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NATIONAL COUNCIL
FOR THE ELDERLY

THE ROLE AND FUTURE
DEVELOPMENT OF
NURSING HOMES
IN IRELAND

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NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on

- *measures to promote the health of the elderly,*
- *the implementation of the recommendations of the Report, The Years Ahead — A Policy for the Elderly,*
- *methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,*
- *ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,*
- *meeting the needs of the most vulnerable elderly,*
- *ways of encouraging positive attitudes to life after 65 years and the process of ageing,*
- *ways of encouraging greater participation by elderly people in the life of the community,*
- *models of good practice in the care of the elderly, and*
- *action, based on research, required to plan and develop services for the elderly*

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THE ROLE AND FUTURE DEVELOPMENT OF NURSING
HOMES IN IRELAND

THE ROLE AND FUTURE DEVELOPMENT OF NURSING HOMES IN IRELAND

By

Eamon O'Shea,

David Donnison

and Joe Larragy

with contributions by

John Blackwell and Mary Marshall



NATIONAL COUNCIL FOR THE ELDERLY
REPORT NO. 22

This Report has been prepared by Mr. Eamon O'Shea, Department of Economics, University College Galway, Professor David Donnison, Director of the Centre for Housing Research, University of Glasgow and Mr. Joe Larragy, Research Officer, National Council for the Elderly. Mr. John Blackwell, Department of Environmental Studies, University College Dublin (currently on leave to the OECD, Paris) and Professor Mary Marshall, Director of Dementia Services Development Centre, University of Stirling also contributed to the study

for

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Foreword

This study on the role and future development of nursing homes in Ireland is a further contribution by the National Council for the Elderly to the series of studies on institutional care services for the elderly begun by its predecessor, the National Council for the Aged.

Taking the *Community-* as its focus, the Council's 1985 study, *Institutional Care of the Elderly in Ireland* established the context in which the general hospital and other hospital and institutional care services can best support the community caring network in achieving its full potential. The role of assessment and the concept of the community hospital were outlined and the issues of registration and funding of nursing homes were addressed.

Two studies followed, *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector* and *"It's Our Home": The Quality of Life in Private and Voluntary Nursing Homes*, in 1986. These studies established the first profile of the structure and process of care in the private and voluntary sector as well as some of the perceptions of nursing home residents about the quality of care.

Together, these reports have contributed to the development of policy and legislation concerning nursing homes in recent years. Many of the recommendations in *The Years Ahead — A Policy for the Elderly* (1988) and some of the provisions of the *Health (Nursing Homes) Act, 1990* reflect the influence of these research reports.

The present study draws together theoretical insights and factual material on a range of relevant issues concerning the future of nursing homes. It sets out the factors likely to influence the future demand for and provision of nursing homes in Ireland. The study deals with the demographic, social, economic and policy variables which should be taken into consideration. Some of these are outside of our control, and predictions are difficult to make. What the study bears out, however, is the importance of policy in determining the future direction and role of nursing homes. For many years, the number of nursing home beds has been rising rapidly. This trend is not altogether desirable and presents a major policy challenge if the goals of community care are to be realised.

An important priority is to avoid inappropriate admissions to institutional care. The range of supports required to maintain the dignity and quality of life of the frail, at-risk or dependent elderly population in their own homes must be provided. On the other hand, when admission to nursing home care is required, we need to ensure that this dignity and quality of life continues to be safeguarded.

The National Council for the Elderly would like to thank the authors of the report. The principal researcher responsible was Mr. Eamon O'Shea, Department of Economics, University College Galway, who worked closely with Professor David Donnison, Director of Policy and Practice and Mr. Joe Larragy, Research Officer of the National Council for the Elderly. Contributions were also made by Mr. John Blackwell, University College Dublin, currently on leave to the OECD's Social Affairs Division, and Professor Mary Marshall, Director of the Dementia Services Development Centre, University of Stirling.

The Council wishes to acknowledge the special contribution of the members of its Consultative Committee established to advise on the preparation of the report. Mr. Michael Coote (Chairman), Dr. Rosaleen Corcoran, Ms. Angela Kerins, Ms. Frances Spillane and Mr. Joe Stanley.

The Council also expresses its thanks to Mr. Bob Carroll, Secretary to the Council, and to Mr. Joe Larragy, Research Officer, for their contribution to the Consultative Committee and to the project. Their assistance and that of staff members, Ms. Celine Kinsella and Ms. Paula Kennedy, in the production and publication of the report is gratefully acknowledged.

Lady Valerie Goulding
Chairman
National Council for the Elderly

July, 1991

Comments and Recommendations by the National Council for the Elderly

Introduction

Over the past 10 years Ireland has experienced a dramatic rise in the supply of nursing home beds which now comprise as many as 50 per cent of all long stay beds catering primarily for the dependent elderly population. Together with the statutory provision — in geriatric hospitals, welfare homes and long stay district hospital beds — they comprised, in 1988, an estimated 19,000 long stay beds in all.

The growth in nursing home care, has happened independently of any government plan or schedule. It has been largely generated by the private sector while both statutory and voluntary provision have levelled out or declined. It has been a relatively silent phenomenon with few adverse newspaper headlines to mark its progress. There has been a gradual realisation by statutory bodies of the need for new and better legislation, policy and practice, as outlined comprehensively in *The Years Ahead* report.'

The most significant response to date is the passing of the *Health (Nursing Homes) Act, 1990*. It broadens the scope of legislation to include voluntary as well as private nursing homes which had been exempted under the previous *Homes for Incapacitated Persons Act* of 1964. The 1990 Act also introduces a system of compulsory registration, clearer standards for the design, staffing and management of nursing homes, new proposals for the subvention of patient care by the health boards and a voluntary code of practice aimed at fostering good quality care and high ethical standards among providers.

Important as this legislation is, it is only one contributory factor in the elaboration of a comprehensive policy on the role and development of nursing homes in the future. It is to this broader question that the present study is addressed and, while work on the study has coincided with the passage of new legislation, the study's implications go far beyond what is enshrined in law. It should be noted, however, that the comments which follow, like the study itself, were compiled prior to the issuing of

guidelines on subventions under the Act. or the draft code of good practice.

Two previous studies commissioned by the National Council for the Elderly have surveyed nursing home care in Ireland in some detail.² The present study is a further contribution to the Council's work in this area. The study should be viewed in the light of the implementation of *The Years Ahead* report, published in October 1988. which outlines a comprehensive policy on the care of the frail or dependent elderly population, designed to take us into the next century. At the heart of the philosophy of *The Years Ahead* is the objective of enabling older people to continue to live in a community setting by developing alternatives to institutional accommodation and deploying relevant health and social services from bases as near as possible to the local community being served.

The role of all institutions, ranging from the high technology acute hospital to the relatively low-tech nursing home or welfare unit, must be defined more rigorously so that all can contribute to the maintenance of the dignity, quality of life and autonomy of the individual for as long as possible. Much as one may wish to avoid having to resort to institutional care, this is not always possible. Persons with high dependency levels requiring intensive nursing care, and even people with moderate or low dependency levels, may require admission to a hospital or home. This arises despite the reluctance of family carers to part from a frail or dependent spouse, parent, or other relative. Where no carers are available — as is frequently the case among a growing proportion of very elderly people living alone — there is a stronger likelihood of admission. Carers, however, remain the main support for the frail and incapacitated elderly. For every 10 elderly persons in long stay institutional care there are still some 35 being cared for at home by their families.

What is important is that nursing homes and other long stay institutions evolve in a way that does not undermine a good balance between community care and institutional care. Policy makers can determine that such a balance is maintained only by making sure that community care is a real choice for those who could benefit from it. In this context the study identifies some important guiding principles and policy options, which we now consider in turn.

1. Balancing Institutional and Community Care

The intrinsic limitations of institutions and the escalating costs of providing continuing care in such settings is — with increasing numbers of

very old elderly — of growing concern internationally) Some European countries such as Switzerland, Finland and the Netherlands are believed to be characterised by particularly high levels of institutionalisation.⁴ However, concern about the need to actively foster alternatives extends to countries, such as Britain, where the level is not particularly high. Research evidence from the latter suggests that many applications for residential care home places are made reluctantly, while the dependency levels of other people in homes suggest a degree of inappropriate placement. Expert opinion too testifies to the possibility of keeping more people in the community, given adequate resources, while experiments have demonstrated the potential of community based alternatives⁵ Meanwhile, in Britain, the amount of money paid in income support (formerly, Supplementary Benefit) rose from £10 million to £1 billion between 1979 and 1989, reflecting the growing overall cost of private nursing home provision.⁶

As in these countries, the concept of community care of the elderly is well established in the minds of policy makers, planners and providers in Ireland, at least since the publication of the *Care of the Aged* report in 1968. However, it is not always recognised that to make a reality of community care it is essential to supply formal community based services to an adequate level. This is the key to making it possible for many frail or dependent elderly people to retain the option of remaining in a community setting. While community care may prove cheaper than hospitals or homes in the long run, the absence of some of the range of essential services in the community could trigger inappropriate admissions to long stay institutional care.

It is also apparent from the rapid growth in the supply of private nursing homes, and the pressure to keep beds filled, that the private sector is more inclined to provide institutional than community care. Unless policy is developed to stimulate the supply of community care services there may be a tendency towards inappropriate institutional provision by the private sector due to supply side pressures. Thus, reduced statutory institutional care might translate into increased private care instead of into community care.

If they are to be at all effective as an alternative type of care, community care services, unlike institutional care services, require deliberate co-ordination of effort between agencies in the statutory, voluntary and informal sectors. Unless, therefore, mechanisms exist for co-ordinating effort at local level which have the backing of the key government departments (Health, Environment and Social Welfare, in particular) the onus may fall on the frail or dependent individual, a relative, a volunteer or a professional, to find a solution when a problem occurs.

In such circumstances there may be a tendency to resort to institutional care by default before adequate consideration of the alternatives.

We therefore recommend that services in the community be provided to a level and standard sufficient to offer a genuine alternative to institutional care for cases where this is appropriate. We also recommend that the model for co-ordination of services for the elderly, as outlined in The Years Ahead, be applied and developed creatively at district level. In this regard, local co-operation between agencies should be facilitated by a willingness at interdepartmental level to promote collaborative planning in the provision of housing, income maintenance, health and personal social services in the community.

The shift towards community care implies an important role for carers outside the formal sector. But there are considerable pressures — economic, social and emotional — on carers who, all too frequently, are viewed as a substitute for formal services, rather than as a complementary source of care. Similarly, the good will of the voluntary sector can be taken for granted as a cheap substitute for the provision of a comprehensive and professional community care service.

The National Council for the Elderly, therefore, reiterates the importance of improving financial aid and providing service supports for carers in the community. *Specifically it recommends broadening the eligibility criteria for the carer's allowance, and increasing provision of day care and respite care centres.*

The Council has already recommended that consideration be given to the introduction of a constant care allowance which would be payable in cases where full time care is required, regardless of means.⁷ It is now recommended that consideration be given to this proposal in the context of creating alternatives to institutional care.

In relation to the voluntary sector which has a significant role to play in the provision of community care services, the National Council for the Elderly recommends that health boards devote resources and staff to the development of voluntary activity, and that health boards and local authorities foster genuine partnership with voluntary agencies through consultation and good practice in relation to funding.

2. Subverting Community and Institutional Care Equally

Apart from the supply and co-ordination of community services by statutory agencies, there ought to be a method of stimulating more community based alternatives to care in nursing homes or hospitals. The present system of subventing care in nursing homes, for instance, has

evolved independently of the planning of other services, particularly services in the community. There is, to illustrate this, no direct community care counterpart to the subvention of nursing home care by health boards.

We recommend that, in principle, there should be a review of policy in this connection. If a person of given means and dependency could benefit more by being looked after at home or in the community than in a nursing home the same amount of statutory subvention and/or services should be made available as is provided in relation to nursing home care.

Within this perspective, mechanisms for the allocation of subvention and the payment of service providers in the community (who might be from any sector — voluntary, statutory or private) need to be developed. The study refers to the Kent and Darlington experiments in *Case Management* by social workers who receive a budget per case to be allocated in the most appropriate way towards a package of continuing care services. The budget is defined and constrained with reference to the cost of equivalent levels of care in a residential or nursing home.⁸

We recommend that the Department of Health re-examine existing practices and policy with a view to identifying imbalances in the incentive structure surrounding community and institutional care. We also recommend that suitable mechanisms be devised and piloted, with a view to delivering the optimal package of services in every case following the example of Kent community care experiments in case management.

3. Assessment of Dependency

The study highlights the importance of dependency measures in determining the care needs and, consequently, the cost of providing appropriate care. It suggests that as dependency increases there comes a point where the marginal net benefit of providing community based care falls below that of institutional care. The authors warn that in particular cases the identification of such a crossover point is not an exact science. Nevertheless, the concept of dependency should be central to the development of assessment services. The social and psychological circumstances of a person could affect decisions about the appropriateness of the institutional care option — even in cases where dependency level alone might predict otherwise. *Despite problems of measurement we recommend that the assessment of dependency should become a pivotal part of the process of referral to institutional care, rehabilitation or community care.*

Assessment of dependency and medical assessment for symptoms of

illness have not been carried out universally in the past. This is partly because institutions such as county homes (now geriatric hospitals) were often perceived as welfare accommodation for a mixture of socially-isolated individuals. Secondly, in the case of private or voluntary nursing homes, the statutory agencies play no role in the admission process at all, unless called upon to provide subvention. Even now, applications for subvention are frequently made only after admission to a nursing home — when it is often too late to consider the alternative of community care.

In *The Years Ahead* report it is stated that no elderly person should be admitted to a (state funded) long-stay bed without an assessment by the specialist or district geriatric team.⁹ Later, in discussing nursing homes, it is recommended that no subvention should be given until the person is recommended for admission by a district team or geriatrician.¹⁰

The National Council for the Elderly supports these recommendations and the emphasis on the role of general practitioners in the ongoing tasks of case-finding and anticipatory care of the elderly at risk. It should also be stressed, however, that the GP has a vital part to play in relation to assessment, rehabilitation and continuing care.

In addition to the assessment of dependency, the housing and family circumstances and emotional state of the person should be established before any long-term decisions are arrived at. Here the role of the general practitioner, the public health nurse, and, where possible, the social worker, can make the difference in identifying the best care option. The non-availability of a carer or the need for constant supervision might still imply admission to institutional care even though physical dependency might not be very marked.

We wish to emphasise the importance of staff and facilities in the area of assessment and rehabilitation. We are particularly concerned that the acknowledged gaps in provision — specifically the needs to develop a network of community hospitals and to expand the number of specialist geriatricians and geriatric departments in general hospitals — be overcome.

Furthermore, we are conscious of the need to ensure access to the best available medical, diagnostic and therapeutic services for all elderly people in need. We therefore wish to highlight the cautionary statement in *The Years Ahead* report to the effect that community hospitals are not meant to act as a substitute for the provision of specialist units in general hospitals but are to be complementary to them.¹¹

Moreover, the organisation of community hospitals must be such as to

integrate the services of the key professionals — the general practitioner, the district liaison nurse and other district team members, and the geriatrician. Care should be taken to ensure that older people assessed in institutions other than in a general hospital are not discriminated against by limiting the range of options open to them, as might be the case were it to become the norm that they must always be referred to a community hospital for assessment.

The establishment of district teams and the appointment of community physicians as co-ordinators of services for the elderly (for a number of such districts) will be crucial to the integration of these services and their co-ordination with other statutory services and voluntary agencies.

Finally, we feel that there is a case for making an assessment service available prior to all nursing home admissions, not merely where an application for a statutory subvention is made by a person or relatives. This is so partly because there may be cases where the "free choice" exercised by private nursing home residents paying fees entirely from out of their own pocket is constrained by the limitations of the services available. It is a fact that while nursing home provision has grown rapidly, there has been little equivalent growth in private care at home or in the community. An assessment in these instances would help to establish what is the most appropriate care and might stimulate the development of the community care option across the social spectrum. In addition, providing a medical and social assessment, regardless of circumstances, is supported on the grounds (a) that needless and costly nursing home care may be avoided in some instances and (b) that a person who does not apply for a subvention on entering a nursing home may do so at a later date if his/her circumstances change.

The Sational Council for the Elderly recommends that the assessment and rehabilitation service be developed and adequately resourced.

We recommend that the complement of departments and specialists in geriatric medicine be increased in line with the norm outlined in The Years Ahead (one physician per 80,000 of the general population) and that access to assessment and rehabilitation in these departments be provided for persons who require it.

We recommend that a network of community hospitals be established, from existing bases if possible (such as geriatric hospitals and district hospitals) and from new bases if necessary. The community hospital should provide assessment, rehabilitation and continuing care services in close liaison with a specialist physician in a department of geriatric medicine, and ensure ongoing consultation with general practitioners in their catchment area.

We also recommend that through the district geriatric team a multi-disciplinary approach be adopted, assessing not only physical dependency but also housing circumstances, psychological condition and social support networks.

We recommend the appointment of community physicians as co-ordinators of services for the elderly with responsibility for ensuring close co-operation between health board services and other statutory and voluntary-agencies.

We recommend, in addition, that staffed psychogeriatric facilities in selected general hospitals be developed as a critical component of this overall service.

4. The Quality of Public and Private Long Stay Care

Legislation now lays down minimum standards for nursing homes and will seek the development of ethical conduct, through voluntary compliance with a code of practice drafted by the Department of Health in consultation with other interested parties. Can it be assumed that health board long stay institutions, which are not subject to regulation under the *Health (Nursing Homes) Act, 1990*, will provide a comparable level of care to that provided by the private and voluntary homes governed by the Act?

There may be a danger that a two-tier system will emerge if the statutory authorities provide only for the lowest income groups in relatively spartan conditions while the private and voluntary sectors offer care and facilities above the statutory minimum to fee paying consumers. Differences in the method of statutory subvention towards care in each sector would tend to increase the two-tier nature of the system (see below). The study therefore argues that all long stay institutions, whether in the public, voluntary or private sector, should meet equally rigorous standards of care.

The Council supports the raising of standards throughout the long stay sector and shares the authors' view that policy should bring all such accommodation above a socially acceptable standard. Such upgrading of standards across the whole long stay sector — to the point where health board geriatric hospitals and homes may be considered close substitutes for nursing homes — should occur in conjunction with the direct provision by the health boards of additional assessment facilities, community hospitals, psychogeriatric facilities or other special centres, where appropriate. Where a health board geriatric hospital is a nursing

home in all but name, its standards should be directly comparable with those of the private and voluntary sectors.

We recommend that Department policy should ensure that there is no distinction in minimum quality or standards between nursing homes and those public institutions which provide long stay care for the elderly.

Inspection services operating in the nursing home sector should have a clear counterpart in the public sector and sufficient resources and training should be provided for the inspection service.

5. Subvention of Care

The study addresses the choices for funding long-term care of the dependent elderly population. At present, various difficulties arise due to the uneven and incremental way that funding policy has evolved. Broadly speaking, there is one system for funding the cost of care in health board units — geriatric long stay hospitals and welfare homes (and some grant aided voluntary equivalents) — while other subvention mechanisms operate in relation to private or voluntary nursing homes. The former system is largely a publicly funded one with a top-up private contribution consisting of most of the person's old age pension. Care in the private (and voluntary) sector is essentially funded from out-of-pocket payments by the individual, with the possibility of a small subvention from a health board. If we exclude certain homes approved by the Minister (Section 54),¹² this subvention is paid selectively on the basis of the person's assessed means and assets, and often with the proviso of a family contribution.

Under the new legislation, subvention anomalies (such as the approval of certain homes by the Minister under Section 54 of the 1970 Act) will be removed. In future a uniform system of subvention will apply. It will be determined on the basis of an assessment of patients' means and assets: assessed dependency will also be taken account of so that, in future, a graded subvention will be paid.

Within such a system there are choices to be made, or questions to be asked, about *comprehensiveness*, *efficiency* and *fairness*. We need to ask if such a system can operate consistently between eight different health boards. Given the complexity of assessment — not just of personal income and assets but of the potential contribution from relatives — there is the possibility of *ad hoc* practices emerging, with varying interpretations from case to case. There may be a danger of undesirable intrusiveness or increased bureaucracy as the administrative task increases.

The study outlines one approach to the problems of means testing for subvention purposes. This approach utilises the three health eligibility categories in operation prior to June 1991 to determine the extent of subvention given. Account is also taken of assets (e.g., house ownership) in the form of a posthumous deductible. The intention is to simplify the system and render it consistent and uniform across regions. (See Chapter 6.).

The Council has considered this model in detail and concluded that with the proposed abolition of Category III — which has been confirmed since the study was completed — it would be preferable to consider all persons not in possession of a medical card in the same way. Thus, we propose that an assessment of means, social circumstances and dependency should determine the level of subvention paid in these instances. While the degree of subvention would be decided case by case in each health board area there should be published guidelines available to inform people of their entitlements under the scheme. In this respect, the Council's recommendations depart from the model favoured in the report.

We recommend, in the context of the 1990 legislation, that the assessment of means, assets and dependency should be based on clearly understood comprehensive, fair and consistent criteria.

We recommend that thresholds and subventions be set at a level sufficient to enable all people with limited means to obtain the continuing care they need.

We recommend that persons covered by a medical card receive full subvention of the cost of care, less a contribution from their pensions with allowance for a retrospective deduction from their estate after the death of the person and spouse.

For all other persons, we recommend that there should be appropriate subvention taking account of means, social circumstances and dependency. Clear guidelines for the assessment of means should be published.

In view of the complexity of means testing in this context we recommend that the operation of the system of subvention be monitored and evaluated by an independent agency on behalf of the Department for a limited period.

Finally, in the context of harmonising standards upwards in all sectors,

we recommend that the same criteria for subvention of care operate in each sector — statutory and non-statutory.

6. Social Insurance for Continuing Care: The Long-Term Solution

There were widely acknowledged drawbacks in the funding practices in operation prior to the implementation of the 1990 Act. but the system now envisaged will retain some fundamental problems. It is not just the issue of how to test means, assets and other resources that is at issue but the reliance on private out-of-pocket methods of funding long term care in the first instance. Currently, the use of tax revenue to fund subvention — and the arrangement of subvention through the health boards — is, along with tax relief, merely supplementary to an essentially privately funded approach. Moreover, it is in no sense a comprehensive method of funding and can play little part in developing real choices for the care of the dependent elderly.

Even at today's level of demand, the total cost of care in all types of long stay unit probably amounts to upwards of £200m.¹³ Costs are also likely to increase in consequence of the new legislation and stricter standards. This will increase the fees to be met from private resources and the subvention to be paid by health boards. With increasing numbers of very old elderly the increased cost can be expected to further expose the weaknesses of existing funding mechanisms. Between 1986 and 2011, the number of people aged 85 or older will increase by 55 per cent, according to the CSO, while the number aged 65 or over will rise by 14 percent.¹⁴

The study, therefore, outlines a case for developing a system of funding of long-term care based on the principles of social insurance. The Council is particularly supportive of this approach which is more in keeping with the philosophy outlined in *The Years Ahead* report, in seeking to ensure a comprehensive service for the physically dependent or mentally frail elderly.

A social insurance scheme covering the eventuality of long-term illness or disability and the care requirements ensuing from them would spread the cost of care across the whole insured population and across generations. Implicitly it involves a relationship of trust, mutual support and inter-generational solidarity.

Incapacity at any age is impossible to predict. Even among the elderly population only a minority will require long-term care. Social insurance cover would, by spreading the costs of care, remove the onus on each

individual to be "self-insured" against what — for the individual — are unpredictable events and possibly extremely high costs.

Currently the Department of Social Welfare and the National Pensions Board are considering the options for developing the pensions system. One important option must be the provision of cover for the risks attendant on increasing numbers of people reaching very old age. In this context the operation of social insurance could cover the cost of providing a package of care services in the community as well as covering continuing care in a nursing home or hospital. Such an emphasis on comprehensiveness and flexibility is currently absent due to the necessarily *ad hoc* nature of the individual and statutory response to the onset of dependency. Under an insurance system the state would be enabled to negotiate with care suppliers on behalf of everyone, much as it does in relation to PRSI dental and optical benefits. In each case the first principle would be to fund a package of services determined on the basis of appropriate responses to individual need.

The development of a long-term approach based on social insurance is not incompatible with the provision of private insurance against similar eventualities. Such private provision would open an avenue to further choice for those who want or can afford it. It is not unlikely that such private insurance policies may come on the market, as the study points out. Indeed the fact that such commercial insurance policies are directly being considered by certain income groups suggests that social insurance against such risks would be appealing for a wider population with a lower average income.

Additional possibilities, following the introduction of a long-term care social insurance scheme might include the phasing out of existing tax relief on private nursing home fees and bring about a more equitable approach to funding generally. Apart from offering the possibility of more comprehensive funding for continuing care, the proposal for social insurance could simplify the process from the point of view of the health boards by reducing their administrative burden and improving consistency. The health boards would be able to concentrate more fully on the planning and organisation of service provision and ensuring that each person receives an appropriate package of care and services while the question of funding individual cases would fall under social welfare.

The Council recommends that, in the long run, funding by means of social insurance offers the most rational possibility for a comprehensive, flexible and equitable continuing care service for the dependent elderly-population, and recommends that options for such a policy should be examined by the Department of Health in conjunction with the Department

of Social Welfare and the National Pensions Board, and through the commissioning of an independent study on the subject.

Conclusion and Summary of Council Recommendations

We have concentrated our comments on the principal conclusions of the study — those which we believe should become the focus of a general policy review. The report contains more detailed discussion and proposals concerning policy, practice and issues for further analysis to which the Council refers the reader. These issues are reviewed and summarised by the authors in an Introduction and Summary chapter and in Chapter 7 of the report.

The key recommendations of the National Council for the Elderly are summarised below:

- 1. We recommend that services in the community be provided to a level and standard sufficient to offer a genuine alternative to institutional care for cases where this is appropriate. We also recommend that the model for co-ordination of services for the elderly, as outlined in The Years Ahead report, be applied and developed creatively at district level.*
- 2. Specifically we recommend broadening the eligibility criteria for the carer's allowance, and increasing the provision of day care and respite care centres.*
- 3. We recommend that (further) consideration be given by the Department of Health to the introduction of a constant care attendance allowance for those caring on a full time basis, regardless of their means.*
- 4. In relation to the voluntary sector, which has a significant role to play in the provision of community care services, the National Council for the Elderly recommends that health boards devote resources and staff to the development of voluntary activity, and that health boards and local authorities foster genuine partnership with voluntary agencies through consultation and good practice in relation to funding.*
- 5. We recommend that, in principle, there should be a review of policy underlying subvention. If a person of given means and dependency could benefit more by being looked after at home or in the community than in a nursing home the same amount of statutory subvention and/or services should be made available as is provided in relation to nursing home care.*

6. *We recommend that the Department of Health re-examine existing practices and policy with a view to identifying imbalances in the incentive structure surrounding community and institutional care. We also recommend that suitable mechanisms be devised and piloted, with a view to delivering the optimal package of services in every case following the example of Kent community care experiments in case management.*
7. *Despite problems of measurement we recommend that the assessment of dependency should become a pivotal part of the process of referral to institutional care, rehabilitation or community care.*
8. *We recommend that the assessment and rehabilitation services be developed and adequately resourced.*
9. *We recommend that the complement of departments and specialists in geriatric medicine be increased in line with the norm outlined in The Years Ahead (one physician per 80,000 of the general population) and that access to assessment and rehabilitation in these departments be provided for persons who require it.*
10. *We recommend that a network of community hospitals be established, from existing bases if possible (such as geriatric hospitals and district hospitals) and from new bases if necessary. The community hospital should provide assessment, rehabilitation and continuing care services in close liaison with a specialist physician in a department of geriatric medicine, and ensure ongoing consultation with general practitioners in their catchment area.*
11. *We also recommend that through the district geriatric team a multi-disciplinary approach be adopted, assessing not only physical dependency but also housing circumstances, psychological condition and social support networks.*
12. *We recommend the appointment of community physicians as co-ordinators of services for the elderly with responsibility for ensuring close co-operation between health board sendees and other statutory and voluntary agencies in each area.*
13. *We recommend, in addition, that staffed psychogeriatric facilities in selected general hospitals be developed as a critical component of this overall service.*
14. *We recommend that Department policy should ensure that there is no distinction in minimum quality or standards between nursing homes and those public institutions which provide long stay care for the elderly.*

15. *Inspection services operating in the nursing home sector should have a clear counterpart in the public sector and sufficient resources and training should be provided for the inspection service.*
16. *We recommend, in the context of the 1990 legislation, that the assessment of means, assets and dependency should be based on clearly understood comprehensive, fair and consistent criteria.*
17. *We recommend that thresholds and subventions be set at a level sufficient to enable all people with limited means to obtain the continuing care they need.*
18. *We recommend that persons covered by a medical card receive full subvention of the cost of care, less a contribution from their pensions with allowance for a retrospective deduction from their estate after the death of the person and spouse.*
19. *For all other persons, we recommend that there should be appropriate subvention taking account of means, social circumstances and dependency. Clear guidelines for the assessment of means should be published.*
20. *In view of the complexity of means testing in this context we recommend that the operation of the system of subvention be monitored and evaluated by an independent agency on behalf of the Department for a limited period.*
21. *In the context of harmonising standards upwards in all sectors, we recommend that the same criteria for subvention of care operate in each sector — statutory and non-statutory.*
22. *The Council recommends that, in the long run, funding by means of social insurance offers the most rational possibility for a comprehensive, flexible and equitable continuing care service for the dependent elderly population and recommends that options for such a policy should be examined by the Department of Health in conjunction with the Department of Social Welfare and the National Pensions Board, and through the commissioning of an independent study on the subject.*

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- ⁶ Will Hatchett: "Inside Private Care Homes — Boom or Bust", in *Community Care*. 26 July. 1990.
- ⁷ National Council for the Aged. *Caring For The Elderly: Part II. The Caring Process — A Study of Carers in the Home*. 1988. P. 13-14
- ⁸ The Kent Community Care Project was a pilot study which compared the level of institutional admissions, cost-effectiveness and quality of outcome for an experimental group of elderly people — for whom case managers bought services in the community — and a control group without case managers. The project confirmed the expected advantages of case management.
- ⁹ *The Years Ahead, op.cit.*. p. 137
- ¹⁰ *Ibid*. pp. 145-6.
- ¹¹ *Ibid*, p 137.
- ¹² Under Section 54 of the *Health Act (1970)* the Minister for Health may approve the provision of in-patient services in non-health board hospitals or homes. The Health Board is then required to make the "prescribed payment" towards such care.
- ¹³ For example. 19,000 beds @ £200 per week x 52 = £197.6 m.
- ¹⁴ Central Statistics Office: *Population and Labour Force Projections*. 1988. p. 48.

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Introduction and Summary

INTRODUCTION

This study was commissioned by the National Council for the Elderly. It is concerned with incapacitated and dependent people living in voluntary and private nursing homes which are subsidised or licensed by the State. Its purposes are to explore and report on:

- current and probable future trends in the needs and demands for nursing home care in Ireland;
- the supply of care required, paying particular attention to the role of private and voluntary nursing homes;
- the relationship between the services provided by these homes and other services which incapacitated and elderly people may need; and
- the role of the State in this field, making recommendations about future policy and practice.

Although no fresh survey was made of incapacitated and dependent people, the researchers have drawn on existing sources to gain an understanding of the way in which they and those who care for them perceive their own needs, and to bear those feelings in mind when framing recommendations for the future. While most of the discussion will focus on the dependent elderly, it should be borne in mind that dependency extends to the non-elderly population too.

