and require temporary care.[42] However, Browne recognises that there are many problems associated with the

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[32] Department of Health, *Health in Ireland - Key Trends 2019* (2019) Statistics & Analytics Services, Department of Health.
[33] Central Statistics Office, 'Census of Population 2016 - Profile 3 An Age Profile of Ireland' (2016) <https://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/agr/>.
[34] Health Service Executive, *ICP for Older People* (2017) < https://www.hse.ie/eng/about/who/cspd/icp/older-persons/> Accessed 1 January 2021.
[35] See <https://www.rcpi.ie/policy-and-advocacy/ageing/#:~:text=In%20Ireland%20the%20over%2D65,years%20of%20the%2020th%20century> Accessed 1 January 2021.
[36] Y MA AND A. NOLAN, *Public Healthcare Entitlements and Healthcare Utilisation among the Older Population in Ireland*, (2017) *Health Economics*, vol. 26/no. 11, 1412.
[37] Health Service Executive, *ICP for Older People* (2017).
[38] Ibid.
[39] Ibid.
[40] Ibid. See also; Institute of Public Health in Ireland, 'Improving Home Care Services in Ireland: An Overview of the Findings of the Department of Health's Public Consultation' (2018) Institute of Public Health in Ireland.
[41] Health Service Executive, 'Home Support Service for Older People' (2020) <https://www.hse.ie/eng/home-support-services/> Accessed 2 December 2020.
[42] Ibid. It should be noted that people younger than 65 years old with cognitive illnesses such as dementia may avail of these services. The home support services are offered freely to all older people who need the assistance, and the services are provided directly by the HSE or service providers contracted by the HSE. The service is offered upon completion of a "Care Needs Assessment" which assess a person's healthcare needs and social circumstances. See also Health

current home care packages available to older people.[43] Home help packages are generally approved to provide set task-focussed care, namely meal preparation or personal care. The care visits are generally 30 minutes in duration, although there is a lack of uniformity across different Irish counties regarding the application process in relation to the hours approved and the tasks covered by the home help packages.[44] Family carers are "becoming over-burdened and unable to continue providing care due to lack of adequate home care packages".[45] A study conducted in 2015 also reveals that only 7.5% of respondents aged 65 years and older received home care from the State.[46] Furthermore, the "Home Care Package" does not provide universal provision of, or use of, available assistive technologies. It is worth recalling that assistive technology takes several forms, it can be used to monitor health, assisting with care and creating smart homes. As noted Casey *et. al.*, assistive technologies can support integrated care, and reduce hospitalisation.[47] Robotic technology in particular has been isolated as a key measure to assist older people in living independently.[48] Industry, governments, and researchers have identified older people as the key demographic who can positively benefit from the use of AT to assist with daily living activities, such as the use of service robots, home automation equipment and digital assistant services.[49] While the initial investment in AT might be costly, these costs are recouped when the adaptions reduce the user's long-term care costs. For example, the economic costs related to caring and managing for falls by people over 65 are significant. It is estimated that over 30% of people over the age of 65 years old will experience a fall.[50] O'Dwyer and Murphy calculate that the average costs of falls is €13.809 per person, estimating

Service Executive, 'The Care Needs Assessments' (2020) <https://www.hse.ie/eng/home-support-services/after-you-apply-the-care-needs-assessment/after-you-apply-the-care-needs-assessment.html> Accessed 2 December 2020.

[43] M. BROWNE, *Responding to the Support and Care Needs of our Older Population. Shaping an Agenda for Future Action. Report of Forum on Long-term Care for Older People* (2016) *Support and Advocacy Service for Older People*.

[44] Health Service Executive, 'National Guidelines & Procedures for the Standardised Implementation of the Home Support Service (HSS Guidelines)' (2018).

[45] M. BROWNE *Responding to the Support and Care Needs of our Older Population. Shaping an Agenda for Future Action. Report of Forum on Long-term Care for Older People* (2016) *Support and Advocacy Service for Older People*.

[46] C. MURPHY et al., *Formal home-care Utilisation by Older Adults in Ireland: Evidence from the Irish Longitudinal Study on Ageing (TILDA)*, *Health & Social Care in the Community*, vol. 23/no. 4, (2015), 408..

[47] C CASEY, T MULCAHY AND J O'FLYNN, T*echnology: Innovation and the Care of Older People*' (Irish Gerontological Society, 29 January 2020) <https://www.irishgerontology.com/news/blogs/technology-innovation-and-care-older-people> Accessed 15 December 2020.

[48] M. SHISHEHGAR, D. KERR AND J. BLAKE, *A systematic review of research into how robotic technology can help older people* (2018) 7 *Smart Health* 18.