This opening statement is presented in four sections dealing with:

- I. The policy environment in which the study was launched.
- II. The Report's main findings, presented in two parts dealing with:
 - (1) needs and demands for nursing home care, and
 - (2) the supply of care.
- III. The Report's main recommendations, presented in three parts dealing with:
 - (1) principles and priorities,
 - (2) financing implications, and
 - (3) the management and development of the system.

IV. The changing culture affecting care of the elderly and public expectations of the State — a brief postscript.

I THE POLICY ENVIRONMENT

The study was timed to coincide with the introduction and implementation of the Health (Nursing Homes) Act of 1990. It follows *The Care of the Aged* report of 1968. *The Years Ahead*, Report of the Working Party on Services for the Elderly (1988) and the *Report of the Commission on Health Funding* (1989), and makes a further contribution to the discussion which they launched.

In Ireland, as in many other countries, private nursing homes have spread rapidly in recent years. They were supported initially by an increasing flow of public funds which was abruptly checked a few years ago. The moratorium imposed then was always intended to be temporary — providing a breathing space for a reappraisal of policy. It has, however, created a pattern which varies from place to place, from home to home, and from one resident to another, following no consistent principles. There has been no effective coordination between the three sectors of residential care provided by the State, the voluntary organisations and private enterprise, nor between their services and those which help people living at home. Standards of care vary greatly and no authority has had sufficient powers to inspect or regulate what goes on.

The Report of the Working Party on Services for the Elderly¹ formed the basis for future policy with respect to the care of old people in Ireland. This report helped to consolidate the movement towards community care begun twenty years earlier by *The Care of the Aged* report but it had to recognise the constraints on public expenditure imposed by the new economic environment. There was now less money to spend on the care of the elderly. To make better use of existing resources and to support the expansion of community care services so that a greater number of people could be maintained in dignity and independence at home. *The Years Ahead* report proposed major changes in policy. Additional resources were proposed for community care services, especially home helps, paramedical care and respite facilities. A rationalisation of residential services was also suggested with the main emphasis placed on the development of community hospitals. Within that framework it was recommended that all subvented admissions to long-stay beds should be subject to prior assessment. In addition, it was proposed that the number

¹Hereafter referred to as *The Years Ahead*.

of day hospitals should be expanded, thereby allowing elderly people to remain in their own homes for as long as possible.

A major new departure was the inclusion of recommendations for the development of the private and voluntary sector. *The Years Ahead* considered that there are many advantages in having a mix of public, private and voluntary beds for the care of the dependent elderly, not least being the provision of extended choice for those eligible for services. To ensure consistent admission procedures in the different sectors, facilities for assessment should exist for all regulated homes and institutions. Furthermore, elderly persons receiving a subsidy towards their care in private and voluntary nursing homes should have available to them all the services provided for those people in public long-stay institutions. Health boards have a responsibility to ensure that all eligible elderly persons receive adequate medical, nursing, dental, and paramedical services when the need arises. To achieve this objective the proposed Co-ordinator of Services for the Elderly is required to establish liaison arrangements with the nursing homes operating in each community care area. In another Report, the Commission on Health Funding (1989)² supported the closer integration of public and nursing home care for elderly persons. In their view all registered nursing homes should be approved for the provision of services on behalf of (their proposed) Health Services Executive Authority, subject to regular inspection and monitoring of standards. In addition to subsidised care in nursing homes, health boards might also arrange directly for the use of fully subvented contract beds in the private and voluntary sectors, where sufficient accommodation is not available in health board institutions for those in need of places.

The recommendations contained in *The Years Ahead* report *vis-a-vis* the nursing home sector have had an influence on the new legislation in this area, particularly relating to subvention arrangements and the assessment of elderly people prior to admission to long-stay beds. There had been much dissatisfaction with previous arrangements. Registration rather than licensing will, however, be the regulatory instrument of government. To qualify for registration, homes will have to meet regulatory and inspection requirements dealing specifically with the process of care. Under the new regulations the current anomaly of approved and non-approved beds will end. Instead, elderly persons who meet income and dependency requirements will be eligible for subvention from a health board. There will be a tiered rate of subvention. The health board will be able to match the subvention to the individual's

²Hereafter referred to as the Commission.

dependency and income. The proposal with respect to dependency is that there would be payments for three categories — light, moderate and heavy (elderly persons with senile dementia would be classified as heavily dependent). A small number of voluntary homes will continue to be exempt from the new regulations. These are homes operated otherwise than for profit which meet the requirements laid down in Section 2 of the Health (Nursing Homes) Act, 1990.

There has been no support in this country for a major shift in financing arrangements for care of the elderly. General taxation is, therefore, likely to continue as the main source of funding for public care and for subvented nursing home care. The Commission's majority report provides no support for a universal social insurance scheme as a means of financing health care. A majority of the Commission favour the retention of general taxation as a means of funding all health services (including long-term care) with a small residual role for private insurance. Although a minority of the Commission supported a social insurance scheme, their position was rejected as too costly to establish separately and offering no real advantages over general taxation. While acknowledging the majority view of the Commission, a strong case is made in this report for the advantages associated with social insurance as a means of financing long-term care. From a pragmatic point of view, however, the policy recommendations contained in this study assume that long-stay care will continue to be financed mainly out of general taxation.

The main questions arising in this policy environment can be briefly summarised. Firstly, there are dilemmas about the balance between different forms of care for elderly persons. At either end of the caring continuum they can be looked after at home or in long-stay institutions. In between there are many other options of which nursing home care is but one. However, very little is known about this continuum. Much of the work that has been done has focused on the cost effectiveness of public care. No wide ranging attempt has been made, in this country at least, to evaluate the outcomes associated with different forms of care. This must change if a more efficient resource allocation mechanism is to be put in place.

Secondly, the measurement of dependency is difficult. There is no agreement on the most appropriate measures to use in care of the elderly. The choice depends on the objectives for which the measure is used. What is known, however, is that uni-dimensional measures of dependency are of little use in deciding on the placement of elderly persons. In most cases a measurement for physical disability is available for elderly persons. Less obvious, but equally important, are the social

conditions in which elderly persons live. Most recent evidence suggests that living alone and bad housing conditions are important factors affecting the decision to transfer an elderly person into institutional care. Factors such as these must, therefore, be taken into account in any general assessment procedures used to determine admission to long-stay care.

Thirdly, we have no information in this country on the relative cost effectiveness of care between the public and private sectors. There is a suggestion in the international literature that the private sector is less costly. The reason seems to lie with lower labour costs per member of staff. Even if these results could be extrapolated for Ireland there is no guarantee that more services could be provided from the available funding if much greater use was made of the private sector. If such a transfer was to take place the marginal cost of private care might increase substantially. As Culver *et al.* (1988) remind us, static comparisons are likely to be poor predictors of the consequence of radical change.

Information about costs is only half the equation. The quality and outcome of care must also be considered. Otherwise the issue becomes one of accounting practice rather than health care performance. But it is very difficult to devise meaningful indices of quality and outcome against which performance can be assessed. For the moment no such universal measures exist, although experiments are being made which may be helpful in the near future.

Meanwhile, major social and economic developments are taking place which are generating new and growing needs, modifying the resources available to meet them and changing the culture which shapes Ireland's response to the frail and the elderly.

II MAIN FINDINGS

(1) Trends in needs and demands

Demographic changes are the main factor affecting needs for nursing home care. The numbers aged 65 or more are expected to increase by 14 per cent during the 25 years after 1986. But it is those aged 85 or more who are most likely to be in nursing homes, and they are expected to increase by 55 per cent during the same period. These needs have to be met in particular places, and at that scale even more dramatic changes are to be seen. In the West and North West regions, which currently have the largest proportions of old people, the number of old people will decline, proportionately and absolutely. But in the Eastern region they are expected to rise by 31 per cent. Dementia, which makes

particularly heavy demands on carers and strikes the oldest people most severely, is bound to increase substantially.

One of the practical difficulties in studies on the likely future development of nursing homes is the distinction between need and demand. Some people demand care but do not need it. Others need care, but do not demand it. Where public subsidy is involved every effort must be made to distinguish between these two concepts. Hence the importance of pre-admission assessment before any subvention is made.

There is also the issue of whether elderly persons are truly sovereign in taking the decision to enter a nursing home. Very often they are not involved in the decision-making process at all. Instead it is the family, sometimes on the advice of health care professionals, who make demands as agents on their behalf. This has implications for the study of demand, the major one being that factors likely to influence family behaviour must also be taken into account. Among these factors are the likely effects of public policy changes. Of equal demographic importance is the likely trend in the number of carers available to look after elderly people in their own homes. An important factor here is the labour force participation rate of women. Participation rates for women, currently much below European levels, are likely to increase over the next 20 years. The significance of this for caring patterns does depend, however, on the future mix of full and part-time options available in the economy. Moreover, if participation does increase, household incomes will rise, enabling some people to buy more care. The result may be more, not less, care in the community. In the long-term, however, it is likely that the demand for nursing home care will rise along with household incomes and the number of women in paid work.

The 1980s was a decade of income improvement for elderly persons. Pensions rose in real terms and the risk of poverty was substantially reduced, although still significant for a minority of elderly persons. The future is likely to see a further increase in incomes as elderly persons reap the reward of occupational pension schemes. This increase in income, however, is not thought likely to be significant enough to bring about dramatic changes in the demand for private nursing home care.

The future evolution of household and family income and its effect on the demand for nursing home care is difficult to predict. What is known is that at a time during the 1980s when the growth of personal incomes was low, and negative in some years, the demand for private care was buoyant. The medium term prediction (over five years) is for personal incomes to climb strongly and economic growth to continue. But past

experience suggests that this is unlikely to have a major impact on demand.

Elderly home owners may be income poor yet rich in assets. There are home annuity and remortgaging schemes available, though not yet in this country, which seek to improve the income of elderly people in this position by allowing them to draw down on their assets. Most old people in Ireland are outright owners of their houses and consequently could benefit if such schemes were introduced here. The extent to which the funds released would cover a very long term stay in nursing home care is, however, open to question, given the gap between public subsidisation and nursing home charges. Such schemes may in fact have as much potential for keeping people at home as for financing costly stays in nursing homes. If such schemes are introduced, great care should be taken to ensure that the elderly person is protected from misleading advertising by financial institutions. Alternative and independent information should always be available to counteract the (naturally) self-interested advice given by the sellers of such policies.

While acknowledging the potential benefits of home annuity schemes it is not our view that elderly persons should have to sell their house before they can qualify for public subsidisation. That may threaten the interests of surviving members of the household, especially spouses, and of those to whom old people would wish to leave their homes. One of the benefits of an annuity scheme is that it allows elderly persons to remain in their own home. Forcing elderly persons to sell their homes contradicts any policy which values care in the home above institutional care. It also frustrates policies for returning old people to the community after a spell in hospital.

The availability of private insurance coverage also affects the demand for private nursing home care. The difficulty for insurance companies is that the elderly in need of nursing home care are a high cost client group. There are few long-term care insurance products available in this country at present. It is unlikely, even in the more competitive insurance market which will develop after 1992, that private insurance will become available to such an extent as to cause an explosion of demand. Fears that they will accumulate bad risks and encourage excessive claims will ensure that insurance companies proceed with extreme caution in this area.

Tax relief on insurance premiums is a means whereby the demand for nursing home care can be enhanced. At the moment relief is available for elderly persons receiving care in homes approved by the Revenue Commissioners acting on the advice of the Minister for Health. Total relief came to £2.7 million for the calendar year 1987 and offset some

of the dampening effects of restricted subventions for elderly persons. Under new arrangements, however, subvention is to be related to means and dependency and will be awarded to recipients in a more flexible and rational way. To retain the tax relief makes little sense in such a changed environment. Retention would lead to inequity between taxpayers and non-taxpayers, as well as between tax payers on different marginal rates of tax. Moreover, the tax relief would continue to encourage institutionalisation unless it was also made available to help finance care at home. A general widening of the scheme to cover the costs of home care would prove a very costly option.

The most important conclusion to stress in this brief review of needs and demands is that all the evidence available shows that most people prefer to live at home for as long as they can. That is where most of the frail elderly are to be found. There are about 20,000 in long-term residential care of all types, but there are about 66,000 needing some degree of care who are living at home — 50,000 of these being looked after by members of their own households.

The choices open to these people and to those who care for them depend, first and foremost, on their own resources. With rising incomes, better housing and the spread of home ownership, most should have a wider range of options available to them. But whether they can get what they want will depend heavily on provisions made by the State, and on the ways in which the State treats voluntary and private providers.

Meanwhile the increasing social divisions brought about by the economic changes of recent years — changes which have given Ireland one of the highest rates of long-term unemployment in the European Community — will for years to come leave large numbers of old people with low incomes. Some of them live in houses which are isolated or poor in quality. These must be the first concern of the State.

(2) Trends in Supply

The official approach to the nursing home sector has been to view it as both complementary to and substitutable for publicly provided services. Those seeking private residential care are not discouraged from doing so, and nursing homes are also used by the State for those elderly people who cannot be accommodated in public long-stay beds. In recent years, as the number of long-stay beds in the public sector has decreased, the level of provision, in the private sector especially, has increased. For example, between 1986 and 1989 as the number of public beds declined significantly in the Eastern region, the number of private nursing homes

grew by 115 per cent (Eastern Health Board. 1989). Private and voluntary nursing homes receive a considerable amount of public funding. In 1986 the amount of subsidy paid by health boards to nursing homes was £15 million (*The Years Ahead*, 1988). The Eastern Health Board has also entered into contracting out arrangements with a small number of nursing homes which have undertaken to provide care at an agreed level and to a particular patient group on the Boards behalf.

It is difficult to estimate in any reliable way the number of nursing home beds in Ireland. In future, all registered nursing homes will be required to make annual returns to the health boards. Included in these returns should be information on the number and dependency of residents, fees charged and the cost of care. These data should then be communicated to the Department of Health in a much more efficient manner than hitherto.

An attempt has been made in this study to estimate precisely the number of nursing home beds in the country using new data only recently supplied by the health boards to the Department. Using this source, an additional 2,649 beds were discovered in the nursing home sector, thereby raising the total number of beds to 9,071. or just under 50 per cent of all long-stay beds.

Equally important is what happens to people within institutions. It is possible to identify four models of the caring process.

- (a) The *supportive model* is characterised by consultation and involvement of elderly people in the care regime. It is consumer oriented with much of the impetus for activities originating from the residents.
- (b) The *protective model* also encourages some degree of choice and consultation within the frontiers laid down by staff.
- (c) Somewhat more constrained is the *controlled model* in which the elderly person is completely subordinate to the care regime.
- (d) Most restrictive of all. however, is the *restrained model* which operates purely for the convenience of care staff.

Unfortunately, it was beyond the scope of this study to investigate the process of care in the nursing home sector in Ireland. It should be noted, however, that in the only qualitative study done on the sector (O'Connor *et al*, 1986). the ethos of care in the homes surveyed emphasised continued dependence and not the maintenance and development of independence.

The new legislation will likely have two major effects on the supply of

nursing home beds. First, some homes are unlikely to be able to meet the stricter standards and regulations and hence will be lost to the regulated sector. These homes will either close altogether or alternatively will re-define their activities in order to remain outside the scope of the new legislation. The other effect is likely to act to increase the supply of beds in the regulated sector. The greater income security for homes promised by the new subvention arrangements (especially if they are significantly more generous than at present) is likely to attract new proprietors seeking to enter the industry, thereby providing a stimulus to supply.

Barriers to entry for such homes are likely to remain low. The average size of homes at 21 beds is small enough to allow many to find the initial capital required. Much depends here on the willingness of the banking system to lend to potential entrants. There is evidence (Birmingham, 1989) that lending institutions perceive nursing homes as a profit-making opportunity and consequently are willing to support the industry. Support from the banking system ultimately depends, however, on the quality of individual applications as well as their timing (Leddin, 1989).

A major factor which will help to shape the supply of nursing home beds is the availability of alternative options for long-stay care. It is a major assumption of this report that the future development of nursing homes will be determined partly by the organisation and delivery of care in the public sector — in particular by the trend in public bed provision and the ability of the public system to deliver more resources for community care. A good community care service will reduce the need for nursing homes. In addition, alternative community living arrangements such as sheltered housing or boarding out may delay or postpone entry into institutional care for vulnerable elderly people. While these factors may create a growing range of alternatives to nursing home care, the supply of unpaid or informal carers will also influence demands for nursing homes, and this supply is likely to decline.

The most important conclusions to stress on the supply side of the equation are that public provision in long-stay hospitals has been declining: voluntary nursing homes have just held their own (but the Churches are finding it increasingly difficult in the light of declining vocations to maintain a strong presence in this area). Meanwhile the private sector accounts for most of the growth in nursing home beds. Together, the voluntary and private sectors now provide nearly half the long-stay beds available.

The growth of the private sector has taken place particularly in the Eastern region. This is likely to be due very largely to the decline in

family size, the continuing flow of people to the cities and suburbs, the high costs of housing in these areas, and the growth of employment amongst women: four closely related factors, all of which are likely to go further in the years to come. Thus unpaid carers will probably decline in numbers.

If, as seems likely, funds from the State for nursing home subvention continue to come mainly from general taxation, that will not provide rapid growth. Resources may, however, be transferred between different branches of the public services.

The prospects for more radical changes in the forms of care offered have not been discussed. The more varied and flexible patterns of care for elderly people, now being developed in the United States, are briefly considered in the Report. If they come to Ireland they may set a useful example from which more conventional services can learn. But they are likely to be used mainly by richer and healthier people and will therefore offer little direct help to the most vulnerable groups.

III MAIN RECOMMENDATIONS

(1) Principles and priorities

These are the main principles underlying the recommendations in the Report. Elderly and frail people — some of whom are not so elderly — and those who care for them should be enabled so far as possible to get the kinds of help they want. That, for most of them, will call for services which enable incapacitated people to stay at home, and hence for a growth in community care and related support services.

- The resources of the State must be used to develop the services best equipped to meet these needs, without tipping the scales arbitrarily in favour of any particular form of service or any sector among the providers.
- When it comes to selecting the individuals who should receive help, priority must go first to those with the greatest medical and social needs, and — among them — to those least able to pay for themselves.
- Principles and procedures should be comprehensible and uniform in all parts of the country.

(2) Financing implications

Long-term care is currently paid for by the government and by elderly persons and their families. The amount of long-term care financed by

Voluntary Health Insurance (VHI) is minimal. The latter will only finance short-term (two weeks) post acute care convalescence in an approved nursing home. Longer-term care will only be financed if the VHI can be convinced of the medical nature of the illness. In the absence of any indications to the contrary, it is unlikely that this method of financing long-term care will be altered, at least in the medium term. New subvention arrangements will, if anything, increase the government's contribution to care.

To get help to those who need it most, means tests will be required. They should be simple, comprehensive and uniform. They should also be similar, wherever possible, to those used in other services. That makes it easier for one to provide a "passport" to the benefits offered by another, without the need for fresh inquiries which cost money and deter people from claiming their rights.

Where home owners are involved, means tests should not compel people to leave their homes sooner than is necessary. Thus, although a charge may have to be made on the estate of a home owner who is "asset rich" but "income poor", living in an owner-occupied house should not preclude people from receiving help.

Tax relief is, in general, a bad way of providing help. It tends to give most to those who pay most tax and are best advised, and therefore to exclude the poor.

But insurance schemes have a great many advantages. Although private insurance is generally unwilling to cover the high costs of residential care, now running at about £10,000 a year, it may be capable of playing a useful part if the State develops basic, public insurance schemes to which the private sector can add a contribution of its own.

A public insurance programme would spread the cost of long-term care over the entire population through a system of risk pooling. In addition, basic home care services might also be included under such a scheme. Beneficiaries would pay for the programme through a payroll tax, income tax surcharge or premium. Other forms of revenue could be used to reduce the contributory tax required to finance the programme. Cost sharing together with a residual role for private insurers might be appropriate here.

The egalitarian nature of such a scheme is attractive. So also is the fact that the costs of care are spread more broadly over the entire population, not only on the pockets of those who use nursing homes. The cost of care is also spread over the life-cycle, thereby allowing the build-up of adequate revenues to finance care at the end of that cycle. There is.

however, little support in this country for such schemes at the moment. Nevertheless, it is the strong recommendation of this Report that research should be commissioned to examine the costs, benefits and feasibility of a move towards financing long-term care by social insurance.

This study, however, is mainly concerned with considering proposals for supporting elderly persons entering nursing homes in the future. It has already been agreed in principle that policy in this regard should continue to rely on full public subsidy for low income individuals and partial subsidy, depending on means and disability, for all other persons. Within this framework, assessment and rehabilitation procedures are in our view the key to an optimum placement policy. No subvention for institutional care, public or private, should be paid unless elderly persons have been assessed as being in need of such care.

It was not part of the brief for this study to investigate the cost of nursing home care. Such a study is required, however, if it is intended to relate subvention payments to costs. Evidence from elsewhere suggests that the setting of fees in nursing homes is an inexact science often bearing little relationship to costs. It is hardly appropriate, therefore, to relate subvention payments to fees charged.

(3) Managing and developing the system

Care of the elderly services should be localised. Some experimentation with case management by health boards would be useful. A local service could be developed within the health boards giving everyone in need of care a "case manager", with an associated budget, who is authorised to meet people's needs in as effective and economical a way as possible. That may be through services for someone living at home, or through support for informal, family-based care, or through residential care — and each of these might come from the public, the private or the voluntary sectors. Ideally, each individual will need a "package" of help suited to his or her needs.

People should be helped by the State to find places in nursing homes — temporarily or permanently — if an assessment of their needs shows that this will be most helpful. Those assessments cannot be properly made until adequate community care is available, on terms subsidised equally with residential care.

Nursing homes should be inspected regularly by teams of staff trained to work in the same way in all regions. The public sector cannot be treated equally as a competing provider of care unless it is subject to the same inspections and required to attain the same standards.

If the private and voluntary sectors are to be major providers of long term and terminal care for frail older people, they will have to confront the issue of dementia. A proportion of their residents will have dementia. And increasingly the priority groups for admission will have dementia, partly because community care systems cannot cope, and partly because of the shortage of long-stay psychiatric beds. This has important implications for the design of homes, the training of staff and inspectors, and the support of relatives and professional carers who will be doing a specially demanding kind of nursing.

Recommendations throughout the Report have many implications for training — for staff of nursing homes, case managers, inspectors, means testers and others. These are briefly noted at many points in the following chapters.

The Report also contains many recommendations for research, noting points at which sociological, financial and administrative data essential for sound policy are not yet available.

IV THE EVOLVING CULTURE OF CARE

We are aware that, underlying our discussion of financial and administrative systems, there are fundamental assumptions about people's obligations to look after their frailer relatives and neighbours. Those assumptions are changing, and public policy may itself bring about such changes. Some fear that too generous provision by the State may kill compassion and social responsibility.

Our own standpoint starts from a conviction that the great majority of people care about those for whom they have a responsibility, and they and those they care for know better than anyone else what help they need. The great majority of incapacitated and dependent people are still cared for by relatives and neighbours — willingly, and often at great social and financial cost. We have found no evidence that people are, in general, less willing than they used to be to help frail relatives and neighbours.

If people's willingness to provide unpaid care is nevertheless declining, that arises from changes in their economic and social circumstances. That may be because there are fewer children in modern families to share the burden of caring for the elderly; or families have scattered and no longer live close to each other; or more people have been able to get married and have children of their own; or old people have become more determined to preserve their independence and privacy and are better equipped to do so; or because higher housing costs and better

working opportunities for women convince them that it would be better to go out and earn money to meet family needs — including the need to buy care for elderly dependents.

Manipulative public policies will not make these people "more caring" or make the elderly more willing to move in with younger relatives. We must, instead, provide the kinds of support which enable carers to give the help they can best offer, and enable dependent people to live as comfortably and independently as possible.

CHAPTER 1

The Policy Framework

Introduction

It is not possible to examine the nursing home sector without first of all considering the general policy framework for care of the elderly in this country. This chapter is concerned with providing such a policy context. After a brief description of early approaches to care of the elderly the major recommendations of *The Care of the Aged* (1968) report are outlined. Resource allocation in the twenty years following the publication of this report provides important clues as to the relative successes and failures of the period. The successor to *The Care of the Aged* report was *The Years Ahead* (1988) report. A major part of the chapter is devoted to an analysis of the recommendations contained therein. Until the publication of this report the general policy approach to nursing homes, especially private ones, was to ignore them. Certainly no effort was made to plan for their integration with public sector provision. This did not prevent the growth of the private sector. Rather it made control of the sector more difficult than it might otherwise have been if efforts had been made earlier to prepare for the changes which were about to unfold. It is only now that public policy is being directed specifically at nursing homes with a view to improving regulatory control, rationalising the subventions paid to the sector and bringing about their integration into the general system of care for elderly persons.

Early Approaches to Care of the Elderly

Institutionalisation has always played a key role in care of the elderly in Ireland. Public long-stay provision for the elderly dates from the 19th Century. However, much of the early policy was concerned with discouraging the uptake of public care. The purpose of Poor Law relief was not to seek out applicants for long-stay care but to create an environment whereby applicants would be discouraged. In this way it was believed

that only those who were genuinely destitute would apply. These workhouses, as they were called, contained a mix of persons all of whom were deemed to be destitute. Institutional care specifically for elderly persons did not exist. As *The Care of the Aged* report remarks, such a variety of inmates in these workhouses led to difficulties of management and did not lend itself to the comfort or improvement of residents.

Towards the end of the 19th Century public opinion demanded a modification of the existing system of relief. The suggestion with respect to old people was that they should be removed from the workhouses to a County Institution to be known as the County Alms House or more usually called the County Home. A Royal Commission on the Poor Laws which reported in 1909 was in agreement with this view stressing that there should be classification by institutions and not merely in institutions.

It was not until the early years of the State, however, that the workhouse system was dismantled and specialised hospitals and homes were substituted for the former general mixed workhouse. Generally one workhouse was retained to serve as the County Home. While the view was that such homes should be solely for infirm and destitute elderly, the absence of alternative arrangements for classes such as unmarried mothers, children and "mental defectives" meant that in many places the County Home retained many of the characteristics of the old mixed workhouse. Certainly the change in status did little to change the institutional bias of public policy nor the generally poor conditions which persons in these homes had to endure. In the absence of any policy with respect to community care there were, however, few alternatives available to elderly persons without means.

Criticisms of county home provision by an Inter-Departmental Committee in 1949 resulted in a White Paper two years later which sought to encourage an improvement, though not a replacement, of the system of care. Some reconstruction of existing homes was carried out in the 'fifties and 'sixties and new accommodation was provided in some areas. In all, an increase of 2,195 beds was achieved between 1951 and 1966. The large number of institutional beds¹ (20,714 beds) in 1966 was, however, in sharp contrast to the absence of comprehensive community services for old people at home. It is acknowledged that there were some public efforts directed towards the development of a skeletal community care system but, on the whole, it was left to voluntary organisations to provide as best they could in this regard.

¹Not all of these beds were for elderly persons.

The *Care of the Aged* Report (1968)

It was in response to the poor standard of institutional care and the absence of community care services that the Inter-Departmental Committee on Care of the Elderly reported in 1968. This report provided the impetus and philosophy for public policy for the next twenty years. In contrast to the haphazard nature of care that went before. *The Care of the Aged* report recommended that the basic objective of policy should be to enable the aged to live in their own homes for as long as possible. In order for this objective to be achieved, significant improvements in community care would be necessary. Specifically, the report addressed the need to provide adequate housing (including sheltered housing), home nursing, home help, paramedical care and a more flexible general practitioner service. It also called for a reorganisation of existing institutional care and the introduction of a new form of welfare home provision.

For the first time a set of objectives for care of the elderly was made explicit. The Committee considered that the aim of services provided for the aged should be:

- (a) to enable the aged who can do so to continue to live in their own homes;
- (b) to enable the aged who cannot live in their own homes to live in other similar accommodation;
- (c) to provide substitution for normal homes for those who cannot be dealt with as at (a) or (b);
- (d) to provide hospital services for those who cannot be dealt with as at (a), (b) or (c).

It did not, however, envisage centralised planning to achieve these objectives. While acknowledging the desirability of a rational integration of services it went on to say that the extent to which particular measures are necessary, desirable or feasible will vary from place to place and from time to time. Given the paucity of community care services there was little scope for flexibility in this regard. Services had to be developed from first principles in most places if the Committee's objectives were to be achieved. The major recommendations in this regard were:

- the provision of a domiciliary nursing service in all areas;
- the availability of specialist advice for the aged on an outpatient or domiciliary basis:

- the recognition of the importance of general practitioners in caring for the elderly;
- the development of a home help service. Where the service is operated by voluntary bodies, health authorities should contribute to the costs involved;
- that boarding out schemes should become a normal feature of services for the elderly;
- that day hospital procedures should be provided on an experimental basis in some large general hospitals;
- and that health authorities should arrange for the provision of day centres in populous areas.

The emphasis of the Committee on an integrated approach to care led to it also making recommendations with respect to the income maintenance and housing of elderly persons. It recommended that in addition to the payments made under the general schemes of pensions, benefits and assistance, supplements should also be paid to elderly people experiencing exceptional income difficulties. As regards housing the recommendation was that housing authorities should reserve specifically for elderly persons a percentage of all dwellings provided. In addition, sheltered housing should be provided for elderly persons who would benefit from such accommodation. In all cases, whether with respect to community services, income maintenance or housing, due recognition had to be given to voluntary provision already in existence. The roles of the voluntary sector and the public sector were to be complementary and the aim was to achieve the optimal provision of services for elderly persons.

Along with the development of a community care service, a major determination of the Committee was to rid the institutional system of the concept of the county home, which was still perceived as a place of last resort with considerable stigma associated with admission. To this end the recommendation was that long-stay institutional care was to be provided through:

- (a) the concept of geriatric hospitals (to replace county homes) to cater exclusively for those patients who need continuous nursing care, or are bedfast and need nursing care or are incontinent, and
- (b) welfare homes to provide institutional care for elderly people "who do not need care in a hospital setting but for whom institutional care is required".

Places in such facilities were to be filled only following screening by the local Chief Medical Officer.

Geriatric assessment, along with rehabilitation, in short stay units headed by consultants in geriatric medicine, was to be made available as a specialist service in the main general teaching hospitals. These units would necessarily be a scarce and centralised resource and so would benefit from "other units" located on a "geographic basis" aiming to bridge the gap between local services and the specialised units. Where possible, long-stay units were to be located close to a general hospital though, in reality, the existing dispersion of county homes would indicate the location of the "geriatric hospitals" (which were, in general, to operate from the same premises as before). Nevertheless all geriatric hospitals were to be "associated with" a general hospital. The specialists in geriatric medicine were to have "overall responsibility" for the long-stay hospital units, assisted by local general practitioners.

The recommended provision of welfare homes by statutory authorities represented a new departure. It was aimed at providing alternative facilities for those who used to be found in county homes but were merely "frail", or admitted for mainly "social" reasons. Provision was also to be more comprehensive, extending to cover welfare cases who were not typically in the poorer categories that had tended to populate county homes. While calling for research into precise needs, the report recommended about 20 welfare home beds per 1,000 elderly over 65 years of age (or, in 1986 population terms, 7,687 beds). This is in addition to the recommended ratio of 15 beds per 1,000 elderly in long-stay hospitals (or, in 1986 terms, 5,766 beds) and a proposed ratio of 4.5 beds per 1,000 elderly in geriatric assessment units (or in 1986 terms 1,730 beds). We will see later in this chapter that some of these objectives, particularly with respect to welfare beds, were not fully realised.

In addition to statutory long-stay units, the 1968 report referred to and recommended a continuing and extended role for similar institutions run by voluntary, usually religious, organisations which received a capitation fee under the 1953 Health Act. The report recommended that health authorities make contractual arrangements with suitable voluntary establishments in order to provide welfare home accommodation subject to health authority inspection. The report, while acknowledging the existence of private nursing homes, made no provision for any role for these institutions. However, although the role of private and voluntary nursing homes was not defined in *The Care of the Aged* report, legislation had been introduced in 1964 covering Homes for Incapacitated Persons in the private sector and regulations were issued under the Act in 1966. With the Health Act, 1970, and the setting up of eight health boards to

take over from local health authorities, quite separate provisions were made which allowed health boards to subvent beds in all "approved" nursing homes (section 54). The nature of these provisions and current policy in this area are discussed later in this chapter.

Notwithstanding these interim developments, it is fair to say that *The Care of the Aged* report did not anticipate the enormous growth of the nursing home sector. All it did advert to in this regard was a possible role for voluntary nursing homes through their conversion into state subvented welfare homes to operate alongside statutory welfare homes. As a part explanation for this omission it could be said that were the recommendations for improvements in community care services, as envisaged by the Committee, fully implemented the need for private sector provision would have been reduced accordingly.

Policy Evaluation

There is no doubt that The Care of the Aged Committee approached its task with what was for the time a radical belief — "that it is better, and probably much cheaper, to help the aged to live in the community than to provide for them in hospitals or other institutions." Within this framework public and family care were regarded as complementary not substitute forms of care. These were novel and innovative concepts at this time (in many senses they still are) for a system of care still rooted to the stigmatizing institutionalisation of elderly persons. What is disappointing, however, is that *The Years Ahead* (1988) should have to make more or less the same call for a move away from institutional care towards care in the home. While substantial progress has been made towards the implementation of many of the recommendations of *The Care of the Aged* report it cannot be claimed that the system turned out as envisaged twenty years ago by members of the Committee.

Certainly community care services are better. There is no comparison between the service now and that which existed pre-1970. Despite such progress, however, many elderly people are still forced towards residential care because of a lack of community care resources. The National Economic and Social Council (1988) reported that access to home helps, public health nurses and meals on wheels services is limited and varies considerably within and among health boards. Resource constraints have meant even more restricted access to community nurses for elderly persons in recent times (Commission on Health Funding). The Commission also report that home helps are available to no more than a small proportion of elderly people living alone, and are virtually unavailable outside that group. A forthcoming study by Blackwell *et al.*

on the comparative costs of community and institutional services confirms the weaknesses of community care provision. Paramedical services for elderly persons living in the community are negligible (and not much better in institutions) while support for informal carers remains half-hearted, leaving them outside the official sector. In addition, the programme structure within health boards has meant that services have remained patchy, lacking the integration so desired by The Care of the Aged Committee.

There is no doubt that the case for community oriented care of the elderly, so well made in 1968, is generally accepted in principle. Moving from principle to practice has proved more difficult. It would appear that while the policy ends of community care were identified, the means to these ends were not adequately worked out. Much more resources were required if community care was to become a reality. This did not necessarily mean an increase in total resources. There was scope for redeployment from the institutional sector which did not, in fact, occur.

Perhaps as important as resources was the absence of a fulcrum within the system to discriminate positively in favour of home care. This might have occurred if the concept of the community care team had worked as intended. This did not happen, with the result that there was inadequate co-ordination among the services provided and a continuing bias towards institutional care. Perhaps if the research envisaged by the Committee had been initiated then more practical support would have been raised for the deployment of greater resources in the community. As it was, almost no research on the comparative aspects of community and institutional care was carried out until very recently (Blackwell *et al.*, forthcoming). The result was the absence of any kind of empirical basis from which to make judgements on the actual rather than presumed relative merits of the alternatives in this area.

What has been the trend with regard to long-stay beds? The Commission on Health Funding report that the total number of elderly persons currently in long-term care is approximately 20,000. This figure includes elderly persons in public long-stay, private, voluntary, acute care and psychiatric hospitals. An audit done in 1968 by The Care of the Aged Committee reported a total number of beds in the system of 20,217. Given the growth in population of elderly persons this means that the total number of beds has declined from 63 per thousand elderly in 1968 to 52 per thousand in 1988. Even if we allow for an additional 2,649 private beds, not yet in the official statistics, the ratio for 1988 at 58 per thousand is still below the 1968 figure. In that respect at least The Care of the Aged objective of reducing long-stay beds has been achieved if not in absolute terms then at least relative to population growth. There

have, however, been changes in composition. The most dramatic increases have been in the private sector while new welfare homes have added approximately 1,500 beds to the system. This growth has been offset by a decline in the number of public long-stay beds and a reduction in the number of elderly patients in acute hospitals and psychiatric institutions.

We have noted that a key innovation of *The Care of the Aged* report was the recommendation to provide welfare homes for the not-so-heavily dependent elderly. By 1975 there were 23 welfare homes catering for 896 patients. In 1980 the number of patients was 1,185 and in 1988 there were 37 homes looking after 1,460 elderly persons, (following a peak of 38 with 1,509 patients in 1986.). However, the building of welfare homes slowed down considerably after an initial surge and eventually was stopped completely in the last decade. This was long before the Committee's target of 20 beds per 1,000 elderly could be achieved. Originally conceived as substitute home centres for the less dependent elderly who might otherwise be expected to go into geriatric hospital care, it appears that the age of residents, and the associated degree of dependency, increased steadily over time. For example, the proportion aged 75 and older rose from 62.8 per cent in 1980 to 75.7 per cent in 1988. With the less intensive staffing provided in welfare homes, as compared with geriatric hospitals, this trend was problematic and the inflexibility of the welfare home concept came into clearer focus. Moreover, the obvious desirability of keeping elderly persons out of long term care raised doubts (Comhairle na nOspidal, 1985) about the whole concept of welfare homes. While acknowledging that *The Care of the Aged* Committee recommended the welfare home as an alternative to the county home, it is perhaps surprising that other options such as sheltered housing or boarding out, were not more used, particularly as they would have also served to underline the general thrust away from institutional care.

Health board geriatric long-stay hospitals, largely former county homes, numbered 36 in 1966 and accounted for 8,057 patients. The number of beds in place in 1980 is estimated at 7,836. This figure declined further during the 1980s, falling to an estimated 7,005 beds in 1988. The role envisaged by the Committee for the long-stay sector never materialised. The atmosphere of custodial care survives in some of these institutions. Admissions procedures have not always followed best practice and it has only been in the last decade that admissions committees have begun to function in some places (Blackwell *et al.*, forthcoming). More significantly the appointment of physicians in geriatric medicine and the development of specialist assessment and rehabilitation units has been

slow. The result is that there are still too many persons in long-stay institutions who have been inappropriately placed. For example, the data on reasons for admissions for the years 1980-1988 (*Health Statistics*, various years) reveal that 'social', 'mental handicap', 'chronic psychiatric' and other (non-acute, non-chronic or non-terminally ill) cases account for 25 to 30 per cent of all patients. Blackwell *et al.* (1991, forthcoming) confirm that some long-stay institutions contain a high proportion of low dependency elderly persons. Nevertheless, it would be incorrect to infer that there should be large scale decanting of patients from these institutions. The preferences of current residents, their degree of institutionalisation and the adequacy of resources in the community, including family and friends, to care for the person, all need to be taken into account before any decision on discharge is made.

There is no doubt that *The Care of the Aged* report was a major catalyst for change and improvement in care of the elderly. It began the modernisation of services in this country. It did not, however, succeed in fulfilling all its objectives, particularly in relation to the development of comprehensive and integrated community services. Neither did it provide any mechanism to deal with the rapid and largely uncontrolled growth of the private and voluntary sector. Moreover, much of the impetus for change was being curtailed by the end of the 1980s because there were less real resources available for health care. This was as a result of the cutbacks deemed necessary due to the perilous state of the public finances and the heavy burden of foreign debt. It was against this background that the challenge for the future was taken in *The Years Ahead* (1988). This report sought to consolidate the real transfer of care and resources to the community within the constraint of general public expenditure retrenchment and specifically less resources available for spending on care of the elderly. Major changes in policy were recommended. These are discussed in the next section.

The Years Ahead—A Policy for the Elderly

The guidelines which influenced the Working Party in formulating a policy for the elderly in *The Years Ahead* report are not dissimilar to the principle which underlined *The Care of the Aged* report. The Working Party suggested that the following considerations must be faced up to within the constraints and reality of a finite set of resources available for community care:

- that old age demands our special respect;
- that improvements in life expectancy and the increasing number of

elderly persons require a clear-cut public policy for the future in regard to the State's role towards the elderly:

- that the underlying aim of policy should be to help the elderly maintain their dignity and independence by protecting them from economic and social hardship;
- that the dignity and independence of the elderly can best be achieved by enabling them to continue to live at home with, if necessary, support services provided by the State;
- that when ill or disabled, the elderly are entitled to the same standard of treatment available to the rest of the population even if services have to be organised in ways that meet their particular needs;
- that when admission to long-term care is unavoidable, such care should be of the highest standard and should respect the dignity and individuality of the elderly person.

The Years Ahead report confirmed the primacy of community care for elderly persons. It made specific monetary proposals to increase the amount of resources for community nursing, home helps and paramedical services. This was a fundamental change from *The Care of the Aged* report. At the same time, however, the underlying budget constraint was recognised and redeployment of, rather than increases in, resources was to be the source of funding for the improvement in services.

Recommendations were also made with regard to service provision. Services for the elderly should, according to the Working Party, be organised as far as possible in local districts serving a population of 25-30,000 people. Within each district, co-ordination of services would be the responsibility of a district liaison nurse supported by a district team. This proposal is an effort to overcome the lack of integration which has afflicted service provision up to now. At the community care area level, which would incorporate three to four districts, a community physician would act as overall co-ordinator of services for the elderly. The rationale for this proposal is once again to improve the comprehensiveness, co-ordination and integration of services for old people across existing programmes of care (community, acute, long-stay and psychiatric). Not only that, but the recommendations emphasise the desirability of close liaison with carers in the home, the voluntary sector and the housing authorities. In practice, the district liaison nurse, supported by the overall co-ordinator of services, would be the facilitator of change in the new system. There has not been such a role in the system up to now,

which perhaps might go some way to explain the slow progress made in moving away from institutions and towards care in the home.

Some elderly people will, of course, continue to need long-term care in an institution. The recommendations contained in *The Years Ahead* report recognise this need but also include suggestions for the radical restructuring of existing long-stay hospitals to enable them to function as community hospitals. The latter would continue to provide long-term care but would be much more concerned than before with providing assessment and rehabilitation for patients. In addition, the following services would be provided: convalescent care, respite care to support caring relatives and information, advice and support for those caring for elderly persons at home. The key variable in this proposal is the formal recognition of the need for pre-admission assessment and post-admission rehabilitation under the guidance, wherever possible, of a specialist physician in geriatric medicine. The Working Party maintains that the effectiveness of extended care facilities is contingent on assessment by professional staff. In those parts of the country where assessment prior to admission to long-term care is routine, much more effective use is being made of the long-stay beds than in those areas where admission is still from waiting lists.

For the first time, the private nursing home sector was explicitly recognised in a policy document. The substantial growth in the sector together with the £15 million (in 1986) subsidy paid by health boards to nursing homes (*The Years Ahead*, p. 143, 1988) served to concentrate minds in this regard. Recommendations were made for a licensing system for all nursing homes, including those in the voluntary sector. The report also recommended that the current restrictive and anomalous subsidisation of homes be discontinued. Instead subsidy should be determined in function of the means and dependency of applicants. This would be an improvement on the current position whereby subsidies apply to beds in homes approved before 1980, the year in which approvals were discontinued due to budgetary restrictions. Most importantly of all, subvention approval should only be granted in the first instance if an elderly person has been assessed as needing long-stay care by a specialist geriatrician or close substitute. According to the Working Party the emphasis should be on maintaining people in their own homes, not supporting them to enter inappropriate long-stay care. The right of individuals to choose and pay for care in a nursing home out of their own pockets was not, of course, denied. As we shall see, not all of the recommendations of the Working Party with respect to nursing homes were adopted by the Health (Nursing Homes) Act, 1990. It is fair to

say, however, that the Working Party anticipated much of what now constitutes the new regulations in this area.

Nursing Homes in Context

The Care of the Aged Committee estimated that in 1966 there were 1,510 elderly people in "voluntary and private general hospitals and nursing homes" and 3,470 in "private homes for the aged and similar centres". Such provision generally reflected the long standing tradition of religious orders involved in hospital and institutional care of older people as well as the emergence of a small "for-profit" private sector.

The Committee called for further use of such non-statutory provision, as an alternative to direct statutory care, by using existing legislation, in particular the Health Act, 1953, to give capitation funding wherever such hospitals and homes cared for patients on behalf of the State. In addition, they advocated similar funding for voluntary bodies providing care equivalent to that intended in the proposed new welfare homes. Apart from that, as mentioned above, little further reference was made to the private and voluntary nursing home sector.

The first legislation dealing specifically with nursing homes had been the Health (Homes for Incapacitated Persons) Act, 1964. It provided for standards and inspection and the notification of all new establishments. But it had its shortcomings. It was confined to the for-profit sector, did not require registration of homes, and the first regulations on standards, published in 1966, were too liberal. These were eventually updated in 1985. The Act said nothing about statutory subvention of nursing home care.

The Health Act (1970) introduced the concept of ministerial approval of institutions outside the statutory sector providing "in-patient services" i.e. "institutional services provided for a person while maintained in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto". Under Section 54 of the 1970 Act, the new health boards would be required to make a "prescribed payment" in accordance with ministerial regulations to such approved homes.

Throughout the 1970s many nursing homes in the private and voluntary sector sought and got approval under this clause. In 1980, however, for budgetary reasons, the Department ceased the approval of homes under Section 54 (as mentioned above). Apart from the cost, there were difficulties with this funding mechanism which merely involved a payment per day, per occupied bed, and took no account of either the

means or dependency of the resident. With the cessation of Section 54 approvals an additional anomaly, or confusion, was to emerge between "Approved" and non-approved homes — despite the fact that being "Approved" did not denote a superior quality of care.

The anomalies in Section 54 Approvals under the 1970 Act were avoided, by the Eastern Health Board (EHB) in particular, by confining the period over which the prescribed payment would be payable to six weeks. Instead, the EHB provided long-stay subvention to means tested persons under Section 26 of the same Act. When the Minister ceased to approve any more homes in 1980, Section 26 provided a continuing basis for subventing beds in all homes operating satisfactorily under the 1964 legislation. Since 1985, however, the Eastern Health Board has tended to limit the number of Section 26 subventions to four beds in newly notified nursing homes.

Other forms of funding also operated, in the voluntary sector in particular. Some homes received an annual budget while others, deemed to be providing welfare, rather than nursing home accommodation, received lower levels of capitation.

The Health (Nursing Homes) Act 1990 was the result of many years experience of and concern about previous legislation and arrangements for the regulation and subvention of nursing homes. Among its more notable features are:

1. The repeal of Section 54 of the Health Act 1970 which was a source of much dissatisfaction.
2. The introduction of a tiered system of subvention varying with means and dependency levels. It will most likely involve three levels of dependency and a scale of means.
3. The extension of regulation and inspection to the voluntary nursing home sector — which had been excluded from the 1964 legislation.
4. Tightening of quality control through (a) compulsory registration; (b) stricter enforcement of standards of design, nursing care, nutrition, general management; (c) greater accountability of proprietors and stiffer penalties for offences; (d) more powers for health boards to deal with offenders; (e) better information and complaints procedures for the consumer.

Some of the criticism levelled at the new Act focuses on the principle of treating the non-statutory sector separately from statutory accommodation. Their differing origins and development may be said to account for the different policy roles fulfilled by each. But a convergence

may be taking place. *The Care of the Aged* report (1968) indicated the need to limit the scale of institutions in the statutory' sector in its recommendations on welfare homes. Many of these have since begun to take on the character of nursing homes. It could be argued too that many, though not all, of the long-stay geriatric hospitals are, in effect, large scale nursing homes, some of which could evolve further in this direction. Simultaneously, many district hospitals have evolved to become nursing units for dependent elderly people.

It may be important, therefore, to make comparisons between the statutory and non-statutory sectors in order to examine convergences and divergences in practice and to identify how the two sectors may best be developed in a combined way. There are important implications flowing from such a perspective, both in relation to the method of assessment, admission and subvention of different classes of resident and in connection with the concept of the community hospital developed in *The Years Ahead* report. These issues are developed in later chapters.

Conclusions

The *Care of the Aged* report sought to change the thrust of care of the elderly in the country, away from institutions and towards care in the community. It had some success but the results so far have been disappointing. What then are the chances that the recommendations of the Working Party will effect the desired changes in our system of care for the elderly? The major factors which improve the likelihood of a real and sustained emphasis on care in the community are as follows:

- the proposed recommendations for more resources for community services, albeit a redeployment within a fixed budget constraint;
- the proposed appointment of key actors to co-ordinate and integrate services within the community and between these services and institutional care;
- the proposed insistence on assessment before admission to all forms of institutional care;
- the proposed reclassification of long-stay units as community hospitals with rehabilitation, day hospital and day care provision.

While the above do not do justice to the many recommendations made in *The Years Ahead* report they do constitute the fundamental differences between it and *The Care of the Aged* report. The general principles remain the same but the chances of transforming principles into practice have been improved.

The chances of real progress in this area have been further enhanced by the agreement reached in the *Programme for Economic and Social Progress*. Under this Programme primary care and other community based services are to be expanded (assuming satisfactory economic growth) over the next seven years. This expansion will, among other things, enable old people living in the community to continue to do so and allow others living in institutions to move back into the community. The overall additional cost comprises:

- capital investment of £100m (at 1990 prices) over the course of the next seven years
- progressive increases in the annual level of current expenditure which will, by the final years of the seven-year programme, be £90m above the present level in real terms.²

While the increase in current and capital expenditure will be shared with people having a physical or mental handicap and psychiatric patients it should provide the basis for the development of community services for elderly persons in line with the recommendations of *The Years Ahead* report. What is important now is that the correct choices are made with respect to the allocation of the additional expenditure among services for the elderly. In addition, the availability of extra resources for community care should not reduce the pressure for the ongoing deployment of resources away from institutional care.

²An extra £8m has been provided for 1991. It should also be noted that an extra £5m was allocated to care of the elderly by the Minister for Health in 1990. That money was also intended to improve community services for old people, though health boards, by and large, had some discretion in how their allocation was spent.

CHAPTER 2

Issues in Long-Stay Care

Introduction

The previous chapter outlined the policy context in which the issues of institutional care and the role of nursing homes have arisen in Ireland. In this chapter we will examine how much is known, theoretically and empirically, about the relative merits of community and institutional care. The evidence with respect to cost and outcome is investigated. Any discussion of cost must include consideration of formal and informal inputs. It is not correct to ignore the care provided by the family and friends of elderly persons. Neither can the difficult task of measuring quality and outcomes be avoided. At the limit, the cheapest care is none at all. Within this framework measurements of dependency must be considered, for whole populations as well as at the level of the individual seeking admission to a nursing home.

While much of the literature on balance of care relates to choice within a public system (because that is where almost all published work has been done) the issues raised have a direct relevance for nursing home care. If it can be established that care in the community is both cheaper and better than in institutions then the rationale for subsidised care in the latter, either public or private, is much reduced. On the other hand, if resources in the community are inadequate, people may end up choosing nursing home care that they would otherwise have avoided. That is not to say that the relative cost advantages of public and private care cannot be compared. This has been done, though not in Ireland. It is unusual, however, for such studies to include any information on relative outcomes. Though, as we will see, this is perhaps not surprising given that research in this area is only in its infancy.

Balance of Care

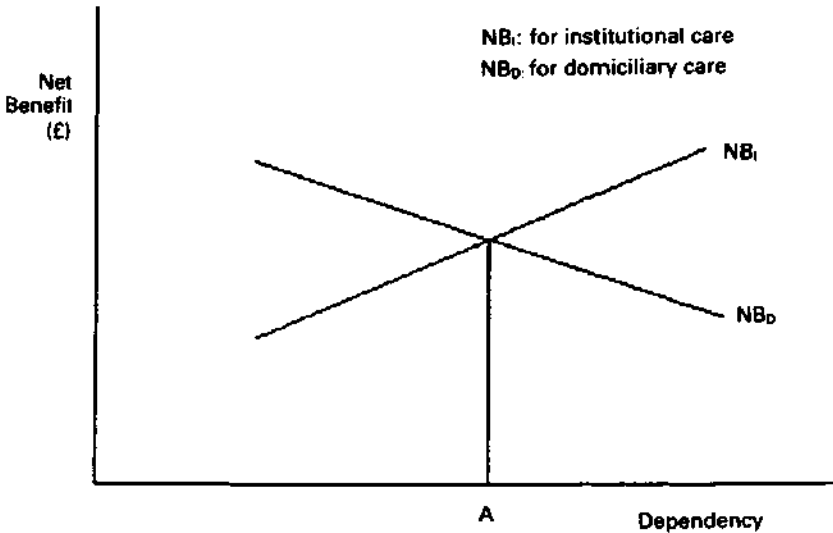
The economic and social evaluation of care of the elderly has usually been concerned with the optimal balance between community and institutional

care. This framework may be subdivided into such different regimes as hospital, nursing home, residential home, boarding out homes, sheltered housing and domiciliary care. When evaluating the balance of care, it is necessary, therefore, to specify the types or combinations of care regimes which are being used in the institutional sector. Similarly, the specification of household type and size is important in domiciliary care. Notwithstanding this *caveat* it is possible to consider the following questions within a balance of care framework: whether existing resource allocation is optimal: whether there exist cross-over points at which some regimes of care become more or less efficient than others: where increases in resources for the elderly should be concentrated and why: and where resources for the elderly are to be reduced, how best to make these cuts.

Taking as an example an evaluation of the balance of care between institutional care and community care, it is possible to indicate the theoretical framework for discussing these issues. This is done in Figure 2.1. which shows a hypothetical case for community care and for institutional care. The critical issue in terms of the optimal location of care, is the relationship between the marginal net benefit (marginal benefit less marginal cost) to the level of dependency. The definition of net benefit often causes some controversy. Economists are often accused of a minimalist definition incorporating only the measurable, usually costs.

FIGURE 2.1:

Likely net benefit patterns for domiciliary and institutional care



in money terms. Where this approach is used it is not correct. Any assessment of net benefits must include consideration of qualitative benefits, i.e. health status, where the latter is defined widely to incorporate medical, social, mental and emotional factors. In addition, there is a need to consider the costs and benefits of caring which fall on carers and their families.

The "cross-over" point is that level of dependency at which one form of care changes from having a lower net benefit (at the margin) to having a higher net benefit. For levels of dependency greater than A. the marginal net benefit of care is greater in the case of institutional care than in the case of community care. Below this dependency level the most efficient provision for the elderly is community care. Benefits are greater and costs are cheaper. The marginal cost and benefit diagrams are drawn in such a way that at extreme levels of dependency (very low and very high, respectively) the best decisions for elderly persons are quite clear. For elderly persons with a level of dependency around A it is, however, crucial that information on the costs and benefits of alternative forms of care are known. Otherwise inefficiency in resource allocation may occur, due to incorrect placement decisions being made.

One should be warned that balance of care models are overly suggestive about the precision one can achieve in decision-making about placement. If only life were so easy. In practice there is a wide margin around which decisions are made. One should not expect, therefore, that the techniques associated with this model will enable one to determine precisely the most cost effective form of care for a particular old person, except between wide parameters. Nevertheless, it is a convenient way of thinking about these issues and a valuable aid to decision-making.

Moving from theoretical models to the actual measurement of dependency and the valuation of costs and benefits is more difficult. There has been, for example, a wide variety of approaches used to measure dependency. These range from broad descriptions, incorporating just a few indicators, to specific measurements which take account of all possible health characteristics. Similar complexities arise when measuring and valuing cost. There is a sharp distinction, for example, between public expenditure accounting and an opportunity cost methodology. Within the latter framework all options are evaluated by asking what other uses could have been made of the resources concerned. This is a measure of benefits forgone. Finally the measurement of outcomes is, only now, being explored. It will be some time, therefore, before one can use data about "quality adjusted years of life", for example, as a basis for allocating resources to and within services caring for elderly persons (Donaldson *et al.*, 1988). This approach would allow judgement

of performance on the basis of life years gained from alternative regimes and the quality of life associated with these years.

The Measurement of Dependency

It is possible to describe the health (or ill-health) of persons in a variety of ways.¹ The medical scientific approach has been to characterise health as the absence of disease where the latter connotes a medical concept of abnormality in pathological function with an associated set of symptoms, progress and remedial measures. Such a model is not ideally suited for the measurement of the health status of elderly persons as it excludes mobility as well as wider social, emotional and mental indicators. Neither is it appropriate when preventive health care is seen as a priority. An alternative is to define health so broadly as to encompass almost every perception of human welfare. For example, the World Health Organisation defines health as a state of complete physical, mental and social well-being. An intermediate approach is to use consumer-based measures of quality of life with particular emphasis on items such as physical mobility, pain, distress, capacity for self care and ability to pursue normal social roles (work, family, leisure) (Rosser and Kind. 1978. Torrance *et al.*. 1982). While the latter approach has many advantages, it may be less sensitive in picking up changes over time in the disability of older persons than more conventional cardinal scaling (Donaldson *et al.*, 1988). However, before elaborating any further on the relative merits of different approaches to the measurement of dependency it is worthwhile to briefly consider some of the main uses of disability indicators.

Disability indicators can be used in the development of a common assessment procedure for elderly persons on the boundaries of alternative forms of care. Assessment and rehabilitation are crucial in delaying, if not postponing entirely, the admission into long-stay care. The definition of need should not, of course, be restricted to consider only measured dependency but should ideally include other characteristics of the elderly person. For example, the social conditions in which the elderly live and the availability of informal carers are very important. In practice, the progressive long-stay hospitals in the country now make some attempt to incorporate the multi-dimensional nature of dependency in their admissions procedures. For those hospitals without a consultant geriatrician potential patients are usually assessed by an admissions committee. One approach is for the latter to ordinally score multi-dimensional information about patients provided usually by the public health nurse and the general practitioner. Although relative weightings may differ, decisions on admission normally rest on the medical and

¹For a fuller discussion of these issues the reader is referred to Blackwell *et al.*, forthcoming.

social conditions of the potential patient as well as the length of time he or she has been on the waiting list. It should be noted, however, that increasing rigour in admissions procedures is a relatively new phenomenon in this country and in many long-stay units arrangements to carry out prior assessments are not in place. That is why the recommendations of *The Years Ahead* report on these issues, referred to in Chapter 1, are so important.

Reliable measures of disability will, however, serve many other useful purposes. For example, effectiveness in care of the elderly might be measured, at least partly, by tracing the time path of old people along the disability scale. In the provision of long-term care the emphasis would not so much be on improving the position of the elderly person on the scale but rather on slowing down the onset of the next item of disability. One interesting example of this approach is a paper by Bond *et al.* (1989) which reports outcome data, gathered over time, from a multicentred randomized controlled trial undertaken as part of the experimental NHS nursing homes. The outcome data collected included mortality experience, life satisfaction indices, changes in behavioural ability and changes in mental state. In view of the ambitious nature of the study perhaps it is not surprising that a call for further research, in order to develop more appropriate outcome measures, was made by the authors. The approach used by Bond *et al.* (1989) may, however, serve as a useful basis for future experimentation in this area.

The actual measurement of dependency of old people has been approached in the literature in many different ways. Measurement has been made ordinally — simple or tested — across independent measures of disability which are then treated separately throughout the study. Usually no attempt has been made to quantify the magnitude of the interval between items or to combine classifications. Simple unidimensional cardinal scales have also been derived in which point scales are used to rank different categories of incapacity within different classifications of disability. Several studies have, for example, allocated points for ability to perform daily living tasks, and/or for other forms of disability like mental state, degree of behavioural difficulty or physical mobility.

Simple untested ordinal scales take a fairly limited and crude approach to measuring dependency. Such scales, at least those which appear in the literature, are usually confined to mobility and ability to carry out specified activities of daily living. For example, the Avon Study (1981) examining the criteria for admission to long-stay care confined its treatment of disability to five characteristics. Individuals were assessed on the following abilities:

- ability to move around inside without help from others.
- ability to get into and/or out of bed without help.
- ability to dress without major assistance.
- ability to make cup of tea.
- ability to shop or manage small errands.

The above categories were chosen primarily because it proved possible given a person's number of abilities to forecast which abilities these were with a good degree of accuracy. For example, if a person had three abilities, these were likely to be movement inside house, getting in/out of bed and ability to dress. A person's ability was relevant in the decision by the social worker on whether an alternative to residential care was appropriate for the elderly person. The number of abilities were also related to costs. Persons with less abilities required more services or more expensive services than more able elderly persons. An important point emerges here. Even though the scale used in the study was confined to five characteristics it was sufficient to answer the questions posed by the researchers.

Wright and his colleagues (1981) used a tested ordinal — Activities of Daily Living (ADL) based — Guttman Scale to measure physical dependence in their study of care of the elderly. Guttman Scaling had been previously used by Williams *et al.* (1976) in their disability study of handicapped persons in Lambeth and seemed to work well when applied separately for men and women. Individuals lost critical abilities in a well ordered cumulative fashion. Wright *et al.* (1981) developed a Guttman scaling technique based on the Lambeth experience but applicable across different forms of care for both men and women (Table 2.1).

Table 2.1: Guttman Scale from the York Survey

Grade = No. of items disabled	Item of disability added at each grade
1.	Cannot bath without help
2.	Cannot walk outdoors without help
3.	Cannot dress without help
4.	Cannot get out of bed without help
5.	Cannot sit or stand without help
6.	Cannot wash without help
7.	Cannot feed without help

Note: This scale produced satisfactory coefficients of reproductibility (over 0.9) and scaleability (over 0.6) for men and women in the community, residential care and hospitals.

Source: Wright, K.W. *et al.*. *Costing Care: Costs of Alternative Patterns of Care for the Elderly.* (1981)

The scale produced coefficients of reproductibility and scaleability which were deemed satisfactory for men and women and across forms of care. There were of course people who did not fit into these patterns. Wright suggests that in larger studies separate analysis of these non-scale types could yield useful information. For instance, those suffering from senile dementia may provide many of the non-scale types as they tend to lose self care abilities before they lose the ability to move outdoors.

In the Blackwell *et al.* study (forthcoming) mentioned earlier, a variation of the Guttman scale is used to measure dependency. Once again the scale performs well for large populations showing satisfactory coefficients of scaleability and reproductibility. In addition, the scale when used on elderly persons in Ireland is positively correlated with other dimensions of dependency including mental health, incontinence, restlessness, communication and co-operation. This is encouraging, given the major worry associated with uni-dimensional scales that important attributes of incapacity are not properly assessed.

One way of overcoming some of the limitations of uni-dimensional scaling is to use aggregated, cardinally determined point scales to assess severity of conditions. The Modified Crichton Royal behavioural scale (Table 2.2) is a good example of this approach. Cardinal measurement, however, is based on the assumption that abilities and incapacities are not only cumulative but additive as well. Neither can cardinal scaling guarantee homogeneity of dependency across scale points because various combinations of disabilities can yield the same score. There is no doubt that within the objectives of particular studies the aggregation of point scales can provide useful information. However, they are not a solution to the problems of combining scales, but may be a convenient method of making quick progress, as Wright (1987) points out.

This may be why many small scale, local studies have tended to use points scales, and why many admissions committees making judgements on applicants for long-stay care in public hospitals tend to use some variation of multi-dimensional points scales. Gibbins *et al.* (1982) use a modified version of the form used by local social workers in assessing suitability for admission to homes for old people. The criteria assessed under this procedure were as follows: mobility, dressing, feeding, use of lavatory, bathing, continence, medication, communication, orientation, co-operation and temperament. Each parameter was assessed using a five point scoring system, one representing the greatest disability and five the least disability. For assessment purposes the parameters in the study were "clustered" to give three groups — physical score, mental score, and medication score.