[49] J. MCMURRAY et al. '*The importance of trust in the adoption and use of intelligent assistive technology by older adults to support aging in place: scoping review protocol*.' (2017) 6(11) *JMIR Research Protocols* 218.

[50] E. TOWNER AND G. ERRINGTON, '*How can injuries in children and older people be prevented?*.' (2004) Copenhagen, WHO Regional Office for Europe, Health Evidence Network report; <http://www.euro.who.int/Document/E84938.pdf,> Accessed 15 December 2020.

that the costs of falls will reach an accumulative sum of €6 billion by 2046.[51] AT can be used to prevent and detect falls, thus reducing costs associated with falls. However, Casey *et al.* warn that AT can detect falls, but detection alone is not enough, effectiveness is measured on the availability of a coordinated and quick response.[52] This suggests that AT will not function to its best ability without the adequate coordination of a human response, within a well organised integrated care service.

Nursing home care is available on a statutory basis, through the "Nursing Homes Support Scheme".[53] The scheme, often referred to as the "Fair Deal" scheme,[54] provides financial assistance to older people who need long-term nursing home care. Under the scheme, older people can reside in long-term private or public nursing homes. Older people availing of this scheme are required to make a financial contribution towards the cost of their care with the state paying the remainder of the balance.[55] When applying for the scheme, an individual's financial situation, including all personal assets such as savings and property, is assessed to calculate how much a person will be charged.[56] Notably, in *Re Article 26 and the Health (Amendment) (No 2) Bill 2004*, the Supreme Court held that any statutory requirement to pay charges for nursing home care would not infringe the right to life as enshrined in the Constitution of Ireland.[57] It should be pointed out that, while the residential supports are provided on a statutory basis, no statutory regime for domestic home care exists.

On the whole, Roe *et al.* comment that frail older people predominately avail of medical care and fail to avail of social-care, suggesting that this demographic potentially have unmet care needs.[58] Previous studies have also shown that older people in Ireland experience social and emotional dimensions of loneliness, experiencing elements of both family loneliness and romantic loneliness.[59] Older people, particularly males, living in rural areas, with poor health, a low income, widowed, have limited contact with family and no access to transport are at a much higher risk of suffering from social and emotional loneliness.[60]

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[51] J. O'DWYER AND A. MURPHY, *'Investigating the Economic Impact Of Care Clip Automatic Fall Detection Device'* (2018) Health Innovation Hub Ireland <https://hih.ie/project/economic-impact-of-automatic-fall-detection-device/> Accessed 9 January 2021.

[52] C CASEY, T MULCAHY AND J O'FLYNN, T*echnology: Innovation and the Care of Older People*' (Irish Gerontological Society, 29 January 2020) <https://www.irishgerontology.com/news/blogs/technology-innovation-and-care-older-people> Accessed 15 December 2020.

[53] See at https://www.hse.ie/eng/services/publications/olderpeople/nhss%20fair%20deal.html.

[54] Health Service Executive, *Fair Deal Scheme* < https://www2.hse.ie/services/fair-deal-scheme/about-the-fair-deal-scheme.html> Accessed 6 December 2020.

[55]Ibid.

[56] Ibid.

[57] [2005] IESC 7, [2005] 1 IR 105, [2005] 1 ILRM 401. See below section 3 of this article.

[58] L. ROE et al. *The impact of frailty on healthcare utilisation in Ireland: evidence from the Irish longitudinal study on ageing* (2017) 17(1) *BMC Geriatrics* 203.

[59] J. DRENNAN et al. *The experience of social and emotional loneliness of older people in Ireland* (2008) 28(8) *Ageing & Society* 1113.

[60] Ibid.

Older people living in rural Ireland face increasing barriers to access to health care services when they cease driving. Limited public transport and driving cessation are common challenges for older people in rural areas to attend doctors, clinics or hospital appointments.[61]

The main path to address those challenges seems that of enhancing access to integrated care and digital healthcare, to improve physical health, but to alleviate mental health concerns and encourage older people to engage in their community in a meaningful manner.

3. The Relevant Legal Framework

After having provided an overview of the challenges that the Irish healthcare system faces and the policy discussion surrounding those challenges, this section focuses on the legal framework that supports that healthcare system. It also provides an outline of relevant provisions that support the development of a person-centred integrated healthcare system.

3.1. Constitutional Rights

It is important to note that the Constitution of Ireland (*Bunreacht na hÉireann*) contains no express provision on the right to health.[62] Cooke J. in *MEO v Minister for Justice, Equality and Law Reform* concluded that the Constitution does not confer an obligation on the State to ensure the provision of any particular type of medical treatment to Irish citizens.[63] In 2019, the Thirty-Ninth Amendment of the Constitution (Right to Health) Bill 2019 was put forward with the view of inserting into Article 40 of the Irish Constitution, which sets out fundamental personal rights, the statement:

"the State recognises the equal right of every citizen to the highest attainable standard of health protection and shall endeavour to achieve the progressive realisation of this right; the State shall endeavour, within its available resources, to guarantee affordable access to medical products, services and facilities appropriate to defend the health of the individual; and the health of the public being, however, both individual and collective, the State shall give due regard to any health interests that serve the needs of the common good".