It is a small but difficult step from the measurement of disability to the

identification of possibilities for outcome measurement in care of the elderly. Challis (1981) has defined seven measures of outcome in care of the elderly. The origins of some of these can be traced to the developments in the literature on dependency outlined above. Five of these measures relate to the elderly person and two to other groups supporting the elderly. The dimensions include the following: nurture, compensations for disability, independence, morale, social integration, family relationships and community development. Ultimately, however, those who choose particular dimensions of dependency or specific measures of outcome are using a simplified model to represent a complexity of issues which are far from resolved. Given this reality, the objective for which the measures of dependency are required is crucial to the decision on which one to use. What is important, however, is that if assessment is to be introduced as widely as intended then measures of dependency must be relatively homogeneous across institutions. This is not the case at present, at least as far as we know from available information (Blackwell *et al*, forthcoming). This does not rule out flexible arrangements to deal with extraordinary circumstances, particularly those relating to the social problems of elderly persons. In fact such flexibility should be positively encouraged. Nor is it to deny the possibility of rapid changes in the dependency characteristics of elderly persons which in turn may demand a revised approach to caring.

Table 2.2: Modified Crichton Royal Behavioural Rating Scale

Dimension		Score
A Mobility	Fully ambulant including stairs	0
	Usually independent	1
	Walks with supervision	2
	Walks with aids or under careful supervision	3
	Bedfast or chairfast	4
B Orientation	Complete	0
	Orientated in-ward, identifies persons correctly	1
	Mis-identifies persons but can find way about	2
	Cannot find way to bed/toilet without assistance	3
	Completely lost	4
C Communication	Always clear, retains information	0
	Can indicate needs, understands simple verbal directions, can deal with simple information	1
	Understands simple information, cannot indicate needs	2

Dimension		Score
D Co-Operation	Cannot understand information, retains some expressive ability	3
	No effective contact	4
	Actively co-operative	0
	Passively co-operative	1
	Requires frequent encouragement or persuasion	2
	Rejects assistance, shows independent but ill-directed activity	3
E Restlessness	Completely resistive or withdrawn	4
	None	0
	Intermittent	1
	Persistent by day	2
	Ditto, with frequent nocturnal restlessness	3
F Dressing	Constant	4
	Correct	0
	Imperfect but adequate	1
	Adequate with minimum supervision	2
	Inadequate unless continually supervised	3
G Feeding	Unable to dress or retain clothing	4
	Correct, unaided at appropriate times	0
	Adequate, with minimum supervision	1
	Inadequate unless continually supervised	2
H Contenance	Requires feeding	3
	Full control	0
	Occasional accidents at night unless toileted	1
	Continent by day only if regularly toileted	2
	Urinary incontinence in spite of regular toileting	3
I Memory	Regular or frequent double incontinence	4
	Complete	0
	Occasionally forgetful	1
	Short-term loss	2
J Bathing	Short and long-term loss	3
	Washes and bathes without assistance	0
	Minimal supervision with bathing	1
	Close supervision with bathing	2
	Inadequate unless continually supervised	3
	Requires washing and bathing	4

Source: Wilkin & Jolley, 1979.

The Cost of Care of the Elderly

The distinction between public expenditure accounting and the opportunity cost approach is particularly relevant in assessing the cost of care of the elderly. A public expenditure approach to costing health care programmes concentrates on the direct formal costs and expenditures of each of the public agencies associated with caring. Costs, formal and informal, which fall on agencies or individuals outside of the public sector are not deemed relevant. Even within the public expenditure framework the focus is quite narrow. For instance, capital costs are not usually treated as a cost because health boards or local authorities are rarely, if ever, required to pay interest on the moneys used to construct hospital or health centres.

The opportunity cost model is concerned that the costs of a particular health care programme are measured in terms of the benefits forgone or resource sacrifices that are implied. For example, because no interest or rental is paid on capital or floor space does not mean that the resource is free. There is usually an alternative use for these resources, i.e. a benefit that would be derived from using them in other health care activities or in other non-health care programmes. Likewise with housing costs, there is usually a valuable alternative for freed housing resources. Consequently, the use of housing services is a valid cost and must be included in an opportunity cost treatment of resource use.

Personal consumption of the elderly must also, if appropriate, be included in the measurement of costs under an opportunity cost approach. People who are living in the community use up resources in personal consumption of items such as food, heating, lighting, clothing, etc. If the same elderly person was being cared for in an institution such items would be paid for out of the budget of the hospital or the nursing home. Hence, in comparing institutional and community care, personal consumption costs must be included under both forms of care. A public expenditure approach to costing would not include personal consumption in community care because such costs do not fall on the exchequer.

The public expenditure approach ignores informal, non-market, costs of care. Wright *et al.* (1981) points out that the main difference between a conventional accounting notion of cost and the economic concept of opportunity cost is the non-recognition of informal, non-market, carer time in the former. By not valuing informal care, however, those interested in minimizing public expenditure can almost by stealth distort the resource patterns implied by alternative regimes of care. However, few studies have been able to document, or value, the work carried out by carers of dependent persons in the home. The costs for the carer in

terms of employment opportunities forgone, fatigue, worry and leisure time forgone, may nevertheless be immense (Wright. 1987).

Institutional Cost Factors

Variation of costs among institutions has caused particular concern. One would expect that differences, where they exist, are related to case-mix and quality of care, which, in turn, are associated with the explicit (though more usually implicit) objective of the institution. There is some evidence, however, that high cost is not necessarily associated with better quality, particularly in long-stay care (Darton and Knapp 1984). Nevertheless it has to be acknowledged that final outputs, such as those outlined by Challis (1981) are difficult to estimate. That is why most official measurements have tended to focus on intermediate outputs. This has meant that much emphasis has been placed on the services provided. Resource factors such as staff, buildings and equipment are crucial in determining the process of care. So too are qualitative factors which incorporate the social and caring environment within the home as well as the characteristics of the residents themselves. Both sets of factors must be examined if one is to achieve a satisfactory measure of the cost effectiveness of long-term care.

Economies of scale in residential care arise from the use of individual resources such as buildings and equipment, the bulk buying of some inputs, the specialization of inputs and the fact that some variable inputs increase less than proportionately with outputs. Diseconomies of scale arise primarily because homes become more difficult to manage without a significant increase in administration and personnel. The evidence on the most efficient size of home is mixed but there is some support for the view that homes between 50 and 60 beds are cheaper to run than either the very small or the very large homes, although average costs do not seem to vary much over quite a large range (Knapp. 1981). This evidence is for the UK. Private nursing homes of that size in Ireland would be well above the average of 21 beds. The conventional wisdom in this country, as yet untested, seems to be that small is beautiful, though whether this is within the managerial framework of a profit maximizing or profit satisfying strategy is unknown.

Resident characteristics will of course exert the same type of influence on cost in long-stay care as case-mix does in acute hospitals. More dependent elderly persons receive more hours of care from staff and require more paramedical and other services (Blackwell *et al.* forthcoming). International research on the relationship between the characteristics of old people and the cost of care indicates that age, sex, marital status, mental health, and functional status have all been found

to be significant (Pollak. 1976). One way, therefore, that private and voluntary nursing homes may keep costs down is by using strict criteria to admit only less troublesome, low or medium dependent people.

Staff characteristics also influence the cost of care in long-stay institutions as do the location, ownership and design characteristics of the capital stock. As Knapp (1981) warns, however, particular care should be taken in the interpretation of any observed association between costs and staffing levels (and capital stock), for this association may only be reflecting the simple accounting identity which is of little value for policy purposes.

Community Care versus Long-stay Care

The comparative cost of care between formal community care and institutional care has been the subject of much research. The type of institutional care usually considered is public long-stay care, reflecting the easier access to information about such homes compared to those in the private sector. It is clear from the work that has been done that living at home is cheaper than public long-stay institutional care. For example, Wright *et al.* (1981) calculate that the cost difference between residential and domiciliary care for people living alone is £30 Sterling per week (1977 prices). Much of their subsequent analysis centred on calculating the community care services that this money differential could purchase in order to keep elderly persons of agreed dependency at home. Similarly Wager (1972) estimated the amounts by which the resource costs of institutional care exceeded those of domiciliary care under various circumstances. The differential set an upper limit to the amount of resources that could be ascribed to additional domiciliary care in an effort to maintain a standard of care equivalent to that provided by residential homes.

Very much within this framework the Kent Community Care experiment has been looking at an integrated approach to service provision for elderly people living at home (Challis and Davies. 1980). Within an agreed budget, set at two thirds the cost of alternative institutional care, social workers are empowered to demand and allocate diverse resources on behalf of elderly persons with the objective of keeping them out of institutions. Sometimes, the relative attractiveness of community care is confined to particular categories of people. For example, Gibbins *et al.* (1982) suggest that augmented home care is cheaper for selected chronic elderly invalids. Patients are suitable for home care only if they can be left unsupervised at night or if a relative is available to provide supervision.

One of the problems with much of this research is the absence of a valuation for informal care. Without such a valuation the cost of community care is underestimated. A recent Irish study (OShea and Corcoran, 1989) applied an opportunity cost valuation to a small survey of elderly persons living in the community but on the margin of institutional care. They found that when informal care is valued in this manner the cost of community care is not significantly different to that of institutional care. This finding does not, of course, necessarily weaken the case for community care. In fact, it is possible to infer the opposite conclusions from their work. i.e. that community care, even with the monetary valuation of informal care, is still not more expensive than institutional care. A forthcoming study by Blackwell *et al.* on the comparative cost of care of the elderly will deal more comprehensively with the possibilities which exist for the valuation of the informal sector and the implications for policy-makers of such valuations.

The valuation of statutory services can also pose problems for the researcher. The cost of community care is usually estimated on the basis of actual service provision. There may, however, be differences between actual and optimal provision. Costs may be low because the level of care provided is inadequate, not because it is more efficient. The choice, therefore, is to apply cost effectiveness analysis to existing services, ignoring standards of care, or alternatively to analyse resource allocation at the highest standard of provision, always assuming, of course, that health professionals and policy-makers agree on the definitions of optimality. This may not be an easy task. Nevertheless some support can be found in the literature for following the optimal approach to service measurement and valuation. Sinclair (1986) indicates that about one-third of applicants for places in local authority residential care could be maintained at home with a guaranteed delivery of intensive domiciliary care. Hakansson (1986) has estimated that for two study areas in Sweden a number of people could be discharged to domiciliary care if appropriate services were available. However, the Avon Study (1981) comes closest to establishing some measure of optimum community care.

Of course, comparing the cost of care across regimes of care is only one aspect of the economic evaluation of balance of care options for elderly persons. The other major issue is the identification of factors crucial to the placement of elderly persons. Mooney (1978) found that living alone and not being able to walk outdoors are important influences on the decision to transfer elderly people from community care to institutional care. O'Shea and Corcoran (1989) tentatively suggested that the following variables influenced the placement of elderly persons: sex of elderly person, living alone, living conditions, presence or absence of public health nurse, general practitioner and home help, immobility

outside the home and inability to bathe all over. In his survey on care of the elderly Wright (1986) reports that a major cause of the breakdown of care in the home in European countries was the social isolation of living alone and the ensuing feelings of insecurity and loneliness. Wager (1972) considered incapacity as only one of the problems which affected an application for a residential home place. Other factors such as accommodation problems, difficulties with household relationships and loneliness were also important, giving rise to almost half of all applications.

Notwithstanding all of the above, there is no implication from the literature that the current living arrangements of elderly persons should be disturbed without consulting the elderly persons themselves. Most of the elderly may actually like where they are now living, whether this is in community or institutional care. Here lies a crucial weakness of much research in care of the elderly. Seldom are the preferences of the elderly person taken into account. Instead, consumer satisfaction, if included at all, is measured by proxy. Usually carers or health professionals are asked about the quality and benefits of caring alternatives. Rarely, if ever, is the elderly person consulted. Much more work needs to be done on establishing the preferences of elderly persons with respect to caring regimes. For too long their values and their preferences have been absent from the research agenda.

Long Term Care: Public Versus Private

There has been no attempt in Ireland, and little effort in any other country, to evaluate the relative economic and social merits of public long-stay versus private nursing homes for elderly persons. Part of the explanation for this lies in the difficulty of obtaining information about costs and outcomes in either regime. In addition, the generally haphazard approach to resource allocation has done little to discourage inertia in this regard. It is only recently that an attempt has been made to estimate the cost of care in public long-stay institutions in Ireland (Blackwell *et al.*, forthcoming). There is some limited information on the cost of private nursing home care² which will be considered in more detail in the following chapter. However, these data are neither comprehensive nor dependency specific and are merely a rough indication to the industry on what to expect when operating a nursing home as an economic unit. Even more fundamental perhaps than the absence of good cost data is the fact that there has been no effort to examine the process of

²The Irish Private Nursing Homes Association has, however, recently completed a study to determine the factors which most affect cost in their members' homes.

institutionalisation or what is expected of long-stay care, either public or private.

It is little wonder, therefore, that there is a great diversity of opinion about standards of care in private relative to public institutions as well as what should constitute an appropriate environment for at-risk elderly persons. At the moment there is no way of systematically quantifying whether one form of care is better than any other. All one can say with certainty is whether homes meet certain physical and staffing requirements. If one could be sure that standards of care were equal between public and private, that quality was homogeneous for similarly dependent elderly, then the efficiency argument could be reduced to a discussion on relative costs. The absence of such a certainty makes evaluation difficult. There are, however, models of care available on which to base investigation into these issues.

In particular the following characteristics have been established as important in fostering a positive long-stay environment for the elderly (Wade, Sawyer and Bell, 1983):

- (i) be domestic or homely
- (ii) foster social interaction
- (iii) provide opportunities for choice
- (iv) give recognition to the adult status of the elderly
- (v) provide opportunities for the elderly to undertake activities which are salient to their lives.
- (vi) feature participation and consultation in the care regime by the elderly themselves.

Using these characteristics it is possible to identify four models. The "supportive" model of care is characterised by consultation and involvement of the elderly in the care regime. The process is consumer oriented with much of the impetus for activities originating with the elderly person. The "protective" model also encourages some degree of choice and consultation but within the frontiers laid down by staff. Even more constrained is the "controlled" model of care in which the patient is completely subordinate to the care regime. Most restrictive of all, however, is the "restrained" model which operates purely for the convenience of care staff. According to Wright (1985), patients or residents cared for under this approach are deprived of choice and are essentially "batch processed".

There is a considerable diversity of nursing opinion about whether patients or residents are able to choose what is best for them. Not

surprisingly therefore, there is evidence from Wright (1985) and Blackwell *et al.* (forthcoming) that the process of caring is different among and sometimes within institutions. In some places patients are encouraged to be self-reliant even if this means that considerably more help has to be given in order to achieve this state. In other homes nurses simply carry out tasks for elderly residents rather than encouraging them to do things for themselves. The danger with the latter approach is that residents may quickly become institutionalised, dependent on caring staff in all aspects of their lives (Booth. 1985). Thus, for example. Miller (1984) has argued that nursing actions, instead of responding to dependency, can actually cause dependency, sometimes in a very unsystematic way.

Ultimately, the process of care within institutions affects quality and outcomes. In this regard it has often been claimed that nursing homes avoid some of the institutional excesses of the public sector (IPNHA. 1988). Homes are smaller, care is more homely, individual preferences are respected and standards are as high if not better than public long-stay institutions. One of the difficulties with such comparisons, apart from the absence of evidence, is that one is often not comparing like with like. For example, dependency levels may differ within and among institutions, so also may the goals and priorities of long-stay homes. For example, in the absence of any assessment procedures, one can only assume that the aim of the private nursing home sector is solely to provide long-term nursing care. This is also the objective of some but not all long-stay public institutions. There is also concern that elderly persons in private nursing homes do not have access to much needed rehabilitative health care facilities such as paramedical, day hospital and/or day care services. Not, of course, that some public institutions are often very different in this regard. But all of this does make it difficult to be unambiguous on whether public or private fare better on the quality index.

No firm conclusion on the relative efficiency of public and private provision can, therefore, be made: only costs can be compared. Some of the cost comparisons which have been made (outside of this country) have not, however, been adjusted for differences attributable to the characteristics of the homes and their residents. One of the more sophisticated comparisons was carried out by Judge *et al.* (1986), of the costs of local authority (LA) and private residential homes for the elderly. From a survey of 456 residential homes in twelve local authorities, the mean charge in private homes was 17 per cent below the average cost of LA homes. After standardising for the difference in characteristics of homes and residents in each sector, though not of outcomes, the cost advantage to the private sector was maintained. More subjective assess-

ments by Bradshaw and Gills (1988) suggest that private sector homes also provide good quality care at reasonable prices. Wright (1985) compared the cost of caring for elderly people in NHS long-stay hospitals with care provided in contract beds in private nursing homes. Average costs were found to be 33 per cent less in the nursing homes than in the NHS hospitals even after allowing for the higher level of dependency among patients in hospital.

Generally the reason for the better cost performance of the private sector seems to rest with lower labour costs per member of staff (Judge *et al.*, 1986). Private homes also seem to benefit from the cost reducing features of small businesses. For example, proprietors are closely involved in the running of the enterprise and put in long hours of work. There seems to be an implicit view, though no evidence, that the relative cost advantage of the private sector also holds in Ireland. Again the advantage is assumed to be primarily related to low labour costs with proprietors very much involved in the day to day operation of the home. There is, however, a possibility that nursing and ancillary staff may not in all cases be receiving market rates for their services.

All of this discussion emanates from a static comparison of public and private sector homes. It does not necessarily follow, therefore, that more services could be provided from the available funding if greater use was made of the private sector. If such a transfer was to take place the marginal costs of care in the private sector might increase substantially. An expansion of the sector might attract less motivated proprietors and employees unwilling to continue making the sacrifices (or in some cases putting up with the injustices) to ensure relatively low cost provision. As Culyer *et al.* (1988) remind us, static comparisons are likely to be poor predictors of the consequence of radical change.

Conclusions

Much more information is required on the cost and quality of caring for elderly persons in alternative locations. In particular the role of the informal sector has still to be satisfactorily quantified and valued. Research on outcomes must also be pursued if we are to avoid accepting the accounting balance sheet as a substitute for real health care evaluation. The decision on which is better, community or institution, has implications for the future evolution of the nursing home sector. There is little point, however, in comparing *de facto* community care with its alternatives. All the evidence points to the present inadequacies of that system, at least as currently financed and structured. Moreover, our knowledge of costs and quality is limited in relation to the institutional sector, and particularly in the case of nursing homes, which form the subject of the next chapter.

CHAPTER 3

The Nursing Home Sector

Introduction

In this chapter we present revised estimates of the total number of nursing home beds. Problems with respect to the collection and compilation of long-stay statistics have combined to confuse matters in this area. This is particularly the case with respect to the official statistics which have (up to now, at least) somewhat confusingly disaggregated nursing homes into "voluntary approved" and "other private". We will show that this division does not make sense either at a conceptual level or from a practical point of view. We also present revised estimates for 1988 showing an extra 2,649 beds in the nursing home sector not recorded in Department of Health Long-stay Care Statistics. The location and size of all long-stay units is compared by region across the country. Our analysis indicates variation in the number of beds across regions which cannot readily be explained without recourse to a more detailed model of cause and effect. What is apparent, however, is that it is not always the case that an inverse relationship exists between public and private provision.

The process of care within the nursing home sector is also examined. The evidence in this regard is rather sparse though we will attempt to draw together the information which is available, particularly in respect of the influence of type of home, size, and staffing. The situation is similar with regard to the cost of care within the sector. It would be ideal if we could cite evaluative studies, based on the methodology outlined in Chapter 2, thereby clarifying the cost effectiveness of homes relative to care in the public sector. Such studies do not exist. This presents a problem for the authorities when it comes to fixing subsidies for patient care. We will investigate the possibility of using charges as a proxy for costs when setting subsidies. This will only be good practice if we can establish a clear linear relationship between costs and charges.

Population Ageing

In 1986 there were 384,355 people aged 65 or older, representing 10.86% of total population (Table 3.1). Proportionately, this is not high by

European standards and reflects, in part, continued high levels of fertility in the population which tended to balance out improvements in life expectancy. (It is still the case, however, that life expectancy in Ireland is among the lowest in Western Europe.) Emigration too may affect the proportion of older people in the population. Indeed, the peak levels of emigration in the 1950s actually led to a rise to 11.2% in the proportion aged 65 or over, despite an absolute reduction in the number of older people. In the future, it is likely that reduced levels of fertility will contribute towards a relatively older population structure, though the picture with respect to emigration is less clear. The latter is very difficult to predict in such an open economy as Ireland. The most recent projections by the CSO predict that there may be 437,400 people aged 65 or more by 2011, or 12.62 per cent of population, with a further possible increase to 553,100 (16 per cent) by 2021.

Table 3.1: Population classified by age group at each census since 1926

Census Year	Age Group						Total	Per cent 65+
	0-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and over			
1926	867,879	526,418	743,545	562,470	271,680	2,971,992	9.1	
1936	820,394	522,839	755,394	583,109	286,684	2,968,420	9.7	
1946	823,007	482,777	770,363	564,638	314,322	2,955,107	10.6	
1951	854,810	443,354	771,229	574,809	316,391	2,960,593	10.7	
1961	877,259	391,839	635,250	598,930	315,063	2,818,341	11.2	
1966	900,396	444,645	613,576	602,378	323,007	2,884,002	11.2	
1971	931,152	482,978	626,180	608,119	329,819	2,978,248	11.1	
1979	1,029,908	583,639	797,427	595,868	361,375	3,368,217	10.7	
1981	1,043,729	602,556	837,764	590,402	368,954	3,443,405	10.7	
1986	1,024,701	617,524	922,619	591,444	384,355	3,540,643	10.9	

Source: *Census 1986 Summary Population Report, Table 2.*

Population ageing has also been much in evidence. Throughout this century the fastest growth in the population has been in the oldest subgroups of the population over 65 years. The total number of people aged 65 or over rose by 41 per cent between 1926 and 1986 but among those aged 75 to 79 the increase was 64 per cent (to 75,519) while among the 80+ group it was 62 per cent (to 68,324). (Table 3.2) This trend is expected to continue in the future. Between 1986 and 2011, the elderly population as a whole is expected to increase by 14 per cent. In the same period the 75 plus age group will increase by 19 per cent compared with a more gradual rise of 11 per cent among the 65 to 74 age group.

The number of elderly women exceeds that of elderly men. This reflects the generally higher expectation of life among women and is not confined

TABLE 3.2: Elderly persons in each age group classified by marital status, at each census from 1926 to 1986

Age Group and Marital Status (a)	1926	1936	1946	1951	1961	1966	1971	1979	1981	1986
65-69										
Total	101,212	113,001	114,531	107,548	103,488	114,226	111,751	133,787	133,919	129,498
Single	22,901	28,119	29,797	28,997	27,127	30,083	29,441	32,446	31,731	29,168
Ever Married	50,839	56,751	55,305	51,851	51,742	57,482	57,455	71,325	72,037	70,368
Widowed	27,472	28,131	29,429	26,700	24,619	26,661	24,855	30,016	30,151	29,962
70-74										
Total	82,246	85,940	99,910	100,116	92,790	90,099	98,986	98,284	103,138	110,996
Single	17,199	20,939	24,917	25,961	24,620	23,785	26,114	25,054	25,685	25,572
Ever Married	33,474	34,400	40,592	40,382	37,685	37,830	40,892	42,702	45,716	50,348
Widowed	31,573	30,601	34,401	33,773	30,485	28,484	31,980	30,528	31,737	35,076
75-79										
Total	45,967	52,988	60,502	64,555	63,310	62,801	61,775	68,856	68,451	75,519
Single	8,423	11,254	13,843	15,225	16,132	16,046	15,807	17,731	17,480	18,100
Ever Married	14,682	17,423	20,080	21,680	20,915	21,105	21,135	22,817	23,232	26,458
Widowed	22,862	24,311	26,579	27,650	26,163	25,650	24,833	28,308	27,739	30,961
80-84										
Total	27,397	23,250	26,142	30,887	37,040	35,584	36,375	37,987	40,462	42,884
Single	4,293	4,300	5,485	6,624	8,404	8,731	8,908	9,247	9,889	10,563
Ever Married	6,836	5,916	6,676	8,151	9,630	9,335	9,585	9,329	9,827	10,291
Widowed	16,268	13,034	13,981	16,112	19,006	17,518	17,882	19,411	20,746	22,030
85+										
Total	14,858	11,505	13,237	13,285	18,525	20,297	20,932	22,461	22,984	25,458
Single	1,892	1,780	2,553	2,640	3,932	4,493	4,936	5,502	5,457	6,065
Ever Married	2,694	1,991	2,408	2,545	3,384	3,751	3,664	3,758	3,680	3,624
Widowed	10,272	7,734	8,276	8,100	11,219	12,053	12,332	13,201	13,847	15,769
All Ages	2,971,992	2,968,420	2,955,107	2,960,593	2,818,341	2,884,002	2,978,248	3,368,217	3,443,405	3,540,643

(a) Ever Married includes all married, remarried and separated persons and excludes widowed.

Source: Census 1986, Volume 2, Table 1A.

to Ireland. Again, in the older subgroups of the elderly population, the preponderance of women increases. In 1986, there were 17,449 women aged 85 years or older — more than twice the number of men in the same age group. (Table 3.3) Not surprisingly, therefore, this is reflected in disproportionate numbers of women among long-stay institutional residents.

Location and Dependency

In addition to changes in the age of the population, recent decades have brought about significant changes in household size and composition. The number of elderly people in multi-person households (3 or more persons) fell from 228,550 (72.6 per cent) to 202,961 (55 per cent) between 1961 and 1981. Over the same period the number of elderly people in households consisting of man and wife rose from 30,058 (9.5 per cent) to 65,364 (18.3 per cent). These trends are important in the sense that smaller households and confinement to one generation per household tend to reduce the potential source of household carers and hence to raise the demand for other services. Perhaps even more significant is the increasing number of elderly persons living alone in private households. From 32,210 (10.2 per cent) in 1961, this number has risen to 68,034 (18.4 per cent) in 1981 and to 81,174 (21.1 per cent) in 1986 (Table 3.4). This trend is expected to continue in the future (NCA: 1985). When compared to other OECD countries, however, where typically about 40 per cent of elderly people live alone, the Irish level is relatively low.

TABLE 3.3: Elderly population by age & sex, 1986

	Male	Female
65 — 69	61,080	68,418
70 — 74	50,881	60,115
75 — 79	32,635	42,884
80 — 84	16,126	26,758
85+	8,009	17,449
Total (65+)	168,731	215,624

Source: *Census 1986, Summary Population Report*

Dependency among the elderly in Private Households has been examined in cases where a carer is available in some recent reports (O'Connor *et al.*, 1988a; 1988b; Blackwell *et al.*, forthcoming). According to O'Connor *et al.* (1988a) some 66,300 (19 per cent) of elderly people living in private households were receiving care in the community. The degree of care required varied from "a lot of care" (36 per cent) to "some care"

TABLE 3.4: Persons, males and females age 65 years and over distinguishing the number and percentage living alone in private households, in 1986

Age Group & Sex	All persons	Persons in Private Households	Persons living Alone		
			All persons	As % of all persons in the age group	As % of persons in the age group in private households
Age 65 years and over	384,355	351,478	81,174	21.1	23.1
Persons					
Males	168,731	157,243	27,973	16.6	17.8
Females	215,624	194,235	53,201	24.7	27.4

Source: *Census 86 Summary Population Report*

(38 per cent) and "occasional care" (26 per cent) (Table 3.5). Blackwell *et al.* (forthcoming), using a standardised Guttman scale, show that 45.5 per cent of their sample of elderly persons being cared for at home are in the lowest dependency category (A) (Table 3.6). The remainder are spread across successively higher categories as follows: Category B (19 per cent). Category C (13 per cent). Category D (9.1 per cent) and Category E (5.61 per cent). The remaining 7.1 per cent are non-scale, but would be closest to Category C if scaled using a Likert format. Those in the lowest category of dependency still received an average of approximately 38 hours of care per week. Those in higher categories received correspondingly more care with the most dependent elderly persons receiving 86 hours of care per week.

TABLE 3.5: Level of care required by elderly persons, classified by their age (based on data from households which contained an elderly person)

Age Group	A Lot of Care	Some Care	Occasional Care	No Estimated Care	Total Number
	%	%	%	%	(000)
65 — 69	11.0	13.2	8.4	41.0	120.1
70 — 74	17.9	20.1	27.3	34.7	109.4
75 — 79	24.2	17.3	24.5	14.8	55.2
80 — 84	21.8	31.7	25.4	7.2	37.3
85 — 89	14.8	12.6	10.9	2.1	14.5
90 and over	10.3	5.1	3.5	0.2	4.9
Total	100.0	100.0	100.0	100.0	
Estimated Total No. ('000)	23.9	25.0	17.3	275.2	341.5

Source: O'Connor *et al.*, 1988a

TABLE 3.6: Dependency level of elderly persons living in the community and aggregated across four selected public long-stay institutions

Guttman Scale Level of Dependency	Community		Institutions	
	N	%	N	%
A	90	45.5	65	21.8
B	38	19.7	21	7.0
C	26	13.0	39	13.1
D	18	9.1	48	16.1
E	11	5.6	117	39.3
Non Scale	14	7.1	8	2.7
All	198	100	298	100

Source: Blackwell *et al* (forthcoming)

Not all elderly people live in private households. But the proportions who do have tended to be stable in recent decades: in 1961 some 91.3 per cent of people aged 65 or more were living in private households while the figure was 91.7 per cent in 1981 and 91.5 per cent in 1986. Thus the total elderly population in non-private households has tended to vary around 8.5 per cent in recent decades. This compares with 3.2 per cent of the general population living in non-private households in 1981. Non-private households include such locations as boarding houses, hotels, guest houses, barracks, hospitals, nursing homes, religious institutions, welfare institutions, prisons and ships. Obviously, not all of these categories are relevant in the long-stay care of the elderly, while others will have virtually no elderly people in them at all.

Unfortunately, a breakdown of the distribution of elderly people in each type of non-private household is not available from the 1986 Census of population. Estimates in *The Years Ahead* report suggest that 18,500 persons or 4.8 per cent of the elderly population are in long-stay care (excluding acute care). The Commission on Health Funding estimate that the total number of elderly patients receiving long-term residential care is about 20,000. Using official sources only, we estimate that some 16,000 (4.2 per cent) elderly people were resident in geriatric long-stay units (in geriatric hospitals, welfare homes and nursing homes) in 1986.'

District hospitals account for approximately 0.4 per cent of old people. A further 1.3 per cent were likely to be in-patients of psychiatric hospitals and related hostels, while approximately 1.2 per cent were estimated to

This figure does not take account of the likelihood of additional beds in the nursing home sector. We were not in a position to incorporate all data for 1986 in a revised estimate as done for 1988. See note (3) on Table 3.7.

Table 3.7: Estimated distribution of the 1986 elderly population (65 and over) by location

Location	Population Aged 65+	Percentage of all Aged 65+	Notes
Private Households			
Receiving Care at home	68,190	17.74	(1)
Independent of Carer	283,310	73.71	(2-1)
Total in Private Households	351,500	91.45	(2)
Non-Private Households			
Long-stay Geriatric Units (ex District)	16,034	4.17	(3)
Psychiatric Hospitals and Hostels	4,926	1.28	(4)
Acute Hospitals (ex District)	4,590	1.19	(5)
District Hospitals	1,450	0.38	(6)
Other Non-Private Households	5,860	1.53	7-(3+4+5+6)
Total in Non-Private Households	32,860	8.55	(7)
Total Population Aged 65+	384,360	100.00	(2+7)

(1) Percentage figures pertain to research during 1985.