[61] A. AHERN AND J. HINE, *Accessibility of health services for aged people in rural Ireland* (2015) 9(5) *International Journal of Sustainable Transportation* 389.

[62] A. MCAULEY, *The Challenges to Realising the Right to Health in Ireland* (2014) TMC Asser Press, The Hague 373.

[63] [2012] IEHC 394.

The purpose of the Bill was to give constitutional status to the right to health. In the *Dail* debate it was suggested that the "Bill would, therefore, crystallize the right to health within the Constitution so as to protect individuals and generate new legislative initiatives".[64] However, the Bill was defeated by vote.

Article 40 recognises and protects the right to life.[65] The right to life guides judicial interpretation of a patient's autonomy rights, particularly when reviewing cases authorising medical treatment in the absence of appropriate consents[66]. Denham J. in *In re a Ward of Court (withholding medical treatment)* (No. 2) stated:

"The right to life is the pre-eminent personal right. The State has guaranteed in its laws to respect this right. The respect is absolute. This right refers to all lives – all lives are respected for the benefit of the individual and for the common good. The State's respect for the life of the individual encompasses the right of the individual to, for example, refuse a blood transfusion for religious reasons. In the recognition of the individual's autonomy, life is respected."[67]

Furthermore, as noted in *Fitzpatrick & Anor -v- K. & Anor*, the right of patient autonomy is encompassed by the State's obligation to protect the "person" in Article 40.3.2 of the Constitution. That right is also a dimension of the unenumerated right to bodily integrity as recognised *in Ryan v. Attorney General.*[68] In the case *The State (C.) v. Frawley*[69] it was also accepted that the right to bodily integrity includes a right to freedom from torture and inhuman and degrading treatment. Additionally, in the light of the decision of the Supreme Court in the decision - already mentioned - *In re a Ward of Court (withholding medical treatment)* (No. 2),[70] it is clear that a competent adult is free to decline a medical treatment, even if such a refusal can lead to his/her death. In that judgment of Denham J. stated:

"Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g. in regard to contagious diseases or in a medical emergency where the patient is unable to communicate. This right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be a trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights".[71]

[64] https://www.oireachtas.ie/en/debates/debate/dail/2019-11-20/19/#:~:text=The%20Bill%20will%20be%20entitled,shall%20endeavour%20to%20achieve%20the

[65] Article 40.4 Note the Health (Regulation of Termination of Pregnancy) Act 2018 allows for the Oireachtas to pass laws regulating the termination of pregnancy.

[66] *Governor of X Prison v McD* [2015] IEHC 259.

[67] *Re a Ward of Court* (withholding medical treatment) (No. 2) [1996] 2 IR 79, at p. 160.

[68] [1965] I.R. 287

[69] [1976] I.R. 365

[70] [1996] 2 I.R. 79. The case was about a person in vegetative state and the right to refuse treatment.

[71] Ibid. p. 156.

The right of autonomy in the context of refusing medical treatment will only be upheld once it is shown that the patient at the time the decision was made had full capacity and came to the decision freely.[72] Although, it should be noted that while the right to life allows for a person to die a natural death, it does not extend to providing a right to allow a person to terminate their life.[73]

3.2. Decision Making and Health

In terms of medical consent, a medical practitioner is required to obtain consent from a patient prior to commencing any medical treatment. A patient may indicate their consent expressly, either verbally or in writing, or can imply their consent by their behaviour.[74] All Irish citizens have a right to self-determination that is expressed through their consent. An adult person's right to self-determination is not invalidated by age or incapacity, as noted by McMenamin J. in *HSE v (M)X*:

"A person suffering from such incapacity continues to enjoy individual rights such as the exercise of freewill, self-determination, freedom of choice, dignity and autonomy".[75]

As noted above, Denham J. clarified that this right is not complete and some exceptions to the general rule exist.[76] A patient's consent is not required in circumstances where it is in the patient's best interest to receive treatment, where it is in the public's best interest to prevent the spread of contagious diseases, in times of a medical emergency or where a Court of law has issued an order for the medical treatment.[77] When capacity is required, a "valid" form of consent is required, meaning that the patient has the capacity to consent, the consent is provided voluntarily, without the presence of any element of duress, and the patient has been informed of all relevant risks, side-effects and alternative treatments.[78] As noted by Wade, the issue of capacity has received little judicial development.[79] However, the 2008 ruling, in *Fitzpatrick v K*,[80] clarified and expressed the criteria for assessing legal capacity. Laffoy J., following the

[72] Ibid.