(2) CSO: *Census 1986 Summary Population Report*, Table 13.

(3) According to the Department of Health Survey there were 15,233 residents in long-stay geriatric units in 1986, for which year the survey covered 95% of "known" beds. Correcting for this gives a figure of 16,035 (4.17%). There is still some underestimation due to the existence of a number of nursing homes "unknown" to the Department at the time. This is corrected in Table 3.9.

(4) In 1986 there were approximately 12,700 inpatients in psychiatric hospitals and hostels. Figures are not usually published on the age of patients but in 1981 some 39% were estimated to be 65 or older by the Department (See *The Psychiatric Services — Planning for the Future*, 1984, Page 39). This suggests that about 4,926 patients were elderly in 1986.

(5) There were 16,876 beds in December 1986, giving 6,159,740 available bed days. Actual occupancy, based on 566,105 discharges by 7.4 days average length of stay comes to 4,189,177 or 68%, suggesting 11,475 patients. According to the Department, at least 40% are over 65 years, giving 4,590 elderly patients. This is 1.19% of the elderly population.

(6) There were 2,293 beds in District Hospitals in December 1986. The occupancy rate of 83.6% gives 1,917. Various sources suggest the preponderance of elderly patients. If we assume 75%, we get 1,450 approximately or .38% of the elderly population.

(7) *Census of Population*, 1986.

be in acute hospitals. This leaves approximately 5,860 (1.5 per cent) old people in other non-private households. Table 3.7 provides an overview of the location of elderly people and notes on how the figures are derived.

Blackwell *et al.* (forthcoming) provide information on the distribution of scaled dependency in long-stay institutions. Their work allows comparative analysis on the distribution of dependency among elderly persons in the community and in institutions. We have already seen that almost half of their sample of elderly persons receiving care at home are in the lowest category of dependency. Using the same scale and methodology their work also provides an estimate of the distribution of dependency among elderly persons in a selected number of public long-stay institutions. Fewer elderly persons are in the lowest category of dependency while more people are in higher categories of dependency, compared to the community survey (Table 3.6). It should be noted, however, that among the four institutions surveyed there is quite a difference in the distribution of dependency. For instance, while one institution had only 7 per cent of its residents in the lowest category of dependency, another had 38 per cent of all residents in that category.

The Nursing Home Sector

Nursing homes for the elderly may be run privately, for profit, or voluntarily, mainly by religious communities or a charitable body. Information based on a 73 per cent response rate from all nursing homes identified in 1985 suggested that 38 per cent of homes could be classified as voluntary, the remainder (62 per cent) as private for profit (O'Connor *et al.*, 1986). More recently the Minister for Health said that there were 332 nursing homes in the country, 86 per cent of which are private, 14 per cent voluntary (*Dail Report*, 9th November, 1989). One cannot assume from these figures, however, that between 1985 and 1989 the mix of private and voluntary homes has altered dramatically in the country. A real problem exists in establishing just how many nursing homes there are at any given time. This is evident if one compares the estimate of voluntary homes provided in *The Years Ahead* (1988) with the estimates quoted above by the Minister for Health (1989). Combining section 9.39 and Table 9.11 of *The Years Ahead* suggests that 24 voluntary nursing homes were known to the Department of Health in 1988, seven of which were approved for subvention. Yet the Minister's speech one year later suggests that there were 46 voluntary homes (14 per cent of 332) in the country. These differences are explained primarily by more information becoming available on homes already in existence but which were previously unknown to the authorities.

The identification problem arises mainly from the way nursing homes have, up to now, been regulated. Existing legislation — i.e. prior to the Health (Nursing Homes) Act 1990, which at the time of writing is not yet in force — obliges a person who proposes to set up a private nursing home to notify the relevant health board in writing one month before it is proposed to admit residents. In theory this should allow an accurate register of private nursing homes to be established. There is, however, the possibility that private homes are set up which do not comply with the regulations and the health board has to retrospectively set about ensuring that the regulations are met. Some nursing homes may also be inefficient in sending in returns, providing irregular rather than annual information. The major cause of poor data in this area is, however, the system of notification between the health boards and the Department of Health, which is notoriously sluggish. Health boards have apparently no obligation to immediately relay new notifications to the Department. Nor is there any great urgency to ensure that homes are taken off lists when they are known to have ceased trading. Needless to say this can only be detrimental to the efforts of the Planning Unit in the Department to monitor this sector.

In some cases retirement or rest home status may have been used to avoid the obligations of the legislation. Proprietors who are in fact nursing dependent elderly persons may classify the homes as rest or retirement thereby avoiding the regulatory controls of the health board. More generally, the accurate quantification of the sector is made more difficult by the fact that voluntary homes are not covered by the 1964 Act and have in the past been under no obligation to inform the Department of Health of their existence. Consequently, the exact number of these homes has never been known to the Department of Health. This has resulted in the different estimates referred to above. Changes in estimates, when they do occur, are often due to chance factors bringing these homes to the attention of the authorities.

If more evidence of the absence of clarity in this area is required it is provided by the estimate of nursing home beds contained in the long-stay statistics produced by the Department of Health. Up until 1983, estimates of nursing home provision showed the total number of beds (Table 3.8)². From 1983 onwards the sector is broken into "voluntary approved" nursing homes and "other private" nursing homes. This division does not make sense because there are beds in private nursing homes which have been approved for subvention. Moreover, we are

²A breakdown is also available for 1982 though not included in the official statistics. The relevant figures are 3,413 beds in the approved sector and 2,576 beds in the other category.

also aware that there is a large non-approved voluntary sector. Neither sector is explicitly included in the official statistics. The Department of Health is now revising its presentation of statistics in this area. In the future, long-stay institutions will be categorised into public, voluntary, private and other non-registered (in so far as information is available on the latter). This should improve matters considerably by allowing the data to be interpreted in a meaningful way which has not been possible up to now.

Revised Estimates

In this section we present revised estimates of the number of long-stay beds (excluding acute care and psychiatric) in the country for 1988. What makes our estimates different from the official sources for the year is the use of a more complete listing of nursing homes based on a search of health boards by the Department of Health, conducted in November 1989, in the context of the new legislation. This search brought to light well over 100 homes which had been omitted previously. We have combined these units, and data on the number of beds in each, with the data on which the official figures for 1988 were based. We have also re-classified nursing homes, more simply, into voluntary and private homes. In spite of some possible problems of boundary definition, we believe that this represents a substantial improvement on the existing classification in use. Finally, we present a regional analysis of these figures showing the number of units, number of beds and average size of each unit for each of the following types of geriatric unit:

1. Health Board Geriatric Hospitals/Homes.
2. Health Board Welfare Homes.
3. Voluntary Hospitals/Homes.
4. Private Nursing Homes.

Official statistics show the size of the nursing home sector to be 6,412 beds (Table 3.8). Our estimates indicate a total of 9,061 beds (Table 3.9). The additional 2,649 beds arise from the inclusion of the hitherto unprocessed data. It is not claimed that these estimates are precise though they are more exact than have been produced up to now. One of the difficulties is that there are still some private homes which do not return any information on bed numbers, even though surveyed every year. While, by definition, excluded from the data it cannot be assumed that these homes have necessarily ceased trading. Nor can we be certain that all voluntary homes are included in the figures. As already noted such homes are not compelled to comply with the 1964 Act. Not-

withstanding these two *caveats* we are confident that the figures provided are the most accurate assessment of the size of the nursing home sector available at this time.

TABLE 3.8: Long-stay geriatric care beds. 1980-1988

Year	Health Board Geriatric Hospitals/Homes	Welfare Homes	Voluntary/Approved Nursing Homes	Other Private Nursing Homes	All Nursing Homes	Total Long-Stay Beds
1980	7,541	1,185	—	—	4,700	13,426
1981	7,777	1,342	—	—	4,771	13,890
1982	7,798	1,452	3,413	2,576	5,989	15,239
1983	7,586	1,451	3,270	2,398	5,668	14,705
1984	7,533	1,535	3,153	2,790	5,943	15,011
1985	7,275	1,506	3,197	3,091	6,288	15,069
1986	7,302	1,509	3,150	3,272	6,422	15,233
1987	6,971	1,474	3,099	3,171	6,270	14,715
1988	7,077	1,433	3,171	3,241	6,412	14,922

Source: Department of Health *Long-stay Geriatric Statistics Reports* (unrevised): various years.

TABLE 3.9: Geriatric beds* in all health boards by type, 1988

Type	No. of Units	No. of Beds	Average Beds/Unit	Standard Deviation	Min. Size	Max. Size	No. of Section 54 Beds (if applic.)
Geriatric Hospitals & Homes	45	7,005	155.67	94.01	14	364	—
Welfare Homes	42	1,589	37.83	6.92	19	60	—
Voluntary Hospitals/Homes	59	3,509	57.47	47.56	9	197	682
Private Nursing Homes	262	5,552	21.19	14.94	4	151	1,672
All	408	17,655	42.27	—	4	364	2,354

*Excluding long-stay beds in District Hospitals

Source: Revised estimates compiled from Department of Health data.

In our inventory of total long-stay beds we have also included an estimate of the number of geriatric beds in district hospitals. For this we draw on a survey of district hospital beds carried out by the Department of Health. There are no detailed figures on the age of patients in district hospitals, but the average length of stay for each unit is known. Our approach is to assume that any bed occupied for more than 30 days, by the same person, is a long-stay geriatric bed. Using this methodology, a total of 1,465 beds in 30 hospitals have been identified (Table 3.10).

The total number of long-stay beds is 19,120, excluding those in the acute sector and in psychiatric institutions. The Eastern region contains the lowest number of public long-stay and welfare beds per 1,000 of the elderly population (Table 3.11). In contrast, however, this region has the highest rate of voluntary beds and the third highest rate of private accommodation. The mix of public and private provision is generally quite varied within and among regions (Tables 3.11 and 3.12). The Western Health Board, for example, has 403 welfare home places and 949 geriatric hospital beds compared with 157 welfare and 1,051 geriatric hospital beds in the East. Yet it has only half the number of elderly in its population. The West, however, has much fewer private beds (495) and no recorded voluntary provision. The overall bed provision ranges from 38 per 1,000 elderly persons in the West to 61 per 1,000 in the Mid-West. The North-West has the lowest private provision (3 per 1,000) while the Mid-West has the highest (24 per 1,000). Voluntary provision is highest in the East with 20 beds per 1,000 population.

TABLE 3.10: District hospitals and beds by region and district hospitals and beds where length of stay is greater than 30 days, in 1988

Health Board	Total Number of Hospitals	Total Number of Beds	No. of Hospitals with LOS >30 days	No. of Beds in Hospitals. LOS > 30 days
Eastern	3	370	3	370
Midland	4	194	3	161
Mid-Western	2	70	2	70
North-Eastern	—	—	—	—
North-Western	5	210	3	137
South-Eastern	7	180	5	133
Southern	17	745	14	594
Western	3	137	—	—
Total	41	1,906	30	1,465

Source: Department of Health Data.

TABLE 3.11: Beds per 1,000 elderly population in all long-stay geriatric units and district hospitals by health board areas, in 1988

Health Board	Health Board Geriatric Hospitals	Health Board Welfare Homes	Health Board District* Hospitals	Private Nursing Homes	Voluntary Hospitals/ Homes	Total Beds
E	9.7	1.8	3.4	19.0	20.3	54.2
M	27.6	6.9	6.9	9.6	7.2	58.3
MW	29.2	3.5	2.0	23.8	2.5	61.0
NE	31.7	3.7	0.0	10.1	1.4	47.0
NW	20.4	8.6	4.5	2.9	6.8	43.3
SE	21.8	3.8	3.2	22.0	1.7	52.3
S	12.3	2.6	9.3	9.4	11.4	45.1
W	19.3	8.2	0.0	10.1	0.0	37.5
All	18.2	4.1	3.8	14.4	9.1	49.7

*Length of stay greater than 30 days.

Source: Revised Estimates Compiled from Department of Health data.

TABLE 3.12: Long-stay geriatric unit and district hospital beds by health board area in 1988

Health Board	Health Board Geriatric Hospitals	Health Board Welfare Homes	Health Board District* Hospitals	Private Nursing Homes	Voluntary Hospitals/ Homes	Total Beds
E	1,051	197	370	2,055	2,198	5,871
M	639	160	161	223	167	1,350
MW	1,029	123	70	837	89	2,148
NE	1,010	118	0	323	46	1,497
NW	621	260	137	88	208	1,314
SE	918	159	133	928	70	2,208
S	788	169	594	603	731	2,885
W	949	403	0	495	0	1,847
Total	7,005	1,589	1,465	5,552	3,509	19,120

*Length of stay greater than 30 days

Source: Revised Estimates Compiled from Department of Health data.

Explaining the observed variation in bed provision is more difficult and beyond the scope of this study. A detailed model would be required to examine this issue. Such a model would focus ultimately on whether there were morbidity and dependency characteristics across regions which gave rise to differences in bed provision, especially public provision. As well as this the model would have to consider factors such

as age, sex, marital status, number of people living alone and social conditions, as well as the availability of carers in the community. Even then one would be surprised if the model succeeded in explaining all variation, particularly as some of it more than likely relates to historical factors. The buildings were available (often the remnants of the old work-houses) so they were used. This was never subsequently corrected by the use of more scientific resource allocation mechanisms, although it is acknowledged that the rational closure of traditional public long-stay institutions is a difficult and often protracted process.

What does not seem to have happened is the development of a general inverse relationship between the number of beds in the public and private sector. It is tempting to point to the East, North East, Midland, North West and West as indicating just such a relationship. What holds true for these regions does not, however, hold for the Mid-West, which has a relatively high bed-to-population ratio for both the public and private sector. The South East is another exception, while the South has relatively low rates for both. Finally, suspicions of more random, non-need related factors at work are aroused by evidence of relatively low waiting lists in areas with low bed to population ratios (Working Party Report). It would seem that regions with relatively fewer beds are coping just as well, if not better than regions who are better endowed (Department of Health, 1983).

In the absence of a model to explain variation one is hesitant to make any general policy related statements at this point. Although, given the evidence on waiting lists, there does seem to be some justification for encouraging high bed regions to bring down their numbers in line with the national average. To make any more definite pronouncements would be ignoring the complex relationship between care in the home, in the community and in institutions. It will be a key point, repeated many times throughout this study, that the number of elderly persons in institutions is related *a priori* to the absence of incentives and resources to allow them to be cared for in their own homes. It is also much more difficult — and very often bad practice — to discharge an elderly person from hospital than it is to prevent their admission in the first place. A key factor, therefore, in reducing variation in the number of long-stay beds across regions is the implementation of uniform assessment procedures designed to prevent unnecessary admission in the first place.

Characteristics of Nursing Home Residents

It was not part of our brief to present any new information on the residents of nursing homes. Consequently, in this section, we rely mainly on data provided by O'Connor *et al* (1986) in their study for the National

Council for the Aged. Evidence from this survey shows that more than three-quarters of the nursing home population are aged at least 75 years of age compared with 26 per cent in this age group in the general elderly population (Table 3.13). Once in nursing homes, residents tend to stay there on a long term basis. More than half of the elderly in nursing homes have been there for two or more years. Of those discharged from nursing homes, the majority return to the community (Table 3.14). In 1987, 35 per cent of "approved" home (as defined by the Department of Health) discharges were to the community and 10 per cent were to acute hospital care. In that year 48 per cent of residents died. Most admissions also originate in the community though a significant proportion of the elderly in "Approved" homes (35 per cent) are referred from acute hospitals (Table 3.15). The principal reason for admission differs between private and voluntary homes (O'Connor *et al* 1986). The need for nursing care is most important in the private sector while inability to look after oneself, allied with fear of living alone or loneliness

TABLE 3.13: Percentage of elderly residents of nursing homes compared with population of Ireland aged 65 years and over, by sex and age group

Characteristic	Private Nursing Homes	Voluntary Nursing Homes	All Nursing Homes	Elderly Population of Ireland* 1981
	%	%	%	%
SEX				
Male	19.7	22.5	21.2	45.9
Female	80.2	75.9	77.8	54.1
No information provided	0.1	1.6	1.0	—
AGE GROUP				
Under 65*	2.7	4.6	3.8	27.4
65 to 69	4.1	3.4	3.7	26.4
70 to 74	11.4	8.1	9.6	20.3
75 to 79	21.4	18.1	19.6	13.5
80 to 84	28.7	30.0	29.4	8.0
85 or more	28.8	27.7	28.2	4.5
No information provided	2.9	8.1	5.8	—
Total	2,413	3,051	5,464	508,220

*To facilitate comparison with census data it is assumed that the lower limit of this age group is 60 years. The equivalent category for the census data is, therefore, 60 to 64 years.

Source: National Council for the Aged: *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector* (1986).

TABLE 3.14: Destination of discharges from long-stay geriatric units in 1987

Destination of Discharge	Category				Total
	Health Board Geriatric Hospitals/Homes	Health Board Welfare Homes	Voluntary Approved Nursing Homes	Other Private Nursing Homes	
	%	%	%	%	
Community	37.9	28.1	34.9	41.9	37.7
Acute Hospital	8.7	19.4	10.0	7.4	9.1
Long-stay Hospital/Home	6.7	27.7	5.5	5.7	7.3
Death	43.1	24.2	47.5	44.7	43.2
Other	3.3	0.6	0.3	0.3	2.2
Not Stated	0.3	—	1.8	0.1	0.5
Total Number	6,584	480	1,624	1,918	10,606

Source: Department of Health *Long-stay Statistics*, 1987.

TABLE 3.15: Source of admission to long-stay geriatric units in 1987

Source of Admission	Category of Unit				Total
	Health Board Geriatric Hospitals/Homes	Health Board Welfare Homes	Voluntary Approved Nursing Homes	Other Private Nursing Homes	
	%	%	%	%	
Community	48.1	53.9	48.3	56.5	50.1
Acute Hospital	42.1	19.6	35.1	37.1	38.9
Long-stay Hospital/Home	8.1	23.2	10.5	5.8	8.8
Other	1.5	3.4	6.1	0.7	2.2
Not Stated	0.2	—	—	—	0.1
Total Number	6,031	475	1,726	1,997	10,229

Source: Department of Health *Long-stay Statistics*, 1987.

were the main reasons for admission to voluntary homes. Voluntary nursing homes were more likely to have a waiting list and were also more likely to place conditions on entry, such as that residents must be ambulant.

Many of the elderly in both the "approved" and "other" nursing home sector are there for social reasons (Table 3.16). However, the numbers so defined are relatively fewer than found in health board welfare homes.

TABLE 3.16: Medical/social status of patients resident in long-stay geriatric units on 31/12/86 and 31/12/87

Category of Unit	Health Board Geriatric Hospitals Homes		Health Board Welfare Homes		Vol. Approved Nursing Homes		Other Private Nursing Homes		Total	
	1986	1987	1986	1987	1986	1987	1986	1987	1986	1987
Social	% 16.3	% 17.6	% 64.7	% 72.3	% 32.1	% 35.0	% 50.2	% 53.9	% 31.7	% 34.7
Acute Illness	3.5	2.7	1.9	1.3	3.8	6.4	3.0	3.7	3.3	3.5
Chronic Sick	64.1	62.9	18.2	15.0	40.7	48.2	31.6	31.0	47.7	48.0
Terminal	4.2	3.3	0.8	0.6	1.8	2.1	3.9	3.3	3.3	2.8
Mental Handicap	3.1	3.7	2.3	2.0	0.6	0.7	1.4	1.8	2.1	2.4
Chronic Psychiatric	5.8	7.2	10.2	7.6	5.3	4.3	4.5	3.6	5.8	5.9
Other	3.0	2.7	1.7	1.1	3.9	1.7	2.9	1.8	3.0	2.1
Not Stated	—	—	0.1	—	11.8	1.7	2.7	0.9	3.0	0.5
Total Number	6,804	6,462	1,436	1,415	2,924	2,895	3,056	2,945	14,220	13,717

Source: Department of Health Long-stay Statistics, 1986, 1987.

The majority of elderly in the nursing home sector are defined as chronic, though again the proportion is less, this time, than in health board geriatric hospitals. More detailed estimates of dependency in nursing homes is, once again, provided by O'Connor *et al* (1986). Their findings indicate that elderly persons in nursing homes are not (just as the evidence for public long-stay institutions shows) homogeneous with respect to dependency characteristics. The results indicate that overall 38 per cent are self-reliant with respect to personal care, 50 per cent are ambulant without assistance, and 63 per cent are mentally alert (Tables 3.17, 3.18 and 3.19). There are, however, significant numbers of residents very dependent on each of these dimensions. Unfortunately, it is not possible to compare this information with other studies on the dependency of elderly persons in the community and in public long-stay institutions (Blackwell *et al.*, forthcoming). The scales used are different as indeed are the objectives behind the measurement.

TABLE 3.17: Distribution by personal care* category of elderly residents, in nursing homes for the elderly, classified by type of home

Personal Care	Private Nursing Homes	Voluntary Nursing Homes	Total Nursing Homes
	%	%	%
Self reliant	26.9	45.9	37.5
Need help with some tasks	34.0	21.7	27.1
Dependent**	38.0	28.9	32.9
No information provided	1.1	3.5	2.5
Total	2,413	3,051	5,464

*Personal care refers here to washing, feeding and continence.

**Incapable of getting to and using the WC, washing hands and face and feeding self.

Source: National Council for the Aged: *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector* (1986).

TABLE 3.18: Distribution by mobility category of elderly residents in nursing homes for the elderly, classified by type of home

Mobility	Private Nursing Homes	Voluntary Nursing Homes	Total Nursing Homes
	%	%	%
Ambulant without assistance	42.6	55.5	49.8
Ambulant only with aids or personal assistance	34.4	22.2	27.6
Bedfast/chairfast	20.2	15.5	17.6
No information provided	2.7	6.9	5.1

Source: National Council for the Aged: *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector* (1986).

TABLE 3.19: Distribution by mental state of elderly residents in nursing homes for the elderly, classified by type of home

Mental State*	Private Nursing Homes	Voluntary Nursing Homes	Total Nursing Homes
	%	%	%
Mentally alert	60.5	64.7	62.8
Confused	26.4	21.2	23.5
Severe dementia	10.4	4.9	7.4
No information provided	2.7	9.1	6.3
Total	2,413	3,051	5,464

*Refers to dementia only and not to functional mental illness such as schizophrenia or severe depression.

Source: National Council for the Aged: *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector* (1986).

The Caring Process

The caring process cannot be separated from the physical living environment of elderly persons within nursing homes. It is in this respect that some of the findings of O'Connor *et al.* (1986) study on nursing homes are worrying. For example, only 25 per cent of buildings used by private and voluntary homes were built specifically as nursing homes and only 13 per cent in the case of private homes. It is worth making the point, however, that some new homes can be almost too utilitarian, lacking the intimacy and character of some of the converted houses. For all that, the low proportion of purpose built homes is a cause of concern. So also is the absence of prosthetic devices within some homes.

This study also provided information on the staffing of the nursing homes. Most are headed by a registered general nurse although more than one-fifth are not. This does not mean, however, that the latter homes contravene the Department of Health's 1985 regulations which only require that the person in charge of a home at any given time is a nurse. The ratio of full-time equivalent nurses to residents is higher in private homes than in voluntary homes. Without information on need it is impossible to say whether such a difference in nursing provision is warranted or not. The evidence on medical staffing suggests that less than half of the nursing homes surveyed have their own doctor. However, in the majority of homes residents are visited by their own doctors with visits more likely to occur on a weekly basis in private homes and as required in voluntary homes. The optimality of such arrangements is, of course, again difficult to establish.

Much of the information on the actual process of care within nursing homes in Ireland is based on a small sample of twenty-four nursing homes (the mix of private and voluntary was not made clear) taken by O'Connor *et al.* in 1985 and published by the National Council for the Aged (1986). The following are some of the main criticisms raised in this report:

- the ethos of care in the homes surveyed emphasised continued dependence and not the maintenance and development of independence;
- the lack of facilities in some homes is sufficiently serious as to break Department of Health regulations;
- the absence of choice and flexibility within homes was noted;
- structures were not in place that would allow residents to maintain links with the community;
- staff training and career development was not encouraged;
- assessment procedures were not generally in place which would evaluate prospective patient needs as well as the suitability of homes to answer these needs;
- the absence of a contract of care to protect resident's rights, complemented by a Resident's Charter covering all aspects of care, accommodation and facilities was seen as a weakness.

In a response to these findings the IPNHA (1986) agreed that there was a need to examine some of the issues raised by the report to ensure a better standard of care in their homes. They did point out, however, that in some instances value judgements were made without recourse to much evidence — often on the basis of one reported statement by staff members, resident or relative. Notwithstanding this criticism, the report does provide the only profiles we have of life within nursing homes in Ireland. It should not be inferred, however, that many homes are not striving for excellence. Nor should it be implied that the majority of nursing homes are not providing a very good service for residents. Some problems have been highlighted and there have been reports of individual cases where standards have been below acceptable levels but evidence of widespread shoddiness in the sector is absent.

This is not to suggest that nursing homes, unless carefully monitored and regulated, do not have the potential for inferior standards of care. There is plenty of evidence from other countries of the difficulties encountered when expansion has been too fast and unregulated. Butler (1980) offers the view that the majority of homes in the United States

during the 1970s could be described as halfway houses between society and the cemetery. Further documenting the American experience Mendelson (1974) accused nursing home operators of exploiting helpless patients and extracting huge sums from the government. In a review of private rest homes in the United Kingdom, Holmes and Johnson (1988) refer to the "scandal" of poor quality care within these institutions. They argue that the response to the poor quality of some homes should not only focus on improved regulation and greater monitoring, but that community care facilities should also be enhanced and alternative independent living options explored so as to remove the necessity for some elderly persons to go into these homes. One of the dangers associated with an explosion of nursing home provision, regulated and unregulated, is that placing an elderly person in these homes becomes an easier option, for both public authorities and families, than continued care in the community. This is particularly likely to occur if community services are weak or non-existent.

One further point with respect to process is the argument sometimes made by nursing home proprietors that care in their homes is better because it is provided in smaller units. *A priori*, although we know of no evidence linking size of home to patient outcome, there is an inherent logic to this argument. Smallness may prevent patients becoming institutionalised in the way that large impersonal settings do not. Communication should be easier and the potential to involve the elderly person in the home should be enhanced. The evidence with regard to size confirms that the private sector is providing care in the smallest units in this country (Table 3.20). Geriatric hospitals are still very large with an average bed complement of 156. District hospitals and welfare

TABLE 3.20: Mean size of long-stay geriatric units & district hospitals by health board area, 1988

Health Board	Geriatric Hospitals	Welfare Homes	Private Nursing Homes	Voluntary Hospitals/Homes	District Hospitals
E	150	33	23	71	123
M	107	40	19	42	54
MW	275	41	28	30	35
NE	126	39	19	46	—
NW	207	37	13	69	46
SE	131	40	27	23	27
S	158	34	15	52	42
W	190	40	17	—	—
All	156	38	21	57	49

Source: Revised Estimates compiled from Department of Health data.

homes have a similar average size (38 and 41 beds respectively) though there is more variation in the former. Voluntary homes have an average size of 57 beds, nearly three times the size of private homes.

The Cost of Care

There have not been any studies done in this country on the real cost of care in nursing homes using the opportunity cost approach outlined in Chapter 2. This is not surprising, given that so little is known about public sector costs, where information should, in theory, be easier to get. Evidence soon to be published will, however, help redress the information gap with respect to the cost of public long-stay care (Blackwell *et al*, forthcoming). The findings of this report show that the average weekly cost of care in long-stay public (non-assessment) institutions is in the region of £200 per week. This estimate takes into account all elements of resource use, current, capital and personal consumption. How the private sector costs for the care of similarly dependent elderly persons compares remains, for the present, unknown.

What is known about the nursing home sector is the range of fees charged to residents. Research for the National Council for the Aged (O'Connor *et al*, 1986) established the distribution of fees charged by both private and voluntary homes at that time. Not surprisingly fees tended to be lower in the voluntary sector. The modal category for private homes was £120 to £139. Adjusted for inflation this would imply a modal category of £135 to £155 in 1990. Informal enquiries have, however, led us to believe that this is below the true modal category which is more likely to be in the region of £190 to £200 per week. More recent evidence reported in the *Irish Times* (21st April, 1990) suggests that the cost of private nursing home care covers a broad range from about £130 a week for a person sharing up to £250 for top quality accommodation (though we know of one home in the Dublin area charging £300 per week). One can only conclude from the above that low cost private provision is less prevalent in the early 1990s than it was in the mid-1980s.

There is, of course, no official rate stipulated for nursing home charges either by the Department of Health or by the IPNH A. One would expect a close relationship between charges and the cost of care. For instance the following variables should have a major influence: location, staffing, single or shared room, dependency of resident and range of facilities provided. However, there is evidence from elsewhere of little coherence in the setting of charges. While the above factors are clearly important they accounted for less than half of the variation of charges observed by Challis and Bartlett (1988) in their study of private nursing homes in the

United Kingdom. Proprietors mostly set charges on the basis of what they heard about other homes' charges, their own instinct, the money they needed to finance improvements and so on. These findings are consistent with those of Knapp (1984). All of this should make us wary of relating subvention payments to nursing home charges. Instead, every effort must be made to estimate independent cost functions for the industry. To that end, nursing homes caring for subvented residents should be asked to submit detailed financial accounts to the authorities.

There have been objections to the view that nursing homes should be required to submit detailed financial accounts to health board authorities (Yates, 1990). It is perhaps not surprising, therefore, that there is no provision, either in the Act or the Regulations for the collection of detailed financial information. Indeed the Minister for Health clarified the position in this regard on the 7th March 1990. at the Committee stage of the Nursing Homes Bill, when he said there was no intention of requiring nursing homes to submit financial records. This does not change the fact that it is unrealistic to base the level of public subsidy for nursing homes on prevailing fees in that sector. Because of the fragmented nature of nursing home care, the cost and fee structures are extremely variable and therefore not easily compared or standardised (Parker, 1987). An independent system of cost determination based on a rigorous evaluation of the financial accounts of nursing homes seems to us the only sensible basis for setting "approved" fees in different types of homes in different places. Once independent cost information becomes available the public authorities and the nursing home proprietors could negotiate an agreed rate of return for the latter. What must be avoided is public moneys being allocated to the sector without any idea of whether this subsidy is related to the cost of care. Of course, this principle should equally apply to care of the elderly in public long-stay institutions. The latter should also be subjected to rigorous and independent cost appraisal on a comparable basis to homes in the private and voluntary sector.

Our only source of information on the financial cost of care in nursing homes is provided by an executive summary of a report on the nursing home industry commissioned by the Irish Private Nursing Homes Association from Stokes Kennedy Crowley (SKC) Management Consultancy (1990)³ SKC estimate that the total cost per patient per week (before finance charges) in private nursing homes is £112 (in 1989). Wages and

³The full SKC report was not available to us at the time of going to press. Consequently, all we can report are the main findings as outlined in the executive summary. No attempt is made to provide analytical and comparative commentary on the results because we do not know the methodological and conceptual framework used to generate the findings.

salaries account for 60 per cent of this cost. Direct costs (covering food, cleaning and medical supplies) are the second largest contributor to total cost (21 per cent). Energy costs account for 6 per cent of total costs while overheads such as rates, rent, repairs, insurance, etc., make up the remainder.

SKC estimate that wages and salaries will contribute the largest increase to the cost of care in the coming years. Currently staff in some nursing homes are paid at levels below recommended nursing rates. Pressure from the public sector, within the framework of the new regulations, is likely to force private homes to offer competitive, union-agreed wage rates in the future. In addition, some homes will find it difficult to recruit qualified staff at current rates of pay and will have to offer more attractive terms to encourage applicants.

Somewhat similarly truncated information is available on the likely cost implications of different size and staffed private nursing homes (Carroll, 1989). Information is provided on the marginal cost of increasing the size of nursing homes. The existence of economies of scale suggests that eight bed extensions incur the lowest marginal cost in terms of staffing. This does depend, of course, on the number of residents already in the home. For example, a sixteen bed unit would cost approximately £1,000 per week, adding eight more beds would incur an additional £400 per week, a further expansion to thirty-two beds would have a marginal staffing cost of £300. This is based on paying nurses £4.50 per hour and nurses aides £2.50 per hour. Nurses and auxiliaries must of course be paid standard rates irrespective of fee income, though there is enough qualitative evidence to suggest that a minority of nursing homes do not pay market rates for caring staff. Food per resident has been estimated by Carroll at £20 per week while heat, power and electricity should rarely exceed 8 per cent of total fee income. Overheads would also have to be added for a complete cost profile of nursing homes. Even at that, however, this information is not overly helpful in establishing a data bank on cost structures within nursing homes. It is too generic and some of the figures appear to be under-estimated. In addition, without knowing the dependency characteristics of residents and the quality of care provided, it is impossible to say very much on efficiency where the latter is taken to incorporate the relationship between true economic costs and outcomes.

Conclusions

At the moment, our revised estimates show that there are 9,061 beds in the nursing home sector. This is an increase of 2,649 beds on current official statistics. The discrepancy is due mainly to current weaknesses

in the compilation and communication procedures whereby private nursing homes are notified to the health boards who, in turn, forward details to the Department of Health. The Department base their annual survey on lists received from health boards. A further barrier to establishing a meaningful time series of total beds is the fact that voluntary homes were, until recently, under no obligation to notify the health boards of their existence. It is strongly recommended that data collection procedures are improved by making annual returns compulsory for all homes registered under the new Health (Nursing Homes) Act, 1990. This is a necessary but not sufficient condition for improvement. Ultimately, communication channels between health boards and the Department have to be made more efficient. This will only occur if data collection and evaluation procedures are generally given a higher profile in the system.

There is wide variation in the mix of public and private provision across health board regions. In some health boards there is an inverse relationship between the ratio of public and private beds. However, this is not true in all regions. There does seem to be some scope for high bed to population regions to reduce bed complements towards the national average. One must tread warily here, however, in the absence of information on special factors which might explain high ratios in the first place. While acknowledging the need for a more detailed model there is some suspicion that a version of Parkinson's Law is in operation. Buildings were available, with beds, which were filled. This is confirmed somewhat by evidence that regions with less beds do not have longer waiting lists than regions which are well provided with beds.

Overall, the information on process of care within nursing homes is weak. Much of the qualitative data are based on a study of 24 nursing homes. Nevertheless, it is worrying to find that the ethos of care in the homes surveyed emphasised continued dependence and not the maintenance and development of independence. The lack of facilities in some homes as well as the absence of staff training is also a concern. On the other hand, the small size of private nursing homes relative to other long-stay units should mean less institutionalisation and greater involvement of the residents in the running of the home. More comprehensive data, with wider coverage is, however, required before more definitive statements can be made about process. In particular we need to know how integrated homes are with life in the community.

There is currently no information (apart from some truncated data) on the cost of care in nursing homes. There has been no obligation on homes to supply information on costs. This will have to change, particularly if the intention is to relate subsidy payments to the cost of care. It is not

reliable to use charges as a proxy for cost. This is especially true since evidence from elsewhere suggests that charges are, more often than not, related to idiosyncratic factors rather than consideration of the cost function.

CHAPTER 4

Demand for Nursing Home Care

Introduction

In this chapter we investigate the influences on the demand for nursing home care. The major factors considered are demography, income and relative prices. Each of these variables will have an effect on total demand as well as a specific influence on the public/private mix of care. Matters are complicated somewhat by the feedback relationship between public policy and each of these variables. In addition, the potential for growth in the insurance market is also likely to influence the way events unfold. Both of these complexities are examined in this chapter. Most important of all, however, is the suspicion that, unlike the market for more conventional goods and services, consumer sovereignty is not wholly present in this market. Instead, decisions to purchase nursing home care are, more often than not, made by families, with elderly persons playing a subsidiary role.

Whose Demand Curve is it Anyway?

It is usual in demand studies to begin with the premise that the consumer is sovereign; that it is their decision to purchase more or less of a good or service in accordance with their (usually given) preferences. The normal assumption is that changes in price move the consumer along the demand curve while changes in income shift the demand curve inwards or outwards. Within these models, demand is further assumed to be independent of supply.

Sometimes, however, the assumption of consumer sovereignty is undermined. There are many instances in the health care market where demand and supply are intertwined as the consumer cedes sovereignty to the provider. For example, once a patient decides to visit a physician the usual outcome is that all future decisions on services and placement are made by the provider. What is termed the principal/agent relationship develops. This relationship has implications for resource use. There is

evidence, for example, that sometimes physicians make demands on behalf of patients that have more to do with augmenting their own income than enhancing the health status of the patient (Tussing, 1985). What implications has this argument for the long-term care market? The key question is who makes the decision with respect to entry into long-term care. There is no doubt that the elderly person is involved in that decision. So also is the family doctor but in a much less self-interested way than in the acute care market. Mostly, it is the family or the principal carer within the family who takes the initiative to seek admission on behalf of the elderly person. This peculiarity of the market has implications for the way we look at the factors which influence demand. For instance, if the demographic changes in the elderly population are crucial then so also are the changes in the carer population. Equally, the incomes of both elderly persons and their families must be considered if it is the latter who make demands on behalf of the elderly person. Similarly, the effect of relative price movement must also be interpreted in the wider context of the family.

The possibility that the demand function for private nursing home care is largely under the control of families also has implications for future policy. If the authorities wish to effect a behavioural change in the market then policy may have to be focused on the whole family and not just the elderly person. For instance, if the objective is to reduce the demand for long-term care then the correct policy instrument might be to augment the caring resources of the family by means of additional finance or services. On the other hand, if the family is seeking a public long-stay subvention on behalf of their elderly relative it seems both efficient and equitable that means testing should take into account family income and wealth. This issue is particularly relevant to our discussion of financing options and is taken up again in Chapter 6.

Demography

Estimates of future population changes, based on the 1986 Census, have been provided by the CSO (Tables 4.1 and 4.2). The CSO consider overall population growth to have ended in 1986 and to be in slow but significant decline into the next century. At present, the elderly constitute about 11 per cent of the total population. By the year 2011, the CSO predicts that this percentage will have increased to 12.6 per cent; by the year 2021 they predict that the proportion of elderly in the population will have increased to 16 per cent. In the past, projections of the share of elderly in the population have not always proved reliable. Sometimes baseline assumptions about emigration and fertility patterns have turned out to be incorrect. Projections with respect to the actual number of

TABLE 4.1: Projected* population by age, 1986 - 2021 (000's)

Age/Year	1986	1996	2006	2011	2021
0-14	1024.8	861.3	753.8	734.9	690.9
15-29	875.9	812.5	737.1	688.6	643.9
30-44	664.2	744.0	712.1	701.6	680.9
45-64	591.4	691.0	848.0	903.2	894.8
65+	384.4	394.7	405.1	437.4	553.1
Total	354.0	3503.5	3456.1	3465.7	3453.6

*Assumptions: Medium emigration (M_2) and slowly declining fertility (Fi)

Source: Central Statistics Office, 1988, *Population and Labour Force Projections 1991—2021*.

TABLE 4.2: Percentage distribution of projected* population by age, 1986—2021 ('000s)

Age/Year	1986	1996	2006	2011	2021
0-14	28.9	24.6	21.8	21.2	19.9
15-29	24.7	23.2	21.3	19.9	18.6
30-44	18.8	21.2	20.6	20.2	19.7
45-64	16.7	19.7	24.5	26.1	25.8
65+	10.9	11.3	11.7	12.6	16.0
Total	100.0	100.0	100.0	100.0	100.0

*Assumptions: Medium emigration (M_2) and slowly declining fertility (Fi)

Source: Central Statistics Office, 1988, *Population and Labour Force Projections 1991—2021*.

elderly in the population have displayed more robustness. This should not be surprising. Medium-term population projections of elderly persons involve looking at an age group who are least likely to show dramatic change in migration patterns even within country frontiers.

In 1986, there were 384,400 persons aged 65 years and over in the Republic of Ireland. According to the CSO the number of elderly in the country in the year 2011 will be 437,400 persons, an increase of 14 per cent. Older elderly persons are, however, likely to experience a much more rapid increase in numbers. For instance, elderly persons aged 85 years and over are predicted to increase by 55 per cent up to the year 2011 (Table 4.3). The faster rate of growth of the very elderly category has implications for the demand for nursing home places. Currently, 77 per cent of nursing home beds are filled by elderly persons over 75 years of age (Table 3.13). Any increase in their number will tend to increase the demand for nursing home beds. An analysis of elderly persons aged 85 years and over illustrates this point nicely. Current official estimates

TABLE 4.3: Projected* «slderly population by age and sex, 1986 — 2011 (‘OOOs)

Age Group	1986		1996		2001		2011		% Change 1986–2011	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
	65-74	112.0	128.5	106.2	126.5	105.3	122.0	124.1	142.4	11
75-84	48.8	69.6	52.5	79.5	52.0	81.6	52.3	79.3	7	14
85 +	8.0	17.4	9.3	20.8	10.4	23.9	11.2	28.1	40	61
All Elderly	168.7	215.6	167.9	226.8	167.7	227.5	187.6	249.8	11	16
Total Pop.	1,769.7	1,771.0	1,748.8	1,754.6	1,739.1	1,746.2	1,727.3	1,738.4	-2	-2
%Elderly	9.5	12.2	9.6	12.9	9.6	13.0	10.9	14.4		

*Assumptions: Medium emigration (M₂) slowly declining fertility (F₁).

Source: Central Statistics Office, *Population and Labour Force Projections*, 1988.

suggest that there are 2,555 such persons in nursing home beds¹. This is 10 per cent of all persons in that age bracket. If a similar percentage are in nursing homes in the year 2011 this would imply an additional demand of 1,398 beds.

There is also likely to be variation in population changes among regions. Up to now, the highest proportions of elderly persons have been in the Western and North-Western regions of the country. It is likely, however, that counties in these regions will, over the next 20 years, experience decreases in both absolute and relative terms. Regional population projections, based on the 1981 Census, predict that the North-Western Health Board region will show a decline of 12 per cent in the number of elderly persons. Elderly numbers in the Western Health Board will fall by almost 11 per cent. The number of elderly in the Southern Health Board will also decrease but only by 1 per cent. All other health boards will experience an increase in the proportion of elderly persons, ranging from 2 per cent in the Mid-West to a massive 31 per cent in the Eastern Health Board (National Council of the Aged, 1985). The most significant aspect of the increase in the East is, once again, the disproportionate increase in the number of very elderly, aged 75 years and over. In Dublin County their number is expected to more than double between 1981 and 2006. This trend is a result of the rapid population expansion through natural increase, longer life-spans and inward migration to the eastern region over the past forty years. *The Years Ahead* (1988) warns that because of rapid expansion of the elderly population in the East the demand on health and welfare services is likely to be acute. Some of this additional demand will fall on the private nursing home sector, particularly if public policy remains unchanged. The Eastern region is not well endowed with public long-stay beds, relying on the private and voluntary sector to meet a significant portion of demand.

A number of possible *caveats* should, however, be noted. In particular changes in network patterns and relationships may either exacerbate or offset demographic changes. For instance, higher marriage rates during the 1960s and 1970s are likely to mean a fall in the number of elderly never married at the beginning of the next century. Family network relationships are therefore likely to be stronger, providing increased support in old age, thereby potentially reducing demand for nursing home care. This must be tempered however by the likely higher number of widows and reduced family size which will tend to offset the network and support advantages of a higher marriage rate. Mortality differences between males and females, which favour the latter, are likely to remain

¹ It is acknowledged that this estimate is rather crude, taken as it is from Table 3.13 which does not show the revised estimates of elderly persons in nursing homes.

a feature in the years to come. So also is the continued reduction in fertility which is moving Irish rates in line with European averages.

Of crucial importance to the network relationships of elderly persons is the availability of home carers. Other things being equal, one would expect that the greater the availability of informal help (in terms of numbers of carers and willingness to care) the less likely that elderly persons would need to be placed in care. Traditionally, informal carers of elderly persons have tended to be female. A recent survey of those caring for elderly persons found that female carers outnumber males by more than five to one (O'Connor *et al.*, 1988 (a) and (b)). A female carer is most commonly looking after a parent, a spouse or a parent-in-law. The availability of informal carers is, therefore, very much influenced by the participation of females, single and married, in the labour force.

There has been a rise in labour force participation among married women. The rate has increased from 7.5 per cent in 1971 to 23 per cent in 1988. The cohort effects are important here with younger cohorts ageing, taking with them historically higher participation rates (Blackwell, 1989). All the indications are that this rate of participation will increase, albeit slowly over the next twenty years. A report by Keegan and McCarthy (1987) suggests that by the year 2001 the rate will be 34 per cent. There are also some indications that more women are staying in the labour force even with the birth of children, probably due to their, largely correct, perceptions about the difficulties associated with re-entry at a later stage. By European standards, however, the projected participation rates are still low. Moreover, the caring impact of more married women working may be offset by the fact that much of the increase in employment will be of a part-time nature. Analysis of the recent increase in the number of married women engaged in market work bears this out. The total number of women engaged in part-time working increased from 27,000 in 1977 to 50,100 in 1987, of whom 72 per cent were married. It may be the case, therefore, for some women at least, that working outside the home may not greatly interfere with their willingness and ability to engage in home caring of elderly relatives. All it may mean is that they will do some paid work as well as unpaid caring.

An increase in the labour force participation rate of women could also effect a short-run reduction in the demand for nursing home places due to the impact of the improved financial position of households. Families may use the increase in financial resources to facilitate the staying put option. For example, it might be possible to make modifications to housing, in order to facilitate the greater self-care of the elderly person. Home help services could be purchased, perhaps substituting for infor-

mal care provided within the family. In the long run, however, as the caree becomes more disabled, the increase in household income will probably be used to purchase nursing home care at an earlier stage than would otherwise occur.

Changes in household composition are also occurring leading to an increase in the number of one person elderly households. The trend in recent years is for an increased proportion of elderly persons to form independent households. By the year 2001 it is projected that the number of elderly persons living alone will increase by 20 per cent to almost 100,000. The impact of living alone on the demand for nursing home care depends crucially on the willingness and ability of carers to continue caring when the caree lives outside their own home. Most caring is done within households but not exclusively so and there is no evidence of widespread neglect by carers when an elderly person lives alone (O'Connor *et al.*, 1987). There is, however, evidence that living alone is one of the factors likely to affect the placement of an elderly person in public long-stay institutional care (O'Shea and Corcoran, 1989). On balance, therefore, it is also likely to increase the chances of an elderly person seeking admission to private care, unless substantial caring resources are directed to such households.

Income

Income has an undoubted effect on the demand for private nursing home care. In this section we consider the available information on current and likely future changes in the incomes of elderly persons. Most of the information on incomes is drawn from the Household Budget Survey (1987). This means that resources are examined from the perspective of the household rather than the individual. This approach has advantages (Blackwell, 1984):

- the household is usually taken to constitute a unit for the purposes of consuming goods and services;
- resources can be assumed to be shared within the household;
- and, more pragmatically, alternative sources of information on incomes are not readily available.

There are some limitations, however, not least that elderly persons in more complex households tend to get lost in the data. Moreover, information on the incomes of persons living in institutional care is not included.

In 1988, the average weekly direct income (i.e., earned income, before state transfer payments are added and taxes deducted) of households

with spouse and/or children, headed by an elderly retired person, was £63.46 (Table 4.4). This is 31 per cent of the average direct income of all households in the State. The inclusion of state transfers and the tax system reduces the gap between elderly and other households. When both of these factors are taken into account the disposable income of retired elderly households rises to 63 per cent of the figure for all households in the state.

This gap is reduced further when the composition of households is taken into account. The average size of retired elderly households is 2.023 persons compared with 3.50 persons for all households. If each child is counted as 0.25 of an adult the average size of all households is reduced to 2.35 adult equivalents.² Making these adjustments leaves the *per capita* disposable income position of retired old people at £62 per week. This compares to a national *per capita* disposable income of £86. Interestingly the *per capita* income for retired persons in single person households, without spouse and/or children, is £63 per week. For a complete picture account should also be taken of the imputed value of non-cash benefits which elderly persons can obtain. In practice, however, these are much less than the value of social welfare pensions. One estimate suggests that the average non-cash benefit per recipient is approximately 19 per cent of the money value of the non-contributory pension, personal rate (Blackwell. 1984). Of course, taking the imputed value of in-kind state benefits into account for all households could result in a deterioration in the relative position of elderly households depending on the distribution of these benefits across the generations.

TABLE 4.4(a): Average size, composition, and household income, 1987, classified by life-cycle of head of household

Item Description	Head of Household without Spouse/Children	Head of Household with Wife and/or children	
		Retired	State
Av. Age of Head (years)	72.213	73.549	49.983
Av. Persons per Household	1.284	2.023	3.505
Age of Head (% household)	%	%	%
Under 25 years	—	—	3.3
25 to 34 years	—	—	17.7
35 to 44 years	—	—	22.2
45 to 54 years	—	—	17.1
55 to 64	—	3.4	16.3
65 years and over	100.0	96.6	23.4

²This is not the only adult equivalent rate that could be used here. See Nolan and Callan. 1989.

TABLE 4.4(b): Average size, composition, and household income, 1987, classified by life-cycle of head of household

Item Description	Head of Household without Spouse/Children	Head of Household with Wife and/or children	
	Average Weekly Household Income		
	£	£	£
Direct Income			
Employees — Wages/Sals.	4.236	4.201	153.827
Self-employed — non farm	1.642	5.820	15.819
Self-employed — farming	3.190	2.622	14.558
Retirement Pensions	16.982	34.524	8.103
Investment Income	3.779	5.372	2.664
Property Income	1.261	3.182	1.611
Own Garden/Farm Produce (valued at retail prices)	.713	1.511	2.077
Other Direct Income	4.931	6.226	5.453
Total Direct Income (A)	36.736	63.456	204.111
State Transfer Payments			
Children's Allowance	.076	.000	4.424
Old Age & Retir. Pensions	37.666	67.493	12.596
Widow's & Orphans Pension	8.239	.000	3.663
Other Long-Term Social Welfare	1.668	2.153	5.405
Unemployment Benefits & Assistance	1.220	.774	12.382
Education Grants/Scholar.	.000	.000	.635
Other State Transfers	.441	.939	4.609
Total State Transfers (B)	49.311	71.359	43.714
Gross Income (A+B)	86.047	134.816	247.825
Direct Taxation			
Income Tax	4.725	8.133	38.280
Social Insurance	.274	.382	8.585
Total Direct Taxation (C)	4.999	8.515	46.865
Disposable Income (A+B-C)	81.049	126.301	200.960

Source: *Household Budget Survey, 1987.*

Of particular importance to elderly person households is the trend in purchasing power of their social welfare pensions. In this regard old people have fared quite well during the 1970s and 1980s (Breen *et al.*, 1990). Real increase in payments accounted for 83 per cent of the growth in State pension provision in the first half of the 1980s (O'Connor, 1987).

This resulted in a real increase of 22 per cent, between 1980 and 1987, in the value of the contributory pension and the non-contributory pension. More generally, there has been a significant improvement in the income of elderly households relative to other households since 1980. This improvement is reflected in the results of a recent poverty survey (Callan *et al.*, 1989). In this survey the elderly were identified as a low risk poverty group. That is not to say there are no old people experiencing real hardship. Rather that compared to other groups in society, such as the unemployed or households with large families, the elderly are now better off than they were ten years ago.

Notwithstanding this improvement, the average *per capita* disposable income of retired elderly households is still no more than one-third of the price of weekly accommodation in a private nursing home. One unknown element, however, is the extent of intra-family transfers of resources to elderly persons. The policy implications of family support towards the purchase of private nursing home care will be considered in a later section. So also will the potential impact of state transfers and subsidies augmenting the purchasing power of the elderly person. Clearly however, if elderly persons are to be in a position to exert an own effect on the demand for nursing home care in the future, then their disposable income will have to be augmented by support from these sources or by the release of funds at present tied up in assets. Data from the Household Budget Survey confirm that investment income for households headed by a retired person at £5.37 per week is low by comparison to a total direct income of £53.46 per week. Apart from dwellings it seems that relatively few pensioners have significant assets. This view is supported by Whelan and Vaughan (1982), who report that the level of savings among the elderly is extremely low.

But the elderly do, to a large extent, own their own houses. Taking all households, where the head of household is over 65 years of age, 75 per cent own their dwellings outright. (Callan *et al.*, 1989) This is compared to estimates of outright ownership for all households of 45 per cent. Housing assets are, therefore, a very important source of wealth for elderly person households. However, some households may be "house rich" but "income poor". Owner occupied housing does not yield flows of income. From the same survey (Callan *et al.* 1989) it is estimated that 58 per cent of the elderly households who own their dwellings outright have disposable income in the lowest three deciles of the income distribution. Moreover, it is likely that those households with lowest incomes also have the smallest value of assets and poorest housing. Blackwell (1989) reports that not all of the dwellings owned outright by low income elderly people are in good condition and, therefore, capable of realising their income potential. Furthermore, if elderly households

are to be encouraged to liquidise their assets then schemes for such purposes must be both available and attractive. At present, there are no such schemes available in this country.

Blackwell (1989) provides a comprehensive account of home income schemes and how elderly people could liquidise their assets thereby extending their range of choice in old age. He suggests that moneys raised from home income schemes could make a significant difference to the living standards of pensioner households. Given favourable tax treatment one could expect an annual income of £1,000 — £1,500 from a home income scheme. At present rates this would amount to between a third and a half of the contributory pension.

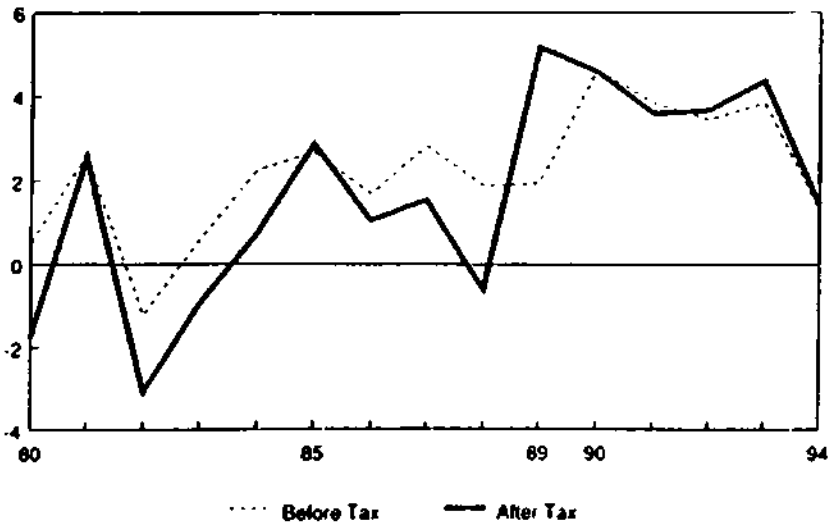
It is clear, however, that while home income schemes would undoubtedly improve the choices available to elderly persons living in the community they would not provide, on their own, for the full cost of long term care in a nursing home. The extent to which asset liquidisation schemes can make a worthwhile contribution to the cost of long-term care depends on the length of time spent in nursing homes and the yearly value of the annuity offered by companies engaged in home income packages. There is evidence from the United Kingdom that ordinary annuities offered to the very elderly are poor bargains (Wheeler, 1986). Experience rather than community rated packages, therefore, are more desirable. This would ensure that annuities or other financial products were devised to take account of the relatively short life span of some residents, thereby enhancing purchasing power in advanced old age.

An alternative to home income type schemes is where the elderly person sells the asset and uses the cash to pay for long-term care. Relying solely on asset-financing of this sort is not a reliable option if the care required is likely to be very long-term and/or for two people. The elderly person(s) may, in the long run, have to depend on the generosity of the state after "spending down" of assets has occurred. Consumer preferences must also be taken into account. There is no evidence that elderly persons in this country have shown a willingness to dispose of assets to pay for long term care. Such a decision would, in any case, affect the spouse and other family members and is unlikely to be entered into lightly. In particular people may have a legitimate desire to pass on property to surviving members of their own family. It is unlikely, therefore, without explicit intervention by the regulatory authorities and/or the exchequer (through favourable tax relief and/or social welfare changes), that either home income schemes or asset disposal will increase dramatically. That being the case, the knock-on effect on nursing home demand will hardly be significant.

This still leaves the family and their influence on the demand for care.

More often than not, members of the family are involved in the decision to place an elderly person in care. Their income is therefore important as an influence on current and future demand patterns. Without more detailed analysis it is only possible to identify aggregate trends in personal income and even then only in the medium term (Bradley and Fitzgerald, 1989). It should be borne in mind, however, that the effects of income changes depend crucially on how they are distributed between various factors of production in the economy. For instance, the ESRI forecast, over the medium term, that the growth of agricultural incomes will be limited due to continued downward pressure on agricultural prices and competitive pressures to liberalise trade. In contrast, non-agricultural wages will be much more buoyant than in recent years due to significant real increases combined with employment growth. Profit margins are also likely to increase, in the medium term. Total transfer income is projected to grow only slowly but this would be a positive influence as it reflects decreased unemployment leading to lower welfare payments. What is shown in Figure 4.1 below is the trend in aggregate real personal income up to 1994.

Figure 4.1: Changes in real personal income, 1980-94



Source: *ESRI Medium Term Review: 1989-1994*, Bradley J. and Fitzgerald J.

If one is to accept the forecast made by the Economic and Social Research Institute, the recovery in the economy will result in an average rise in real personal income over the next four years of double that

experienced in the 1981-88 period. The difference is more marked in the case of real after tax income. Between 1981 and 1988 the rise in rates of direct tax resulted in an average growth rate of only 0.5 per cent. The rate of growth in the 1989-1994 period is expected to be 3.8 per cent boosted by moderate reductions in the tax rates.

It is not possible within the limits of this study to quantify the relationship between change in personal income and the demand for nursing home care. It is expected, however, that increases in personal after tax income will have a positive influence on demand. It is worth pointing out, however, that substantial growth occurred in the nursing home sector during the 1980s, a period in which real income growth was minimal and declining in some years. This is where more detailed information on the distribution of income is important and where econometric analysis would be helpful in disentangling the relative magnitude effects. Without such information one must be tentative in reaching conclusions given the generally weak and sometimes inverse relationship between income and nursing home growth during the past ten years. Our judgement is that while a positive income effect on demand is expected, it will not be the strongest influence on the decision to seek nursing home care for elderly persons.

Prices and Relative Prices

The price of private nursing home care will also affect demand. The usual relationship between price and utilisation is that as price increases utilisation decreases. Most studies confirm such negative price relationships in acute health care markets (Tussing, 1985). though Feldstein (1970) did find a positive relationship between price and utilisation which he interpreted as indicating a permanent excess demand for medical care. We do not, however, have any econometric estimates of the relationship between price and utilisation for long-term care in this country. The evidence on nursing home charges suggests that significant increases occurred during the 1980s. This did not deter consumption during this period leading one to the tentative conclusion that the usual relationship between price and utilisation may not be strong in this market. One *caveat* should be mentioned here and that is the impact of quality on the measurement of elasticity. If price and quality are correlated, price elasticities will be underestimated. This is more than likely the case in this country.

It is difficult to say, therefore, what the precise effects of price changes are in this market. Proprietors of nursing homes, for the most part, set fees according to what the market will bear. That market is highly segmented. At the top end is the market for high quality, high cost care.

which is usually not subsidised. The market is likely to be influenced by degrees of luxury, not price, with demand positively related to the latter. At a level below this are nursing homes which cater for middle income residents who may or may not (at present) be in receipt of a subvention. The size of the latter obviously determines the price that potential residents face. At its maximum the current subsidy covers no more than 20 to 25 per cent of the price charged by nursing homes. This may or may not increase under the new regulations. Budgetary conditions will influence matters here. If it does increase, the likelihood is that, unless countered by other factors, the demand for nursing home care will be stimulated. The attitude of the authorities is also important. Currently, elderly persons seeking a public subsidy are discouraged from seeking care in nursing homes with charges set well above the average rate. The view taken by administrators is that if elderly persons could afford care in such a home in the first place then they can also do without the subsidy. This policy also has the effect of restoring the normal negative price elasticity relationships within the system. We will see below that more flexible subvention arrangements may also effect changes in this relationship.

Relative prices are also important. The major substitute for residential care is community based home care. Relative money prices between these two sectors favour care in the home. After all, nursing homes have charges while care in the home is, in the first instance, free. However, care in the home also carries with it substantial time prices, especially if community care services are inadequate. The day to day caring experience in the home carries substantial costs which may move relative prices in favour of residential care. Blackwell *etal.* (forthcoming), for instance, report that very highly dependent elderly persons in the community are receiving an average of 86 hours of care per week. These costs are exacerbated if a carer has had to give up paid work to care for an elderly relative. Due to inadequacies in community support for care in the home, the likelihood is, therefore, that even though prices have increased in the nursing home sector during the 1980s, relative prices (relative to community) are not any higher in that sector. This is likely to continue unless public policy acts to reduce time prices in the community through a substantial allocation of resources in that direction.

Insurance

Nursing home care is expensive if it has to be financed entirely from "out of pocket" expenses. That is why the availability of an insurance market for long-term care will affect overall demand. There are, at present, very few long-term care insurance products available in Ireland.

The Voluntary Health Insurance (VHI) do provide coverage for what can only be termed *quasi* acute care convalescence in an approved nursing home, mainly in the Eastern Health Board. The VHI will also cover, on a case by case basis, elderly persons suffering from Alzheimer's Disease or other forms of senile dementia but only for a maximum of 180 days in the year. This is not to say there is no potential market for long-term care insurance products. In a recent survey by Swiss Re (UK) (1990) 33 per cent of the people surveyed would welcome the option of an insurance policy designed to meet the expenses of private long-term care. Interest in such a policy was greatest in the higher social class category (47 per cent) and among 23-34 year olds (48 per cent).

The key question is what sort of products would likely emerge, and what be their affect on demand, if the VHI or other companies (post-1992) were to get involved in long-term care insurance in Ireland. Weber (1989) discussing the United States experience has identified three market sectors: individuals moving into nursing homes, retired or near-retired individuals, and individuals in middle age. In the USA. long-term care insurance has been sold primarily to the second group, the retired or near-retired individuals. The earliest policies were restrictive in eligibility and the maximum benefit periods. Competitive pressures have ensured, however, that a wider range of price/benefit options are available. For example, there are now plans which will pay for nursing home care for a maximum of ten years as well as those that will pay for home care. Some plans have developed the long term care rider to universal life schemes, providing for pre-payment of a proportion of the death benefit should an individual be admitted to a nursing home. All insurance packages for long-stay care are, however, extremely expensive and subject to cost sharing and other restrictions mainly to offset the problems of moral hazard and adverse selection (see later discussion in Chapter 7).