[73] *Fleming v Ireland & Ors* [2013] IESC 19.

[74] Certain types of medical treatment require written consent, for example, written consent is required for the participation in clinical trials under the provisions of S.I. No. 190/2004 - European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations, 2004 Schedule 1(3). Additionally, sections 58 – 60 of the Mental Health Act 2001 require written consent for participation in psycho-surgery, electro-convulsive therapy and the continuation of medication.

[75] [2011] IEHC 326 (HC, 29/7/11) at para 2.

[76] [1996] 2 I.R. 79 at p. 156.

[77] *SR (A Ward of Court)* [2012] 1 IR 305; An Irish Hospital v. RF (minor) [2015] 2 IR 377; HSE v. J.M. a Ward of Court & Ors [2017] IEHC 399;

[78] HSE National Consent Policy (HSE, May 2013) para. 7.4; Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Medical Council, 8th Edition, 2016) at para 11.1.

[79] K. Wade, 'Caesarean Section Refusal in the Irish Courts: Health Service Executive v B' (2017) 25(3) Medical Law Review. 494.

[80] [2009] 2 IR 7, [2008] IECH 104.

English ruling of *Re C*[81], set out a three-part test for determining a presumption of capacity that can be rebutted under limited circumstances. Firstly, the established test for assessing capacity, acknowledges that the there is a presumption that an adult patient has the capacity to consent.[82] This presumption can be rebutted if the patient fails to meet to second and third requirements. A second functional test is then applied to determine whether a patient is deprived of capacity to refuse medical treatment.[83] Mainly, the functionality test examines if a patient's cognitive ability or loss of cognitive ability impairs the patient's ability to sufficiently understand the purpose of the treatment and potential consequences of accepting or rejecting the treatment. Subsequently, the third stage of the test explores if a patient's cognitive ability has been impaired to the extent that they are incapable of making a decision to refuse treatment.[84] In assessing if a patient's cognitive ability has been impaired to an extent where they are incapable of providing consent, it must be shown that the patient was not able to comprehend the consequences from not accepting treatment, that the patient did not accept or believe that the refusal of treatment would likely result in the patient's death, and the patient failed to take into account the likely outcomes when making their decision.[85]

The Medical Council further reiterates that medical practitioners have a duty of care to assist and facilitate patients in making their decision and patients have a right to be supported when considering their medical choices:

"As their doctor, you have a duty to help your patients to make decisions for themselves by giving them information in a clear and easy-to-understand way and by making sure that they have suitable help and support. Patients have the right to have an advocate of their choice during discussions about their condition and treatment"[86]

In order to presume capacity, the patient must have been able to comprehend, believe and weigh the treatment information. This presumption of capacity can be rebutted in circumstances where the patient was unable to 'understand, retain, use or weigh' the information communicated to them. It is this presumption of capacity test which forms the basis for the Assisted Decision-Making (Capacity) Act 2015, which now provides the statutory framework to support adults with capacity difficulties to make decisions about their welfare, property and affairs.

[81] [1994] 1 WLR 290.
[82] [2008] IECH 104 at para. 35.
[83] [2008] IECH 104 at para. 288.
[84] [2008] IECH 104 at para. 289 and 290.
[85] Ibid.
[86] Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Medical Council, 8th Edition, 2016) at para 10.1.

This Assisted Decision-Making (Capacity) Act 2015 was adopted to bring Irish legislation in line with the UN Convention of the Rights of Persons with Disabilities (CRPD), which was ratified by Ireland in 2018. It is worth recalling that Article 12 CRPD imposes on States Parties the full respect legal capacity of persons with disabilities (including older people with disabilities). In interpreting that provision, the UN Committee on the Rights of Persons with Disabilities (CRPD Committee) states that legal capacity is a universal attribute inherent in all persons by virtue of their humanity and that it must be upheld for persons with disabilities on an equal basis with others.[87] Article 12 CRPD also provides for support measures be provided to persons with disabilities in order to facilitate the exercise of their legal capacity. However, according to the CRPD Committee, these measures must respect the autonomy of persons with disabilities, their freedom to reject support or to end a support relationship.[88] The purpose of this Act, with regard to health and social care, is to promote the autonomy of persons concerning their treatment choices, to enable them to be treated according to their will and preferences.[89] It places people at the centre of their healthcare decisions by protecting individuals right to the presumption of capacity,[90] formalising the principle of functional capacity[91] and preserving a person's recorded will and preferences.[92] The Act has not yet been fully commenced.[93] Until the Act has been fully commenced, the validity of advanced or future decisions has been approved at a Common law level. In 2015, Baker J. in *X v PMcD* noted: "I consider that as a matter of law … that a person may make a freely stated wish in regard to their future care and that this ought to be, and can in an appropriate case be, respected by those with care of that person."[94] Full commencement will only take place when the "Decision Support Service" within the Mental Health Commission is operational, and it is not yet clear when this will happen.