The elderly are, therefore, a high risk, high cost group compared to other sections of the community. As a result insurance carriers are likely to set premiums for old people based on individual actuarial assessment (experience rating). The likely effect of experience rather than community rating (based on average actuarial assessment) is that some persons will lose out on coverage. The result is, of course, to place the major burden of care of the elderly on the public system. This explains why, just as the VHI have tended to ignore the long-term care requirements of the elderly, so also will competing health insurance companies who are likely to enter the Irish market, post-1992. In the event of a more competitive insurance system prevailing it is unlikely that companies will target the very elderly in need of long-term nursing care. Instead experience rated creaming of low risk populations will take place in the

scramble for profit-making opportunities. The worry for the VHI is that, as a result of their *quasi* public sector nature, they may evolve into the Medicare of the Irish system, dealing only with the needs of the elderly and chronic cases not attractive to their private market competitors. This would in turn have major implications for premium setting. At present, rates are set on a community basis. This would be unlikely to persist in the scenario just outlined unless there was substantial government subsidisation of premia. Alternatively, of course, it may well be that the VHI will vigorously pursue younger, healthier, more cost attractive, clients leaving the elderly to be looked after by the public sector. Either way, only a small minority of old people will be able to afford the experience rated premiums demanded in a competitive insurance sector.

The likelihood is, therefore, that comprehensive private insurance for long-term care will not become a reality in this country. The disadvantages associated with a competitive health insurance sector have led Nolan (1988), for instance, to argue that public financing of the health care system is in any case more appropriate for this country. The major difficulty associated with private funding arrangements is gaps in coverage resulting from an inability to pay high premiums. Attempts to remedy the situation through public sector intervention may cause more problems than they solve. For instance, difficulties are likely to arise in defining groups to be subsidised. And a dual system of financing may lead to a dual system of care. This view, with some exceptions (McDowell, 1989), seems to be generally accepted in this country. On balance, therefore, private insurance, of itself and for reasons of public policy, is unlikely to have a large impact on the demand for nursing home care in Ireland.

Public Policy and the Demand for Care

All of the previous analysis has assumed that public policy remains as it is. This may not be the case and where it changes there may be significant effects on demand. Some hints were given as to the possibilities in this regard. Policy effects are given more explicit treatment in this section.

The major influence that public policy may have on demand is through changing the relative prices of community care and residential care. Imminent new legislation is set to provide more flexible arrangements for the subvention of private nursing homes. This is likely to benefit many more people than before and consequently increase the demand for care, though how much influence it has on demand also depends on the generosity of the subvention payment. Alternatively, if policy also provides for an increase in community care resources to reduce the

mainly time costs of care in the home, relative prices may be little affected and could, depending on the resource transfer to community care, favour the latter. For example, the provision of more home helps and community nursing resources would reduce the time input of family carers. So also would the provision of more day care, day hospital and respite care. The allocation of financial resources to carers would also increase the relative attractiveness of community care. It is quite clear, therefore, that if new subvention arrangements are complemented by increases in community care resources then the demand for nursing home places may not change at all.

Public policy also affects income maintenance provision. For example, the elderly have fared quite well with respect to social welfare increases, during the 1980s. If all the "catching up" has now been done there is likely to be less of a stimulus to demand from this source. Unless, of course, income subsidies were to be given specifically to buy nursing home care. Such a policy would require a much more integrated and flexible approach to caring than envisaged under the new arrangements. It is not impossible, however, that the system might evolve in this manner. In this scenario there would be no distinction between public and private beds and individuals would be given long-term care income vouchers to purchase care from their most preferred option. Such subsidies would still be means tested but all choice would be in the hands of the consumer. This model, though soundly based in welfare theory, is a long way off but is an example of radical public policy change which would influence the demand for care.

A more immediate public policy change might be the introduction of incentives to encourage the up-take of home annuity schemes. It is acknowledged that some element of tax relief is probably necessary to ensure take-up of schemes (Blackwell, 1989). In addition the social welfare system might have to be adjusted to rule out perverse incentives. Both of these changes would encourage the release of funds currently tied up in assets and therefore provide a stimulus to demand. But, bear in mind, as we mentioned earlier, that funds released in this way are not in themselves sufficient to purchase nursing home care without assistance from elsewhere. Nevertheless some direct, if slight, effect on demand would be expected.

Public policy may also be adjusted to take account of demographic shifts in the population. Two specific demographic changes are noteworthy, not only in Ireland but also in the rest of Europe. There will be an increase in the proportion of elderly persons in society and an increase in the share of the very old within the elderly population. This process has been termed the "double ageing" effect. At the same time many

countries. Ireland included, are faced with a less rapidly growing, or declining young population. It may be that the projected decline in births in this country presents an opportunity to redeploy the resources saved to care of the elderly. Certainly a more favourable dependency ratio makes it easier to support services for an increased elderly population. Though it must also be acknowledged that the resource use, *per capita*, of those persons aged 75 years and over is generally far greater than the *per capita* resource use for those persons aged less than 16 years. It should not be expected, therefore, that there exists major potential for shifting resources in this area. There is also potential for a transfer of resources from regions experiencing a decline in elderly numbers to regions experiencing a dramatic growth in population. Such a transfer would concentrate resources in areas of greatest demand. Whether it could ever be accomplished within the current *ad hoc* system of resource allocation in this country is, of course, another story.

Public policy may also change with respect to the provision of tax-relief for residents paying for private care. At the moment tax relief for eligible nursing home residents or their relatives is only awarded for care in an approved home. The latter is defined in this case by the Revenue Commissioners acting on the advice of the Department of Health. In practice, the approved list of the Revenue Commissioners is larger than that of the Department of Health. What has happened is that a compromise has been reached for the purposes of income tax relief whereby the Minister for Health has been prepared to recommend approval status to the Revenue Commissioners for homes which meet the regulations of the Department of Health even though they may not receive subvention from that Department. It will be recalled that, because of funding restrictions, no new homes have been approved for subvention by the Minister for Health since 1980. Approval status for nursing homes is granted, therefore, by three bodies, the Department of Health, the VHI and the Revenue Commissioners. The approval of the latter allows tax relief to be awarded subject to eligibility and is the most inclusive of all potential approvals.

There is no doubt that the tax relief for nursing home care does convey significant financial benefits to eligible elderly persons or their relatives. Nursing homes are very aware of the subsequent effect that approval for tax relief has on demand for care as witnessed by their anxiety to gain that approval from the Revenue Commissioners. The Commission on Taxation urged, however, that there were more direct methods of assisting persons in need of long-term care, mainly through direct expenditure under the health services budget. Nevertheless, they did not recommend abolition of relief arguing that until adequate provision could be made in this way health expenses relief should be retained for

persons entering long-term non-public care. The recent Commission on Health Funding was more forceful, recommending phasing out of the relief on the grounds that it was regressive and that it would not be required under proposed new arrangements.

It is hard to dispute the logic of this advice. There would be strong arguments for retaining the tax relief if current arrangements *vis-a-vis* nursing homes were to remain in place. That is if public beds were to continue to close while at the same time subventions to the private sector were to remain restricted. In such an environment tax relief, even though regressive, does improve choice and relieve pressure on the public system. Under new arrangements (mentioned in Chapter 1 and discussed further in Chapter 6), however, subvention is to be related to means and will be awarded to eligible persons in a flexible manner. In addition, entry to subvented nursing home care will only occur after thorough assessment by geriatrician led teams or their close substitutes. If tax relief were to remain under the new arrangements the result would be inequity between tax payers and non-tax payers, and between tax payers on different marginal rates of tax. Moreover, the tax system as currently structured conveys no significant benefits to families providing non-nursing care to dependent relatives at home, irrespective of the opportunity costs involved. Why, therefore, should it be used as a possible incentive for families to transfer their elderly relatives into nursing homes, thereby qualifying for relief. In such cases tax relief would only serve to distort consumer choice leading to inefficiency in resource allocation. Finally, there is no justification, either on efficiency or equity grounds, for tax relief to remain in place for elderly persons who are outside the scope of the new legislation.

There is no doubt that significant feedback effects are present in the relationship between demand variables and public policy. Without a more formal model, precise relationships cannot, however, be established. Nevertheless an effort is made in the next chapter to consider in greater detail some of the supply side influences of public policy, given that it is a major premise in the report that developments on that side of the market have a crucial bearing on the growth of the private sector.

Values

An examination of the origin and formation of consumer tastes and preferences is considered to be largely outside the scope of this study. In general, the formation of preferences is seen to lie within the ambit of sociology and social psychology while our analysis concentrates on the implications of the pursuit of preferences subject to various constraints. The result is that consumer behaviour is usually examined

in this study from the perspective of rational responses to changing circumstances. Although there is, in general, a danger of reductionism in adopting the standpoint of economics, this may not be too serious in the present context since our focus is principally on market behaviour and decisions of an economic nature. Indeed the identification of independent social values with implications for behavioural change proves very difficult in this area.

For instance, a family decision to seek nursing home care on behalf of an elderly relative may involve a complex, meaningful process that has had to take into account a myriad of influences. Rather than go into this process and into value changes *per se*, our focus is on what, if any, changes have occurred in the economic and social circumstances of the household. For example, a carer may decide to seek paid work outside the home with the result that the elderly person must be placed in a nursing home. The source of the values underlying this course of action is not at all clear. The carer might seem an obvious target for suggestions of materialistic goals coming before filial obligation. Yet it seems plausible to suggest that the carer might be willing to continue caring if more community care resources and/or respite care were available to allow her/him to take up a part-time caring role. At other times, carers may become ill so that providers have no alternative other than to place an elderly person in a long-stay institutional bed. The absence of a comprehensive community care service may make that decision inevitable. On balance, therefore, there appears to be merit in focusing on material constraints and economic circumstances as a basis for inferences about individual choices in this area.

More accessible, and more probably germane, are the dominant values governing policy making over a given period. Much of the current allocation of resources for elderly persons in Ireland is formulated within the constraint of a set of values which direct that public expenditure retrenchment is now the primary responsibility of government. Hence, all elements of social policy, including care of the elderly are subordinate to the prerequisite of restoring order to the public finances. Within this framework, deinstitutionalisation may be a good policy in itself but, even more importantly, it also reduces the burden on the exchequer. If that burden can be placed on the family without too great a demand on formal community care services so much the better. Unfortunately, cost effectiveness is interpreted, in many cases, to mean low cost irrespective of outcome. If informal provision is not enumerated, quantified and valued and if in turn formal provision is less than optimal then community care can appear to be a very cheap option.

Real changes in resources dictated by policy values can therefore either support or undermine existing values among the population. The irony

is that individuals are often accused of uncaring selfish behaviour when the real problem is the manner in which society or its representatives allocate available resources. Indeed one cannot escape the view that it is the availability or non-availability of resources, determined largely by bureaucrats and/or providers, that shapes the values which in turn determine the way elderly persons are treated. Most disturbing of all perhaps is the possibility that it is only through the subtle manipulation and nurturing of guilt among family carers, inspired by societal norms but often given an impetus by governments seeking to reduce public expenditure, that the current allocation of resources is maintained and potential demands on the public sector offset.

Any attempt to extend our discussion of values is impeded by the absence of much published material about the values underlying care of the elderly in Ireland. Nor do we know whether Irish society is markedly different from other societies in the way that elderly persons are treated. The Irish Report of the European Value Systems study (Fogarty *et al.*, 1984) sheds no light on these important issues. The survey did find that satisfaction with family life is high in Ireland, absolutely and relative to the rest of Europe, although it should be noted that the Report indicated that the very elderly do not always feel so secure at home. Part of the reason for this relates to fears about disturbing neighbours as well as feelings of loneliness. Apart from this, however, there are no indications about the role of elderly persons in society. Nor do we know what is considered the most appropriate form of care for dependent elderly persons. That is, whether there is a predilection in Irish society for home care or institutional care.

The guidelines which influenced the recent Working Party on Services for the Elderly (*The Years Ahead*. 1988) are an indirect source of reference on society's perceived obligations towards its elderly citizens. The Working Party suggested the following considerations must be faced up to within the constraints and reality of a finite set of resources available for care:

- that old age demands our special respect:
- that improvements in life expectancy and the increasing number of elderly persons require a clear-cut public policy for the future in regard to the State's role towards the elderly:
- that the underlying aim of policy should be to help the elderly maintain their dignity and independence by protecting them from economic and social hardship:
- that the dignity and independence of the elderly can best be achieved by enabling them to continue to live at home with, if necessary, support services provided by the State;

- that when ill or disabled, the elderly are entitled to the same standard of treatment available to the rest of the population even if services have to be organised in ways that meet their particular needs:
- than when admission to long-term care is unavoidable, such care should be of the highest standard and should respect the dignity and individuality of the elderly person.

Becker (1988) has suggested that public expenditures on the elderly are part of a social contract between generations. Taxes on adults help finance efficient investments in children. In return adults receive public pensions and medical payments when old. Many families will, of course, not require public assistance or social contracts. Instead, a combination of altruism and bequests insulates parents from many of the risks of old age. The opportunity to draw⁷ on bequests provides an annuity-like protection against the vagaries of growing old. Bequests not only transfer resources to children but also give parents the last word which induces children to take account of the interest of elderly parents. It is only in cases where parents are not very altruistic or believe their children to be better off than they are that social norms come into play to moderate the degree of under-investment and under-protection. In the event of social norms failing to provide a private market solution public assistance is required.

Public policy for old people is also intertwined with the exercise and distribution of power within society. In this context Harris (1975) has put forward the thesis that ageing is a process of deprivation. In terms of income and employment the old are deprived relative to the rest of society and relative to their previous life experiences, but this deprivation is mediated by class structure, magnifying it at the bottom and minimising it at the top. In a similar vein Dant (1988) develops the idea that dependency refers to a form of relationship characterised by an unequal distribution of power. Other contributions have focused on ageism as an insidious form of social control as repulsive as racism or sexism. Townsend (1981. 1986) has, for example, argued that the condition of dependency is not an inevitable outcome of the natural process of ageing but is socially structured and hence potentially open to change. This view is the antithesis of the neo-classical tradition of associating the marginalisation of older workers with individual characteristics. It also rejects the structural functionalist differentiation models of Parsons (1964) and Smelser (1959) and their belief in a natural process of elderly disengagement from the social system. Instead, for instance, the institutionalisation of elderly persons, even such a tiny percentage of the elderly population, is seen as symbolising the dependence of the elderly

and legitimising their lack of access to equality of status. To reinforce this argument. Townsend (1981) cites the relatively independent status of many residents of institutional care as well as evidence about social restrictions or authoritarian styles of management.

Artificial dependency may not only be created within institutions but also in community care. Elderly persons are treated as passive recipients of services, the nature and extent of which are decided by others. The denial of adequate resources for community care exacerbates this culture of dependency by not making available resources to complement informal networks within the community. Indeed it is often only the defensive and restorative mechanisms of the family which temper the dependency, which, if one is to accept the above hypothesis, is created by the State.

Conclusion

The demand for nursing home care is affected by demography, income and relative prices. Demographic changes are likely to increase the demand for care. So also will changes in income, though their effects are likely to be weak. Relative prices have not moved strongly against residential care mainly because the absence of a comprehensive community care system has offered few alternatives to hard-pressed home carers.

Demand, however, must be considered in a wider framework. Most decisions about nursing home care are taken by families. Consequently, their income, demographic experience and relative prices also matter. Such changes as are likely to occur will on balance raise the potential household demand for nursing home care, although the weak and sometimes inverse relationship between personal income and nursing home growth during the early 1980s is noted.

Public policy feedback loops are also important. Government policy can affect income, prices and carers' ability to look after their elderly relatives. This is especially true in relation to the supply of public care, particularly in the community, which is the subject of the next chapter.

CHAPTER 5

Supply Side Issues

Introduction

This chapter considers the supply side issues likely to affect the evolution of the nursing home sector in Ireland. Barriers to entry are examined as well as the type of persons likely to be attracted into the industry. The most crucial supply side variable, however, is the availability of alternative sources of provision for the services required by at risk elderly persons. If these needs are being adequately met outside of the nursing home sector the role of the latter is consequently reduced. That is why so much emphasis is placed in this chapter on the role of community care services. It is important that the link between community and institutional care is understood. The latter can either complement or act as a substitute for care in the home. Within that framework the level of real resources devoted to community care will have a major influence on the decision to place an elderly person in a nursing home.

It is unlikely that we will see, in this country, the development of innovative schemes such as Continuing Care Retirement Communities or Social Health Maintenance Organisations,¹ at least in the medium-term. Yet important lessons can be learned from the concepts underlying both of these approaches to care. Moreover, there are also integrated home care schemes operating in other countries which are a low cost, high quality option in the care of the elderly. The proposed re-organisation of services for the elderly in this country may provide an opportunity to introduce integrated packages of care (at least on an experimental basis) within the framework of public care. If that does happen the number of elderly persons in nursing homes is likely to be reduced.

Barriers to Entry

Industries which are dominated by a few large firms are harder to enter than a market characterised by many small firms in direct competition

¹Both of these concepts are explained later in this chapter.

with one another. The nursing home sector is generally competitive with relatively few barriers to entry or exit. It is useful nevertheless to consider the influences on barriers to entry because ultimately this is what determines cost and performance.

Economies of scale (usually taken to mean the size of firm) is an important influence on barriers to entry. For instance, if a market is dominated by a few large firms each producing a significant proportion of industry output the likelihood of a new firm coming into the market is slight. This is because the initial cost of production for such new entrants would be relatively high until they reached the same scale of production as existing firms. This could take a long time and more than likely the new firm would go out of business before then as costs exceeded revenues. This is an argument often used to explain the poor performance of native Irish manufacturing industry. Irish firms are simply too small to compete with their multinational competitors which have large production runs and, of course, large markets.

Economies of scale are, however, not a significant barrier to entry into the private nursing home sector. The average size of homes in the industry is 21 beds which is small relative to public long-stay institutions in the country and in comparison to the nursing home sector in other countries (see Knapp, 1984). Neither is there any evidence of technical economies of scale. This is where technology developments and expense give some firms an advantage in production not capable of being matched by new-comers into the market. The production of nursing care is relatively non-technical; and the process is labour intensive with no general shortages of trained nursing manpower. This is not to ignore elements of product differentiation in the market as some homes provide high cost luxury care at the top end of the scale. However, this is not significant as a deterrent to entry as there is a ready market for less opulent care below this level.

One element which may act as a deterrent to entry is location. The latter is an important factor in determining the profitability of nursing homes and its potential re-sale value in the future. The better the location the higher the fees which can be charged and the greater the value of the property itself. There is no hard evidence that location is acting as a disincentive to entry but informal accounts lead us to believe that the market is saturated in some parts of Dublin, particularly in the South-East of the city. This may be only a short-term constraint on supply, however, as potential entrants take time to identify other less congested areas.

It is not our view, therefore, that there are significant barriers of a

technical nature that will prevent entry into the nursing home market. This leads to the question of whether there is likely to be any change in the type of proprietors entering the market. The levels of prior knowledge, relevant skill and business acumen have a considerable impact on the nature of enterprises, both in terms of the way they are run and their commercial viability. That is why the routes of entry into the nursing home sector and the reasons for entry are influential factors. At present, it is likely that there are four main categories of proprietor in the country: Professional carers are the most likely type of proprietor. Nurses are pre-dominant in this group but one often also finds a small number of doctors and social workers. Homes run by nurses are, however, highly valued by residents and relatives. Not uncommonly, the proprietors are a married couple of whom one is a nurse (usually the wife) and the other is competent in administration and house maintenance.

Business people are the second category of proprietors. The profit motive is an important concern but generally there is a mixture of motives. For example, the attraction of rural locations — for family or aesthetic reasons, the opportunity for spouses to work together, the belief that working with elderly persons will be stimulating (or easy) all figure in the profile of reasons (Johnson 1983);

The third category comprises career changers. This may involve a positive decision to change life-style or more usually is a result of a wind-fall gain through redundancy or the maturing of asset or pension rights.

The final category, often seen as damaging to the industry, is the large corporate proprietor owning many nursing homes in a region or throughout the country. It is often felt that this group has least interest in maintaining standards, and is especially weak in the provision of homely care. The evidence is absent on this point. It need not necessarily be the case that corporate ownership leads to lower standards. The putting in place of an efficient management team together with professional carers may mean the opposite. Instead of the possibly *ad hoc* approach of the family caring team one gets a more professional and ultimately better service. We mention this only to draw attention to the need for more information on this point before coming to the conclusion that non-family proprietors are always bad for the industry. Our view is that this group will seek an increasing share of the Irish market. If the new regulatory controls are working as intended there is no need to fear this entry provided of course that market share does not become too large. As discussed in Chapter 6 there are good reasons why the government should seek to maintain a highly competitive private sector.

The Single European Market and the Nursing Home Sector

There is no reason to expect any major effects on the nursing home sector from the more integrated post-1992 European market.² The European Commission does not, at present, see its role as one of bringing forward legislation dealing with care of the elderly. Instead, all it seeks to do is promote an understanding and consensus among EC countries based on the widest possible dissemination of knowledge and information about policy successes and failures within member countries. It hopes that member countries will learn from each other's experiences in care of the elderly. To assist in promoting this understanding the Commission are setting up an Advisory Committee of higher civil servants drawn from each of the member states. It is also initiating an information gathering project through the formation of an observatory group of national experts who will report on social and economic policies for elderly persons in their own countries.

Networking relationships will also be facilitated by the Commission. So also will European based non-governmental organisations dealing specifically with care of the elderly. None of these measures are, however, likely to have a direct impact on the role and future development of the nursing home sector in Ireland. Whatever regulatory changes may occur will be nationally based and will reflect the objectives of member states rather than the whole Community.

Regulation of the Private Sector

The regulations imposed on nursing homes are also likely to be a major influence on the supply of beds. New regulations about to be introduced will mean that prospective entrants into the market will now have to meet more stringent requirements on standards of care thereby making entry more costly. Some existing homes may also find it too costly to meet the improved standards and will leave the regulated sector. Against this, the more comprehensive and flexible subsidisation of the sector (assuming that subsidy levels are also increased) is likely to be welcomed by existing good quality homes and by some prospective entrants thereby providing a stimulus to supply.

Ensuring that the requisite quality of care is achieved and maintained in all registered homes is likely to incur costs. In the first instance sufficient resources will have to be made available to assess, monitor

²Communication from the European Commission.

and enforce the legislation regarding the suitability of homes for care. In practical terms, policy must be evaluated in the light of how it will actually be applied rather than how it ought to be applied. Secondly, greater use of assessment requires the services of more expensive professional expertise. If such resources are not forthcoming then, more than likely, excess supply, of a poor quality, will ensue. The existence of a contract between elderly persons and the nursing home would reduce the potential for inferior provision of care, at least with respect to process. So also would training and support for staff within homes. However, while all of these factors influence the outcome of care, ultimately they are not a measure of outcome.

Changes in regulatory control are likely, therefore, to have both positive and negative supply side effects. Which will dominate is not possible to say with much confidence. On balance, the incentive to increase supply will depend on the size of subsidy paid to nursing homes on behalf of residents. If that is substantially increased and applied more flexibly there is likely to be an increase in the supply of beds. This would outweigh the potentially dampening effects of more stringent regulation of the nursing home sector, though the latter effect does depend on how much resources are assigned to the regulatory function.

Dementia

If the private and voluntary sectors are to be major providers of long term and terminal care for frail, elderly people, they will have to confront the issue of dementia. A proportion of the people who become very old in nursing homes are at risk from dementia. Some 5 per cent of those aged 65 years or over may become severe dementia victims while among the 80 plus age group, this rises to 20 to 25 per cent (*The Psychiatric Services — Planning for the Future*, 1984). The prevalence of severe dementia among elderly people in Ireland has been put conservatively at 20,000 and this is expected to rise in the coming decades (*The Years Ahead*, 1988). Increasingly, dementia cases will be among the priority groups for admission to nursing homes because community care services and relatives find it most difficult to look after them, and because of the shortage of psychiatric beds. This has important consequences: for the design of nursing homes which must be planned with dementia in mind; for staff who must be trained to work with their patients' remaining cognitive abilities and to minimise problem behaviour such as aggression, catastrophic reaction and wandering; and for staff burnout which must be reduced by constant training, rotation and support of workers and home carers who are doing a specially demanding form of nursing. Inspectors, too, will need proper training to deal with these issues which.

if not wisely handled, will lead to a great deal of poor care and inevitable scandals.

Public Long-stay Beds

Clearly the extent of public long-stay provision will have some influence the development of the private and voluntary nursing home sector. Evidence presented in Chapter 3 suggests that as the number of public beds has been reduced the number of private beds has increased. In 1980, for every 2.2 beds in a health board institution there was one bed in a voluntary or private nursing home. By 1985 the ratio had fallen to 1.6 health board beds to one voluntary or private bed. Given the under-estimation of private nursing homes in the official statistics this ratio should probably be revised downwards for that year. Based on the revised estimates shown in Table 3.9, the ratio between all long-stay public beds and nursing home beds (private and voluntary) is currently 1.2:1.

The likely future supply of public long-stay beds can be distilled from the deliberations of the recent Working Party on Services for the Elderly (*The Years Ahead*). Their suggestion is a norm of 10 beds for extended care per 1,000 elderly in the context of a norm of 2.5 beds per 1,000 elderly in the specialist departments of geriatric medicine and 3 beds per 1,000 elderly for rehabilitation in general and community hospitals. In addition, they recommend a norm of 20 — 25 places per 1,000 elderly in welfare accommodation. The latter is defined to include sheltered housing, boarding out, hostels and some (not clarified) forms of community hospital provision. In 1988, the number of elderly persons in long-stay health board (geriatric and district hospital) beds was 8,470 (Table 3.12). The future provision of public long-stay beds, based on a norm of 10 places per 1,000 elderly population (for the year 2011) will be 3,800, less than half the existing level. While new forms of welfare accommodation will meet most of the additional requirements (It is proposed to make 7,600 — 9,500 places available) the inference is that the private sector will also meet part of the need. No indication is given, however, on how many places the private sector is expected to make available.

It is difficult to make accurate predictions on how many beds are likely to be supplied by the nursing home sector over the next 20 years. At present 24 beds per 1,000 elderly persons aged 65 years and over are provided by that sector. If this ratio were to remain constant then approximately 10,500 elderly persons would be in nursing homes in the year 2011. This figure, however, excludes any increase in places that

may arise from the reduction in extended care beds in the public sector. It is hard to imagine that some effects will not come from this source. It is highly unlikely, in the event of public beds being closed, that welfare and community care alternatives will be ready to take all of the persons who would have formerly been admitted to long-stay care.

One intriguing aspect of this process is the source of the bed norms used by the Department of Health. The planning norm for the aggregate of rehabilitation, long-stay and welfare beds used by the Department during the 1970s was 33.5 beds per thousand elderly population (*The Years Ahead*, 1988). The actual national provision at that time was 45 beds per 1,000 elderly persons leading to the conclusion of substantial excess supply during that period. This feeling is given credence by the wide variation in long-stay beds among health board regions. In addition, as we have seen, waiting lists for admission to extended care places remained less common in areas with low bed ratios than in areas with high ratios. By its own admission *The Care of the Aged Report* (1968) was quite tentative in its discussion on bed requirements. It did establish norms but admitted that much more research than the Committee was able to undertake would be necessary before the exact number and type of beds were known. Not known, however, is the extent to which subsequent Department of Health planning norms reflected this greater research on need.

In *The Years Ahead* report the suggested extended care bed norm is based on proposals made by the Irish Society of Physicians in Geriatric Medicine. But this rate is based on the assumption of a substantial increase in resources for specialist geriatric departments in general hospitals which may or may not occur. At the very least, if norms are used, the criteria of need and resource implications underlying their calculation should be made more explicit than has hitherto been the case. In addition if norms do exist as official policy shouldn't they be met? The failure to do so up to now may, more than anything else, reflect the absence of a consensus that these norms were the most appropriate measures of need in the first place. This is a subject for investigation in its own right and is not considered any further in this report.

Community Care Services

One of the key elements of policy initiatives to keep elderly persons at home is the development of a good community care service. The latter serves to enhance the potential of home care as a viable alternative to residential care for some elderly persons. If needs are being met in the

community it is less likely that the supply of nursing homes will increase. There has, however, been some criticism about the role and adequacy of community care in this country. O'Connor (1987) suggests that the State more usually intervenes to substitute for the family when family care is absent or breaks down than it does to offer practical support to ensure the continuation of family care, in a complementary sense. Support for the importance of community care is also forthcoming from the National Planning Board (1984) who warn that cutting back on support services for families caring for elderly relatives at home is a false economy leading sooner rather than later to higher rates of institutionalisation than are necessary.

There is strong evidence that access to home helps, public health nursing, paramedical services, and meals on wheels is limited and variable within and among health boards (O'Connor, 1987; Blackwell *et al.*, forthcoming). All indications are, for example, that the public health nurse is not in a position to give the elderly the level of care she would wish (SEHB, 1979). Although evaluative information is scarce with respect to what level of nursing provision can be considered optimal. *The Years Ahead* (1988) did recognise an under-provision of services, recommending that additional public health nurses should be appointed, albeit only as resources permit.

A similar picture emerges when one examines the current provision of home help and meals on wheels services. Both of these services are, especially vulnerable at times of financial retrenchment because health boards are not legally obliged to provide them. For instance, between 1980 and 1984 expenditure on the home help service declined by 30 per cent in real terms. Acknowledging the critical importance of home helps in keeping elderly persons out of long-stay institutional beds the Working Party suggested major immediate improvements in resources for the service. A similar request for more resources was made in respect of community paramedical services.

Some evidence on the importance of community care factors in determining placement can be gleaned from work done by O'Shea and Corcoran (1989). They estimated a logit function which identified general practitioner, home help and public health nurse, among other factors, as having an important influence on maintaining elderly persons at home in the community. Both general practitioner and home help were found to be highly significant. Evidence from outside this country suggests that some applicants for residential care could be maintained at home with a guaranteed delivery of formal intensive domiciliary care (Avon County Council Social Services Department, 1981). Other reports suggest that

some institutionalised elderly could be discharged to domiciliary care if appropriate community services were available (Hakansson. 1986).

The closing of hospital beds has put increasing pressure on community care resources in Ireland. This is recognised by the many recommendations contained in *The Years Ahead* (1988) for improvements in community care resources. If such improvements are not forthcoming more elderly persons will be forced to consider nursing home care. Even if improvements do take place it is difficult to forecast at what point optimality in the mix of care will be reached. As discussed in Chapter 2. it is easier to locate optimal placement in theoretical models than it is to assign elderly persons in reality, especially given the existing lack of information on relative costs and benefits.

The manner in which community care services are integrated with private nursing home provision is also important. At the moment, once an elderly person enters a nursing home, community services, with the exception of medical care, tend to stop. For instance, elderly persons entitled to incontinence pads when living in the community lose that entitlement upon entering a nursing home. Moreover, while paramedical services are scarce enough in the community, they are absent entirely from nursing homes. Even though an elderly person enters residential care there are good reasons why contact with the community should be continued. If contact is lost the possibility of an elderly person ever returning to the community may be gone forever. Elderly persons in nursing homes, subsidised by the exchequer, should have the same opportunities as those in long-stay public institutions of returning to the community. Therefore, every effort must be made to move away from the approach that nursing home care is forever. For some elderly persons this will be the case but there will be others who would benefit from a return to the community. They should not be denied the chance to do so.

Most important of all is to have personnel in the community with specific responsibility for care of the elderly. This would allow information about actual and potential need to be generated so that services might be planned in an orderly manner. There have been a number of attempts in the UK to develop schemes that organise individual packages of care to help keep disabled or frail elderly persons in the community. Dant and Gearing (1990) have described some of the features common to integrated care plans in the UK:

- (i) There is one professional worker who undertakes an assessment,

perhaps drawing on other professionals assessments. The assessment is of the person's needs, including their wishes (as opposed to their appropriateness for a particular service).

- (ii) The same worker is responsible for drawing up a plan for a package of care designed to meet these needs.
- (iii) The worker sets in motion the services for that package.
- (iv) The worker also monitors the package, ensuring that the individual's needs are being met.