Finally, it is worth noting that privacy is also key when it comes to decision making in the health context. It is also particularly relevant when it comes to the use of technology to support person-centred systems. Privacy rights are protected by the Constitution of Ireland[95] and the European Convention on Human Rights.[96] Furthermore, personal data privacy issues are protected by the General Data Protection

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[87] CRPD Committee, General Comment No. 1, 19 May 2014, UN Doc. CRPD/C/GC/1.
[88] Ibid. para. 29.
[89] BD. KELLY, *The Assisted Decision-Making (Capacity) Act 2015: what it is and why it matters* in *Ir J Med Sci* 186 (2017), p. 351.
[90] s 8 (1) – (10).
[91] Sections 3(1) –(7).
[92] s 8(7)(b).
[93] This means that some provisions have not yet entered into force.
[94] [2015] IEHC 259 stated at para. 126
[95] Irish courts have consistently held that the right to privacy is one of the unenumerated rights which is protected by Article 40.3 of the Constitution.
[96] The right to privacy is one of the unenumerated rights protected by Article 40.3 of the Constitution. Article 8 of the European Convention on Human Rights enshrines the right to respect for private and family life.

Regulation (GDPR),[97] which is given further effect by the Data Protection Act 2018.[98] The 2014 Health Identifiers Act provides for the creation of a unique Individual Health Identifier (IHI) for any person using a health or social care service in Ireland and a national IHI register.[99] All personal data included in the register is processed in compliance with the GDPR and other privacy legislation.

On the whole, the Irish legal framework includes appropriate safeguards to allow the exercise of autonomy, and the full commencement of the Assisted Decision-Making (Capacity) Act 2015 will be of key importance in enhancing the exercise of informed consent, also within the perimeter of guarantee of privacy rights.

3.3. Healthcare Legal Framework

The Irish Parliament (the *Oireachtas*) has responsibility for passing health related legislation, often upon the proposal of the Minister for Health, and a vast legislative regime governs issues such as medical negligence, regulation of medicines, medical confidentiality and medical records, consent to treatment and mental health law exists.[100] However, the actual functioning of the healthcare system is mostly the result of soft law and government policies.

As mentioned above, the HSE has operational responsibility for managing the public health system, on the basis of the Health Act 2004.[101] The Mental Health Commission, another independent body set up by the Mental Health Act 2001, oversees mental health services.

As shown in section 2, most of the governance and direction for the implementation of the system is supported by a mix variety of soft-law and governmental policies.[102] As noted above, the actual vision of the healthcare system is now framed by a soft law document such as the *Sláintecare* Report,[103] and by the governmental plan *Sláintecare Implementation Strategy and Next Steps,* in which the Irish government identified strategic actions to translate into practice the *Sláintecare* long-term vision.[104] Those actions revolve around "strong health service governance, leadership, accountability, a focus on clear outcomes,

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[97] Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) L 119/1 Recital 89.
[98] http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html
[99] http://www.irishstatutebook.ie/eli/2014/act/15/
[100] S. MILLS and A. MULLIGAN, *Medical Law in Ireland* (Third edn, Dublin, Ireland, Bloomsbury Professional Ltd, 2017).
[101] The Health Service Executive (Governance) Act 2019 amends the Health Act 2004 by providing that the HSE shall be governed by a board and no longer by a directorate.
[102] The most comprehensive of which is the HSE's 'eHealth Strategy for Ireland' (2013). The Strategy sets out the processes for the transition of health care provision in Ireland to a more patient centred model through the use of emerging ICT.
[103] See above section 2 of this article.
[104] The strategy is available at <https://assets.gov.ie/9914/3b6c2faf7ba34bb1a0e854cfa3f9b5ea.pdf>

providing support to the frontline to drive change and sustained stakeholder engagement".[105] This Implementation Strategy also places at the core "the engagement of the public, which must continue to be the leading voice and influence in this reform process", and requires for the public to "be properly empowered to look after their own health and wellbeing and ultimately to hold the health service to account for the delivery of our ambitions".[106] In particular, in the most recent *Sláintecare* Action Plan 2019,[107] adopted on the basis of the Strategy, emphasis is placed on the participatory approach in co-designing the Irish health service. Attention is also placed on the development of eHealth, and on ensuring that relevant ICT infrastructure supports an integrated, patient-centred care and to deliver an "efficient, effective and collaborative care".

Separately, the Nursing and Midwifery Board of Ireland (NMBI) an independent, statutory organisation, regulates the nursing and midwifery professions.[108] The Medical Council (*Comhairle na nDochtuirí Leighis*) regulates the medical profession. It promotes high standards of professional conduct and professional education, training and competence among doctors. The independent public body 'Health Information and Quality Authority' (HIQA) is responsible for monitoring health and social care services in the state.[109]

4. Facilitating Smart and Healthy Ageing in Ireland: Is the Legal Framework Supportive of Integrated Care?

The current challenges that the healthcare system is facing, in particular, the quest of addressing the need of an ageing population, have prompted a new vision of integrated care in Ireland – a vision in which technology is front and centre and is a vital tool for elderly care. While Ireland is still lagging behind, innovative technology-centred health and care services were introduced with good success by Norway, Denmark, the Netherlands, and Germany.[110] These countries have shown that innovative eHealth technologies can assist in alleviating healthcare costs, whilst simultaneously improving healthcare services and products, as well as playing a pivotal role in supporting person-centred systems. Integrated health technologies are particularly suited to assisting older people's ability to live at comfortably at home independently while maintaining an active connection with the community. Donnelly recognises that technology can be used as a 'measure of reassurance' for family members or carers of older relatives

[105] Ibid. p. 11.
[106] Ibid. p.11.
[107] See at <https://assets.gov.ie/22606/4e13c790cf31463491c2e878212e3c29.pdf>
[108] The NMBI operates under the provisions of the Nurses and Midwives Act 2011.
[109] https://www.hiqa.ie/
[110] K. CULLEN, D. MCANANEY, C. DOLPHIN, S. DELANEY AND P STAPLETON, *Research on the provision of Assistive Technology in Ireland and other countries to support independent living across the life cycle* (2012) National Disability Authority. B. GANNON and B. DAVIN, *Use of formal and informal care services among older people in Ireland and France* (2010) 11(5) The *European Journal of Health Economics* 499.

knowing that certain AT is being used to monitor health, detecting falls and monitoring for dangers and providing memory aids.[111] Advocacy groups for older people and people with disabilities recognise that innovative technology-led solutions should be prioritised to support integrated care delivery.[112]

While certain forms of AT have the potential to improve an older person's ability to live independently longer, there are many reasons why an older person may reject the use of technology. Gitlin notes a rejection of technology maybe based on the person's perceived need for the technology, the functional status and ease, and the fit with the person and home environment.[113] More recent research indicates that the threat of invasion of privacy are additional concerns reported by older users of technology. Yusif *et al.* recognise that research is limited in understanding the extent of the ethical anxieties caused by an older person's perception of assistive and monitoring technologies.[114] Furthermore, this research indicates that privacy is now one of the critical concerns to older adults, alongside an older person's trust of the AT and its functionality.[115] In that regard, we contend that the rules on privacy and informed consent establish underpinning ethical principles for the fair and proportionate implementation of integrated health care. An invasion of privacy might still occur, for example when family members are using the AT to monitor older people with cognitive impairments, or where personal data is been used by the services providers or technology hosts unknowingly by the technology user.[116] However, the current legal framework might address these pitfalls.

A robust informed consent process is also needed to ensure that the older person has the capacity to provide his or her consent to use the AT within an integrated care context. When fully implemented, the Irish Assisted Decision-Making (Capacity) Act 2015 will provide the legal basis for providing and accepting decision-making where a person lacks capacity. The Act provides the legislative basis for respecting a person's past and present will and preferences.[117] For older people with cognitive impairment, such as dementia, it is imperative that the person is offered appropriate advance decision-making to alleviate informed consent issues that may arise when the person's health deteriorates.

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[111] M. DONNELLY, *Technology and Older People: The Importance of Privacy Rights* 2020 Irish Gerontological Society, 3 February 2020) <https://www.irishgerontology.com/news/blogs/technology-and-older-people-importance-privacy-rights> Accessed 1 January 2021.

[112] ENABLE IRELAND and DFI, *Assistive Technology for People with Disabilities and Older People. A Discussion Paper*. November 2016.

[113] L.N. GITLIN, *Why older people accept or reject assistive technology* (1995) 19(1) *Generations: Journal of the American Society on Aging* 41.

[114] S. YUSIF, J. SOAR AND A. HAFEEZ-BAIG, *Older people, assistive technologies, and the barriers to adoption: A systematic review* (2016) 94 *International Journal of Medical Informatics* 112.

[115] Ibid.

[116] Ibid.

[117] B.D. KELLY, *The Assisted Decision-Making (Capacity) Act 2015: what it is and why it matters* (2017) 186(2) *Irish Journal of Medical Science* 351.

To date, technology users are somewhat protected by Irish law, but the law does not go as far as ensuring an older person's right to available assistive technologies. As noted above, the *Sláintecare* implementing policies have in fact made a strong pivot on eHealth and ICT, but, in the same vein, do not facilitate the use of AT by older people. In line with the *Sláintecare* Report, the HSE has adopted a series of policies aimed at moving towards integrated care. In 2017, the "Making a start in Integrated Care for Older Persons" internal guide was adopted.[118] In recognition of the ageing population, the guide acknowledges that current health and care services need to transform from acute, episodic care to a coordinated and integrated care approach which reflects the complexity of care needs. This guide builds on previous plans aimed at reforming healthcare services for older people, namely, the "Government's Positive Ageing Strategy"[119] and the "National Clinical Programme for Older People Specialist Geriatric Services Acute Model of Care".[120] While referring to the importance of ICT and assistive technology, and highlighting the role of technology in the realization of integrated care, it has not yet engendered a change. *De facto* older persons who want to use AT are required to purchase and pay for their own products or services. Some older people will receive use of available AT provided by certain home care services packages or funded government academic projects. In that regard, we contend that a fairer distribution of accessible AT should be guaranteed and protected by a new legislative instrument, supplemented by soft law.

5. Concluding Remarks

Since March 2020, the outbreak of the Covid-19 pandemic has made even more evident than before the inherent inequalities of the two-tier public and private healthcare system in access to hospital care. Furthermore, the Covid-19 virus has disproportionately impacted on older people, in particular those living in congregated settings. The estimated case fatality rate for those over 80 years old averages at 18%.[121] Residential care facilities were extraordinarily subject to fatal outbreaks in Belgium, Spain, France and Ireland.[122] Over 55.2 of all Covid-19 related deaths during the first wave of the outbreak in Ireland

[118] This plan builds on the National Clinical Programme for Older People (NCPOP) introduced in 2010.
[119] Department of Health, 'The National Positive Ageing Strategy' (2013) <https://assets.gov.ie/11714/d859109de8984a50b9f2ae2c1f325456.pdf> Accessed 1 January 2021.
[120] Department of Health, 'National Clinical Programme for Older People' (2012). Note, this plan was revised and updated in 2016.
[121] R. MARTIN, Experience of COVID 19 Outbreaks in Residential Care Facilities' (*Irish Gerontological Society*, 28 May 2020) <https://www.irishgerontology.com/news/blogs/experience-covid-19-outbreaks-residential-care-facilities> Accessed 7 January 2021.
[122] Ibid. See also; Sciensano. Coronavirus Covid-19, Overall Epidemiological Situation 2020 [18 May 2020]. Available from: https://covid-19.sciensano.be/fr/covid-19-situation-epidemiologique; rtve.es. Coronavirus: Radiografía del coronavirus en residencias de ancianos: más de 17.200 fallecidos a falta de test generalizados 2020 [12 May 2020]. Available from: https://www.rtve.es/noticias/20200505/radiografia-del-coronavirus-reside and; Santé Publique France. Infection au nouveau Coronavirus (SARS-CoV-2), COVID-19, France et Monde 2020 [11 May 2020]. Available

were associated with residents of care facilities.[123] In that, the pandemic has showed the pressing need to overhaul and modernise the provision of healthcare services and to move decisively towards home care and community services.

Plans to move towards a more equal access to healthcare have been advanced under *Sláintecare*. In 2019, a review was completed examining private activity in public hospitals and plans are underway to require all future consultant employment appointments to be contracted for public work only. This is one of the most progressive steps introduced to dismantle the two-tier healthcare system. Additional financial supports have been put in place to support GP doctors, a significant proportion of which is set aside to assist GPs in managing chronic diseases.[124] From a governance point of view, a new HSE management board and a new HSE Chief Executive Officer position have been established, in order to advance the *Sláintecare* vision.

Furthermore, as discussed, facilitating integrated care and supporting eHealth for older people have been placed at the center of the *Sláintecare* Report and the subsequent policies. Since the HSE 2017 "Making a start in Integrated Care for Older Persons" internal guide was adopted,[125] there has been a slow move towards integrated care, which, nonetheless, remains in its infancy. In relation to the specific improvement of health and care services for older people, measures have been introduced to support the implementation of an 'Integrated Care Programme for Older People' (ICPOP). The ICPOP alongside the National Clinical Programme for Older People (NCPOP) is currently developing cohesive primary and secondary care services for older people, emphasising care for people with more complex needs.[126]

In such a context, one of the minor and very few positives to be realised from the outbreak of the Covid-19 pandemic is the acceleration in use of eHealth services, already at the core of *Sláintecare*. Since the outbreak began, there has been a remarkable increase in the use of phone or video medical consultations.[127] The Irish state should build on this acceleration to design and fully implement digital

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from: https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-et-infections-respiratoires/infection-a-coronavirus/articles/infection-au-nouveau-coronavirus-sars-cov-2-covid-19-france-et-monde#block-244210.

[123] Health Protection Surveillance Centre (HPSC). *Epidemiology of COVID-19 in Ireland: Report prepared by HPSC on 20 April 2020 for the National Public Health Emergency Team* (NPHET). <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/april2020/COVID19%20Epidemiology%20report%20for%20NPHET%2021.04.2020%20website.pdf> Accessed 6 January 2021.

[124] A €210 million investment (40% increase) in General Practice over the next four years of which €80 million will be available for the management of chronic diseases, like diabetes and COPD, through family doctors. This is expected to benefit more than 400,000 patients.

[125] This plan builds on the National Clinical Programme for Older People (NCPOP) introduced in 2010.

[126] Health Service Executive, 'Making a start in Integrated Care for Older Persons' (2017) <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/a-practical-guide-to-the-local-implementation-of-integrated-care-programmes-for-older-persons.pdf> Accessed 20 December 2020.

[127] N. REDMOND, M. COOKE AND M. MACLACHLAN, *The use of simple, innovative technology can improve the daily health and wellbeing of older people* (RTE Brainstorm, 21 October 2020)

integrated care policies for older people. Such policy initiatives on the integration of services, including digital services for older people, must involve all interested stakeholders such as health and care providers, including general practitioners, community health providers, private care providers, family carers and the users themselves. It must not be conducted in isolation to ensure that all stakeholders' voices are listened to and respected.[128] This may alleviate some of the concerns voiced by older people, and introduce an element of trust between the technology provider and user. Older people should be offered opportunities to improve their digital literacy so that they can easily navigate accessible technology. Notably, it has been shown that the involvement of users in the design process of AT for older people leads to design of more effective technologies. As the use of AT in older people's residential settings continues to grow, it seems timely to review the current integrated care system which was not originally designed to support gerontechnology. It should be reviewed in light of the ongoing privacy concerns, the desires and requirements of users, and of their individual care providers, aiming to provide a connected community link with GPs, hospitals, public health nurses, pharmacies and physiotherapists.

In recent years the Irish government have supported plans to introduce: Electronic Health Records (EHR), Individual Health Identifier (IHI), Primary Care IT, Cancer Care eHealth Programme, Open Data for Health, ePharmacy, Maternal and Newborn Clinical Management System, National Medical Laboratory Information System (MedLIS), NIMIS - National Integrated Medical Imaging System, and the Cloud First Policy.[129]Additionally, the Health Innovation Hub Ireland (HIHI) has been introduced to support collaboration between the health sector and the businesses to develop new solutions to resolve current healthcare challenges.[130] Ireland should build on these current highly technological developments to support the adoption of a specific AT new legislative instrument, supplemented by policies aimed at facilitating smart and healthy aging. However, in order to design and fully implement digital integrated care policies for older people, the Irish Assisted Decision-Making (Capacity) Act 2015 should be fully commenced and should be a cornerstone to respect a person's will and preferences.[131]

Civil society organizations such as Enable Ireland and Disability Federation Ireland (DFI) have already called for the state to introduce an "AT Passport" to act as a "connector for a comprehensive ecosystem

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<https://www.rte.ie/brainstorm/2020/1020/1172653-how-can-we-age-smarter-and-healthier/> Accessed 11 January 2021.

[128] C. GLENDINNING, *Breaking down barriers: integrating health and care services for older people in England* (2003) 65(2) *Health Policy* 139.

[129] Health Service Executive, 'eHealth Strategy for Ireland' (2013). <https://www.ehealthireland.ie/Knowledge-Information-Plan/eHealth-Strategy-for-Ireland.pdf> Accessed 1 December 2020.

[130] Health Innovation Hub Ireland, 'Healthcare' <https://hih.ie/innovation/healthcare/> Accessed 13 January 2021.

[131] B.D. KELLY, '*The Assisted Decision-Making (Capacity) Act 2015: what it is and why it matters*' (2017) 186(2) *Irish Journal of Medical Science* 351.

of supports".[132] Such a passport would articulate an older person with or without disabilities' technology needs, recording the AT usage, IT support needs and funding history. This passport could be in fact realised within the remit of the *Sláintecare* principles and values. DFI and Enable Ireland have also recommended that the government issue a cross-government policy statement that supports all citizens' right to access AT for any age, in circumstances where there is an identified need. To support the implementation of these recommendations, they suggest that a central coordinating agency with responsibility to manage a varied ecosystem of supports should be introduced.

On the whole, it seems timely for Ireland to introduce the relevant legal "infrastructure" needed to develop AT, but also to fund the technology, train the users and all stakeholders, and successfully support the new developments.

[132] ENABLE IRELAND and DFI. *Assistive Technology for People with Disabilities and Older People. A Discussion Paper*. November 2016.