The Kent Community Care Project (Challis and Davies. 1986) is perhaps the best known example of applying the principles of case management to care of the elderly in the United Kingdom. Social workers are charged with the responsibility of maintaining elderly persons in the community for as long as possible given their dependency and a nominal budget arbitrarily set at two-thirds of the cost of residential care to cover the cost of all departmental services. The social worker has direct control over the resources needed to provide care. The experiment has been successful in reducing costs and raising outcomes for the majority of clients. Comparing the programme with a control group receiving care under the standard organisation of services, the number of institutional admissions was reduced. This was not at the expense of outcome: subjective well-being of the clients, physical abilities and quality of care all rose. The burden on informal carers fell and there was a closer matching of need and provision. Overall, the programme was found to be most cost effective for all but the most severely frail elderly. What is not clear, however, is whether the scheme would be successful elsewhere, although Challis *et al* (1988) have successfully replicated the principles of the experiment in another area.

More serious criticisms have focused on the quasi-experimental design of research in this area (Dant and Gearing, 1990). It is difficult to make definitive statements on outcome when the research is based on comparisons between two groups of matched pairs. Even if matching is successful in establishing a basis for comparison, it is still not clear what brought about the difference between groups. It could have been the use of case-management techniques, but equally it could have been the result, for instance, of having a specialised and specially chosen social work team. It could also have been the "Hawthorne Effect", that is, a change in the behaviour of workers and their clients in response to the close interest of researchers. Each of these causes, as well as many others. Dant and Gearing (1990) warn us, could be contributing to

the observed differences in outcomes between case management and standard provision.

A crucial issue in case management schemes is control over resources. In most schemes (for example, Kent) the case manager not only coordinates care but also manages resources. However, there are other schemes in the United Kingdom (e.g. the Care for Elderly at Home project in Gloucester) where the case manager does not have direct control over resources. In the latter, the case managers act as advocates for their clients, negotiating with bureaucracies and service providers to obtain what is needed by the person. Resource management is the responsibility of somebody else. Hence, in this case, the key worker does not require training in the keeping of accounts or the monitoring of budgets. Instead, his or her task is to work for the elderly person to obtain the requisite resources from the public bureaucracy.

Nowhere has the importance of community care facilities and incentives for elderly persons to remain at home been more important than in the United States. The deluge of nursing home scandals in that country during the 1970s (Medelson, 1974; Vladeck, 1979) was the result of an unregulated nursing home sector, easy access and, importantly, the absence of a countervailing community care option. Policy analysts reacted to the problem firstly by proposing new methods for financing and regulating nursing home demand and supply and secondly by promoting the development of substitute forms of care in the community (Davies, 1986). Case management experiments were introduced in some states where a single individual dealt with the multiple needs of elderly clients and mobilised a range of services for consumption. For Goodman (1981) case managers are an intervention structure between the individual, in this case the elderly person, and the complex array of bureaucracies providing programmes. One of the first priorities in the United States, however, was to upgrade the community care system. The final result of all of these changes was to reduce the number of unnecessary admissions into long-stay care. The most successful experiments were those which intervened most directly in the processes leading to admission to care and not those which defined the strictest criteria for entry based on functional incapacity. Most important of all was the political will to ensure that the case management agency had the authority and power to negotiate itself into the process at key stages not simply at the point of admission to long-stay care. This is an important lesson for policy-makers in this country if case management is ever introduced here.

Equally important to the cost effectiveness of case management projects is the successful targeting of schemes to those elderly persons who would

otherwise be in institutional care. If schemes are generally applied to all elderly persons in the community it is likely, as Kemper *et al.* (1987) warn, that small reductions in nursing home costs for some people are more than offset by the increased costs of providing additional community services to others who would remain at home even without expanded services. Targeting, therefore, involves maximising the input of informal care which is regarded as a "free" service. The difficulties associated with targeting resources have, however, led Callahan (1989) to the view that case management is no panacea. The evidence as to its effects is not clear cut. It is very likely that it will cost more and that any improvements are likely to be more marginal than substantial.

One does not have to go as far as recommending an "internal market" for services for the elderly in this country, although that option might be considered, to argue for the desirability of greater experimentation with individual-specific packages of care for elderly persons. Drawing on the lessons from other countries suggests, however, that resources should be targetted at those elderly persons who are on the margin of institutional care. Neither can case management of itself produce co-ordinated care. A necessary pre-requisite is the integration of funding services and the willingness to commit the additional resources identified by the case manager. The question of who should be the case manager is a matter for debate. There are many suitable candidates, such as, social workers, home help organisers, public health nurses etc. It is our view, however, that if case management is to be implemented in this country then the district liaison nurse, first proposed in *The Years Ahead* (1988). should act as the principal agent for the elderly person in the market (though she would have to receive training to enable her to manage effectively). It makes sense to begin the process of care with a definition of need provided by those working closely with the elderly rather than, for example, to hand down centrally determined planning norms, very often derived from consideration of need and service provision in other countries.

There are also persuasive arguments for providing integrated care for elderly persons within well defined districts. In that way even if the elderly person has to move to sheltered housing, boarding out or long-stay care, at least the dislocation would be confined to an environment familiar to the elderly person. With that in mind it would help if all planning applications for nursing home development were considered in the light of the full range (residential and community) of services already available within an area. Alternatively, of course, a situation might arise where joint ventures between the private sector and the public authorities

were instigated in order to augment institutional services within a particular catchment area. In this regard health boards should be encouraged to implement contracting out arrangements, where appropriate, with the private sector. To facilitate these changes it would help if the current programme management structure of the health care system was replaced as soon as possible by area management. This would encourage the integration of services by client group instead of the current fragmented approach.

Informal Care

The level of support available to elderly persons from family and friends, as well as from conventional community care services, is crucial in determining their ability to remain at home. O'Connor *et al.* (1988) have provided the most comprehensive information on informal carers. They estimate that there are 66,000 elderly persons in the community who require some level of care and that 50,000 of these are looked after by members of the household. There are 24,000 elderly who are very dependent and require care on a full-time basis. Half of carers are aged between 40 and 60 years with 25 per cent elderly themselves. Fifty per cent of carers devote 4-7 hours a day caring for the elderly persons with 35 per cent spending more time than this. Over half of the carers are required to be on call 24 hours a day always or almost always. The majority of carers experience restrictions in their own life due to their caring role. For example, 71 per cent feel confined some or all of the time. Fifty-seven per cent feel overwhelmed by caring some or all of the time, while 58 per cent believe that caring puts constraints on their social life. One-fifth of carers have given up work to care for an elderly person.

Evidence soon to be published by Blackwell *et al.* supports these findings. Their study shows that carers, with an average age of 52 years, who are 75 per cent female, spend an average of 47 hours a week providing care, a figure which increases considerably as dependency gets worse. The bulk of caring activities for low dependent elderly is concentrated on instrumental activities of daily living such as housekeeping, shopping, and preparing meals. For high dependent categories most time is spent providing help with physical activities such as washing, dressing, using the toilet and feeding. Well over a third of carers experience strain in a variety of areas, with 46 per cent finding caring a physical strain. For carers of very highly dependent elderly 80 per cent find caring a physical strain. These results are in line with evidence from other countries (Pitkeathley, 1989)

There are substantial opportunity costs of caring. Of the carers interviewed by the Blackwell *et al.* (forthcoming), 21 per cent said that they would seek paid work if they were not caring for the elderly person. Whether they would find work is, of course, another matter. Carers also experience restrictions on the amount of unpaid work they can engage in at home and in the amount of leisure activities they may pursue. OShea and Corcoran (1989) made an attempt to estimate and value the informal care provided to elderly persons living in the community but on the margin of institutional care. They report that carers in their study provided an average of 8 hours per day to elderly persons. Caring involved giving up work in the market place, work in the home and leisure time. When each of these components was valued in monetary terms, at an appropriate rate, care in the community was no longer a very cheap option.

There is no doubt that family carers make an enormous contribution to care of the elderly in the community, often at substantial personal cost in terms of opportunities forgone as well as physical and mental strain. Yet there is very little recognition by policy-makers of the role played by informal carers. The vast majority of carers interviewed by Blackwell *et al.* (forthcoming) expressed a desire for direct payment for caring. Yet current payment rates are restrictive and often derisory in comparison to the effort expected of carers. In addition, support from statutory sources in the form of more and better services, respite care and advice is almost non-existent. Evidence from elsewhere suggests that carers can often be kept happy in their work for quite small amounts of exchequer expenditure (Wright, 1987). Governments in other countries are increasingly recognising the importance of informal care provision. Norway recognises the contributions of family members, usually women, who care for the elderly by allowing pension credits to such carers, in addition to granting them a symbolic small payment (OECD, 1990). In the Netherlands, expenses in the conduct of volunteer activities are reimbursable and protection in the workplace is provided. In Sweden, the possibility of allowing paid long-term family leave for the care of children or elderly relatives is under discussion.

The irony is that more resources devoted to relieving carers now, resulting in an increase in the provision of informal care, would more than likely lead, in the future, to a reduction in exchequer expenditure on institutional care. Conversely, should the current provision of informal care be reduced due to changes in labour force participation by women, or because of physical and financial strain, there will, other changes notwithstanding, be a need for more nursing home places in the future. O'Connor *et al.* (1988) have already warned that the lack of

statutory support services for carers is likely to result in a breakdown of the family caring system and a consequent admission of the carer to institutional care. It is hard to disagree with this conclusion. There is plenty of evidence on how much carers do to maintain elderly persons in their own homes. There is a strong argument, therefore, that if the choice had to be made between more public funds for subsidised private nursing home care and community care the latter should be chosen: with ultimately more resources, not necessarily financial, devoted to supporting informal carers. It is the only policy which makes sense in the context of current societal objectives for care of the elderly.

Housing

Perhaps the most fundamental of all influences on the ability of the elderly to remain living in the community is the provision of suitable housing. Since 1972, local authorities, in line with the recommendations of *The Care of the Aged* report (1968), have been allocating 10 per cent of all new dwellings to the elderly. At present the stock of local authority dwellings for the elderly is estimated to be over 12,000. What has been happening in recent years, however, is that the absolute number of new local authority dwellings built every year has been falling. Should this continue to happen, the likelihood is, given trends in population, that there will, in the future, be an inadequate supply of local authority housing for the elderly. Currently, government policy favours the subsidisation of provision by voluntary housing organisations.

There is no comprehensive, up-to-date, information on the quality of housing of the elderly in Ireland. Evidence from previous surveys (Whelan and Vaughan, 1982) and from other research projects in this area (National Council for the Aged, 1985, and Power, 1980) suggests that there are vulnerable elderly people living in poor quality housing with few amenities. In that regard *The Years Ahead* (1988), while acknowledging that the vast majority of them are well-housed, recommended that the Department of the Environment carry out a comprehensive survey into the housing conditions of the elderly in order to establish the true picture. There are also elderly persons living in private rented accommodation who, although small in number, are a particularly vulnerable group. And most disadvantaged of all are those old people who are homeless. This group have traditionally found shelter in county homes and in hostels run by voluntary groups. It is not known, however, how many elderly persons in the voluntary sector are there because of homelessness nor whether they will continue to find accommodation in such homes.

Sheltered Housing

Sheltered accommodation usually provides grouped housing with a range of support services including a warden and/or alarm system. The usual target population for sheltered housing is elderly persons who, although not in need of hospitalisation, are too frail or vulnerable to remain in private accommodation. Conventionally, sheltered housing is defined by the presence of a warden although some schemes have only a part-time warden and others rely solely on an alarm system to attract attention as required (O'Connor *et al.*, 1989). There is, therefore, a variety of sheltered schemes available with considerable differences in size, design, on site facilities, and community care services provided. O'Connor *et al.* identified 117 schemes (broadly defined) in Ireland incorporating 3,504 units with 1,000 persons on waiting lists. Establishing the optimum number of units is complex. Indications from the UK suggests a target rate of between 25 and 50 units per 1,000 elderly people. If this target is used for Ireland then the current number of sheltered housing units is considerably below what might be considered even adequate, let alone optimal. However, much more information on need is required before more definite statements can be made in this regard. It is ultimately desirable, however, to avoid a caring system whereby frail elderly persons have to be kept on the move to get the care they need. That is why most emphasis should be put on barrier free, normal housing in the community.

This raises the fundamental issue of what factors should be taken into account when selecting elderly for accommodation in sheltered housing. There is broad agreement that the state of current private housing accommodation should affect decision-making. And poor housing conditions have been identified as the single most recurrent reason for moving into sheltered housing (O'Connor *et al.*, 1989). But the physical and mental health of the applicants also matters. Most crucially of all, it will only be when sheltered housing is seen as part of the continuum of care for elderly persons that optimal usage will result. This means that community care services, organised to meet the requirements of the elderly in sheltered housing, have a vital role to play in the success of schemes. For example, day centres incorporating paramedical and preventive services, which are based in or near sheltered housing schemes, could enable more elderly persons to remain indefinitely in this environment.

The National Council for the Aged (1989) has made important recommendations for the development of the sheltered housing sector. If these

recommendations are implemented then it is likely that elderly persons who might otherwise have ended up in nursing homes will, instead, continue to live in the community. In this way the primary objective of services for the elderly will be enhanced, i.e. to enable elderly persons to live at home, where possible, at an optimum level of health and independence. All the evidence suggests that sheltered housing is a valuable option in the continuing care of elderly persons in the home. Yet the development of the sector has been much slower in Ireland than in other countries. But sheltered housing on its own will not be enough. Unless community care services are also provided as an integrated package for the elderly living in this form of accommodation, the overall benefits will be less than what might otherwise have been achieved. The successful targeting of these services to those elderly who would otherwise be institutionalised will determine whether the option is as low cost an alternative as is often assumed (Van der Vlist, 1984).

Boarding Out Options

One further option which might reduce the number of elderly persons entering institutional care is boarding out. Section 10 of the new Health (Nursing Homes) Act, 1990 provides health boards with the power, under the regulations, to make and carry out an arrangement for the boarding out of elderly persons. The latter entails the placement, usually with a non-relative in a private household, of a suitable old person with the carer receiving some reward for his/her care of the person placed. This option has already been tried in some health boards in Ireland. It is particularly suited to elderly persons who can no longer live on their own but who do not need day to day nursing care. Under the new Act there are strict guidelines laid down regarding the standard of the homes chosen for boarding out and ongoing monitoring of the quality of care within the household. Each home must be inspected every six months by a public health nurse and should a crisis occur the health board assumes direct responsibility for the elderly person. Carers, at present, receive approximately £20 per week from the health board towards the cost of placement while the elderly person pays a similar amount from his or her pension.

The potential of boarding out as a general option in care of the elderly has, however, never been properly evaluated. We do know that there are substantial cost savings associated with boarding out relative to welfare home accommodation, its closest institutional alternative (O'Shea and Costello, 1991). This evidence, however, is restricted to a small number of elderly and assumes that the quality of care is invariant

between regimes, health outcomes are similar and consumers are indifferent between the two forms of care. Clearly more documented research is required before boarding out can be fully endorsed as a national option in care of the elderly. In particular the relative health outcomes of boarding out versus alternative regimes of care must be established. The marginal cost of expanding boarding out may also differ from the current average cost. More carers may only come forward if payment rates are higher. Moreover, the quality of carers may become variable as may the quality of housing. Until now, there have been no standard criteria in place to assess the suitability of carers or housing. Such criteria as are now envisaged will be vital if the service is to expand from its present base.

Most importantly, the extent to which the existing community care service could absorb an expansion of the boarding out option needs to be established. Avoiding institutional placement through boarding out will add to the demands now being placed on formal community-based services, requiring, in turn, an expansion of community facilities.

Continuing Care Retirement Communities

The possibility exists that innovative schemes will develop on the supply side over the next 20 years. One such innovation is continuing care retirement communities (CCRCs). These are residential campuses consisting of independent apartments and cottages and a variety of social and health services in one setting. Usually a nursing home is on or near the campus. In exchange for a large entry fee and ongoing monthly payments CCRCs agree to provide care to residents for the rest of their lives. Originally an American idea, variations of the scheme can now be found in France, Australia and Canada. All schemes have four particular characteristics irrespective of country setting (OECD, 1990):

- they provide independent living units, either apartments, room or cottages;
- they guarantee a range of health care and social services, usually on the premises;
- they require some sort of prepayment;
- they offer a contract that describes the obligation of the tenant and the provider for a term of several years or life.

The major problem with these schemes is the high entrance fee and ongoing service charges. In 1986, the median entrance fee for schemes in the United States was \$48,000. In addition, the median monthly

service fee for a one bedroom apartment was \$756 (Rivlin and Wiener, *et al*, 1988). This has resulted in schemes only within the financial reach of higher income elderly persons who often use the proceeds from selling their home to pay entrance fees. Health services are, however, guaranteed under this system. The financial risk is managed through careful screening of entrants as to health status and greater use of skilled home care rather than high cost institutional alternatives. Careful case management and the availability of alternatives to supplement nursing homes in many care communities appear to facilitate more appropriate use of other services (Struyk *et al.*, 1988).

The development costs of CCRCs are high. The cost of developing and building a CCRC can run to more than \$20 million for some types of community — a heavy financial burden for all but the wealthiest investors. While, in the past, non-profit sponsors played an important role, future growth may depend on an expanded role for proprietary sponsors, perhaps private or public insurance companies. Moreover, because of the expenses involved for entrants to the scheme and the health screening tests applied there is an upper limit to the number of elderly likely to live in CCRCs. Only the wealthier and healthier elderly are likely to be found living in these schemes. If CCRCs were to develop in this country they would therefore be concentrated, initially at least, on high income elderly. There is, of course, always the possibility of exchequer subvention to allow lower income elderly persons to participate. It should be acknowledged, however, that there is no tradition of such schemes in this country. Nevertheless, even if CCRCs never develop here they do carry important lessons for policy-makers. Firstly, not all schemes for private or self-insurance have to be based on institutional care. Secondly, properly managed and available community care services can keep at risk elderly persons out of institutions for a longer period of time.

Social/Health Maintenance Organisations

One final option on the supply side is the development of health maintenance organisations (HMOs) dedicated to long-term care of the elderly. The concept of the HMO involves a fixed capitation fee, paid in advance, that entitles enrollees to acute health care services delivered by physicians, hospitals and other providers affiliated to the HMO. The great advantage of HMOs in the United States is that they avoid the incentives for excess demand built into the fee-for-service system. Instead, there is an incentive to ensure that enrollees get appropriate care at the lowest cost and that means in the community, not in institutions.

A social/health maintenance organisation (S/HMO) broadens this approach by covering long term services not normally included in HMO's (Rivlin and Wiener, *et al.*, 1988). The problem with this approach is that, at present, it is more concept than reality. Certainly the potential advantages of the scheme are quite attractive: substitution of care at home for nursing home care; less expensive home helps for more costly medically biased community care services, the avoidance of expensive acute care services and the prevention of excessive use of all services. Yet the cost of setting up S/HMOs is likely to be prohibitive requiring a massive capital sum and huge borrowings. It is also likely that, as with CCRCs, enrollees would be screened to ensure that only the healthier and wealthier are covered. Finally, premiums would, more than likely, be prohibitive, particularly if plans were open to all elderly persons.

There is no evidence of any support for the acute care HMO in this country. It is unlikely, therefore, that its more embryonic offspring, the S/HMO, is likely to find much support in the future. Nevertheless the concepts underlying this approach to long-term care, once again, carry invaluable lessons for policy makers. The most fundamental is that the movement to community care will only occur if the incentives are such as to change provider and consumer behaviour in that direction. For instance if nursing home care is subsidised at the expense of community care then more elderly persons will end up in long-stay care. Conversely more resources for community care will reduce the numbers in nursing homes.

Conclusions

Many supply side issues are likely to affect the development of the nursing home sector. Of crucial importance is the passing of new legislation. A more stringent regulatory environment is likely to cause some, currently below standard, nursing homes to go out of business, unless prepared to implement substantial and, therefore for them, costly changes in structures and practices. Against this, more flexible subsidisation arrangements are likely to prove attractive to some prospective entrants (particularly if this means higher payments) thereby leading to an increase in supply.

Barriers to entry in the industry are quite weak with economies of scale not a deterrent to potential entrants. Policy changes with respect to the number of public beds will, however, have implications for the nursing home sector. A reduction in public beds tends to encourage a greater demand for private care. On the contrary, alternative residential accommodation such as sheltered housing or boarding out will substitute for.

or at least postpone entry to nursing homes. New schemes such as CCRCs or S/HMOs may also affect change in this area, though the likelihood of either becoming important agents of change in Ireland is slim.

The most crucial element in the future evolution of the nursing home sector will remain the level of real resources available to support care in the home. If such resources are not adequate and if, conversely, subsidisation to the nursing home sector is too generous there is likely to be a perverse incentive for more care in institutions. This would not be in the best interests of elderly persons in this country.

CHAPTER 6

Financing Long-Stay Care

Introduction

This chapter is concerned with setting out options for the financing of long-stay care in this country. At present both the public and the private sector (mainly through out of pocket expenses) play a role in financing care. Views differ on how much relative emphasis should be placed on either sector. Some argue that the primary responsibility for care of the elderly should fall on individuals and their families. The government should only get involved where people have special needs for help. The opposite view is that the government should be the prime source of financing in this area, meeting the requirements of all or most people, regardless of financial need. The source of funds for this involvement would be either general taxation or compulsory social insurance. The government might or might not provide all services. Scope exists in this scenario for contracting out some or all services.

These are extreme polar views. There are many combinations of public and private responsibility and most people would opt for some middle ground. Such is the case in this country. Policy in the future, as in the past, will continue to rely on full public financing of care for low income individuals and subsidised financing, depending on means, for all other persons. Up to now, eligibility has been defined arbitrarily and narrowly by the Minister for Health's refusal to sanction approval for additional subvention earning beds since 1980. The new regulations are set to remove this anomaly by allowing any person, who qualifies on the grounds of means and dependency, to receive a subvention. An evaluation of the optimal approach to the setting of the new subvention arrangements is also undertaken in this chapter.

Funding Options

There are essentially two extreme views on funding arrangements for long-term care. Firstly, there are those who value personal responsibility

for achievements, freedom of choice and market based solutions for health care problems. Such people find it difficult to support any public sector involvement in care of the elderly. In this view individuals are the best judge of their own welfare and priorities should be determined by willingness and ability to pay. Redistribution and equity issues should be dealt with through the tax and social security system while any remaining gaps in health care coverage can be met by charitable means. On the supply side of the market the response will be motivated by the possibility of profit except for those suppliers set up with the sole objective of meeting the needs of those unable to pay their way in the market. Priorities are largely determined, therefore, by willingness and ability to pay and by the costs and market structure of suppliers. In the market, price has to equate demand and supply.

Since few people can pay the high costs of care out of their own pockets, advocates of private sector solutions depend ultimately on the development of insurance markets. The problem is that these markets do not work very well in the case of coverage for long-term care. Insurance companies worry especially about the problem of "moral hazard" and "adverse selection" of insurees. The former relates to the case where insurance coverage that is free at the point of use induces increased consumption of services. Resource allocation in long-term care is not an exact science. Social considerations often play a prominent role and insurers worry about the likelihood of excess consumption particularly if community care services are covered.

Adverse selection will occur if people can predict their use of long-term care services. If this can be done those people most in need of services may disproportionately purchase insurance. The result of such behaviour is usually higher premiums which in turn cause those low risk people who are insured to drop their policies. The insurer is left with a high risk, high cost group as premiums are pushed even higher. To protect against adverse selection insurers usually screen for health problems thereby excluding likely high risk, high cost users. Ultimately, therefore, experience rating by companies results in many elderly persons being forced out of the market.

Because private insurance coverage in a competitive market is itself a profit seeking activity, some risk-rating is always inevitable. Hence coverage is bound to be incomplete and uneven, thereby distorting the ideal principle of personal willingness and ability to pay. This is not to argue that public production is inevitable following market failure in the insurance market. It may be more rational and cost-effective for the State, if concerned about the ability of the elderly to purchase insurance at reasonable rates, to subsidise their premiums but allow the private

sector to supply the appropriate care. Neither does the above analysis deny a valid role for voluntary non-profit organisations. The reality is, however, that in no country is the voluntary sector able to meet the high cost of long-term care for those persons unable to compete in the market-place.

The alternative approach to financing care of the elderly is that which demands free, publicly provided, health care as a natural right for all citizens. In this model priorities are determined by social judgements about need. The erratic and potentially catastrophic nature of demand is not met by insurance. Instead the latter is made irrelevant by the provision of free services. The possibility exists for the use of nominal charges to ration unnecessary use of services though this would not find favour within the pure model of public sector provision. Equality is seen as an extension to many of the freedom of choice enjoyed in private markets by only the few. Some freedoms are inevitably given up but at the gain of a more equal distribution of outcomes among all persons, irrespective of private means. Resources are, however, not infinite and socially determined tax-based constraints force providers, especially, to make judgements on behalf of society on their most cost-effective use.

The reality of free publicly provided services for the elderly is, however, that the absence of any personal financial contribution raises the possibility that the elderly will seek treatment for trivial or inappropriate reasons. Once again the problem of "moral hazard" surfaces. Such excess consumption causes major public finance problems for the exchequer. Evidence from the National Health Service (NHS) in the United Kingdom suggests that easy access to full cost reimbursement for nursing home care has caused an explosion of cost in this area. The tendency is for supply to create its own demand, particularly when the cost of care falls on a third party. This is not to deny, as we have seen, that incentives for moral hazard also exist in the private sector, especially when insurance carriers bear the full third party costs of financing. Priorities and resource use within the public system can, however, also be manipulated by the preferences of providers, particularly if their choices are exercised, in a technical sense, without *de facto* consideration of government budget constraints. Furthermore, attempts to redress the over-consumption can exacerbate the inefficiency problems if done in a crude manner. For example, across-the-board cut-backs tend to penalise both the efficient and the inefficient.

The right to health care met by free publicly provided services may also undermine other desirable objectives of the health care system. For example, in apportioning responsibility for health care the principle of subsidiarity is often cited, particularly in this country, as a valid health

care objective. Applying this principle to care of the elderly implies primary rather than secondary care and an active decision-making and financing role for the elderly themselves. Clearly the right to free health care for all persons, particularly if biased towards nursing home care, may result in the crowding out of this principle.

Within the framework of public financing of long-stay care the case is often made for the introduction of a social insurance scheme. Covering long-term care under a universal social insurance programme avoids the adverse selection problems inherent in private insurance markets. Everyone has to contribute. This is achieved through a comprehensive coverage leading to a pooling of risks, thereby reducing the cost of premiums (contributions) under this scheme. A social insurance scheme would also guard against the development of dual systems of care providing what might become a good quality, high cost service for those who can pay and a residual poorly funded inadequate service for those who cannot. In addition, it would allow contributions to be made throughout the life-cycle thereby ensuring the building up of adequate resources to finance care at the end of the cycle.

Critics of this approach focus mainly on the additional cost burden of setting up the system. Many disabled elderly who now receive no free services would be entitled to benefits. The reduced out of pocket expenses could, it is argued, lead to increased service use (the problem of moral hazard) and the substitution of covered for non-covered services. It must also be acknowledged that the introduction of a social insurance system would entail special difficulties for this country. There would, for example, be much resistance to the introduction of another form of compulsory taxation. More important, however, is the absence of much support for social insurance funding of health services in Ireland. There was a minority view on the Commission on Health Funding which supported this approach but there is no evidence that policy in the medium term will move in this direction.

Notwithstanding such pragmatic objections, social insurance programmes for long-term care have much to recommend them. The equity principle involved is very strong. The essence of social insurance is that everyone contributes to the programme and all contributors are entitled to benefits. Social insurance would, therefore, eliminate the stigma of means testing. Elderly persons could be reassured that in the event of long-term care they would be entitled to the benefits having made contributions throughout their lives. In addition, many variations are possible under this model. The extent of cost sharing will, for example, determine the need for a complementary private insurance market. If public coverage is more comprehensive, the necessity for private insurers

is much reduced but the social premiums are likely to be correspondingly higher. Social insurance financing does not, of course, rule out the private production of services. It is quite feasible to imagine a scheme whereby many private producers (in institutions and in the community) compete for patients on the basis of cost and quality.

It was not part of the brief of this study to examine the options for financing long-term care. We were asked to consider the optimal means of financing care within the guidelines laid down by the imminent new legislation in this area. Clearly, however, there is much to be gained from a wider examination of these issues than has hitherto occurred in this country, especially the option of social insurance

This is not to ignore the reality that most countries tend to favour an intermediate approach to financing long-stay care for the elderly. This means that full provision is only available for those people without any means to support themselves. All the rest are expected to make some personal contribution depending on their financial circumstances. In this manner part of the resource implications of care remain with the State while, at the same time, those elderly people able to make their own arrangements benefit from a wider choice. This is the model proposed for future care of the elderly in this country. Subsidisation will be related to the income of the elderly person as well as his or her dependency characteristics. The thinking underlying this approach is neatly summarised by the Commission on Health Funding who argue, for instance, that the principle of subsidisation of elderly patients in private nursing homes is justifiable. It is their view that unlike the general hospital services, publicly provided long-term residential care for the elderly is not intended to meet all the needs of the elderly population. On the contrary the existence of the subsidy enables those with some private means to avail of nursing home care thereby removing the additional burden which would fall on the State if it had to provide such additional public facilities.

While acknowledging the pragmatic nature of this approach the analysis does beg the question as to the source of the "not intended" clause (referred to above) exonerating the public sector from full responsibility for care of the elderly. It is unclear, for example, why, if all persons are soon to be entitled to free acute hospital treatment in a public bed, old people are not provided with the same right when in a long-stay bed. The inference must be that society's basic value judgement in this regard is concerned only with absolute consumption rather than the consumption of one person relative to another or the consumption of the same person at different stages of the life-cycle in different forms of care. But why should the consumption of acute care patients be treated

differently from that of elderly persons at the end of their life in need of another form of institutional care? While acknowledging the budgetary implications of financing long-stay care in institutions, perhaps, if the system could have had more confidence in long-stay admission procedures, it would have been possible to confer equal funding rights on beds in the long-stay sector. The *ad hoc* manner in which admission to long-stay care evolved made it difficult, however, to be concerned with principles of equity or social justice across generations. Instead, budgetary pre-occupations and legitimate worries about easy access may have had more effect in shaping the public-private mix than any other considerations. This has certainly been the trend in the relationship between the State and the nursing home sector in Ireland.

The Public Funding of Long Term Care: The Old Arrangements

Under the Health (Homes for Incapacitated Persons) Act. 1964, the Minister for Health may make regulations to govern the operation of nursing homes managed for profit. Nursing homes managed by voluntary organisations do not come within the scope of this legislation. Under the 1964 Act. persons setting up a private nursing home must notify the health board in writing at least one month before commencing operation. No such obligation applies to nursing homes set up by voluntary organisations. Similarly the more comprehensive Homes for Incapacitated Persons Regulations. 1985. relate only to private nursing homes although, *de facto*, voluntary nursing homes which have been approved for subvention also come within the scope of the legislation. In addition to laying down minimum standards for accommodation, food and care in the home, the 1985 regulations have also introduced standards in relation to patient records, staff qualifications, fire safety and equipment. Additional guidelines from the Department of Health require health board inspection teams to ensure that in addition to medical and nursing care elderly persons also have access to dental and ophthalmic care. They also recommend minimum space requirements as well as setting out sanitary standards.

Health boards are obliged under Section 54 of the Health Act 1970 to subsidise the care of eligible elderly persons who choose care in approved nursing homes. In 1988. only one-third of all known nursing homes were approved for subvention under the Act. However just because a nursing home does not have approval status does not necessarily mean, as we have seen, that service provided is below acceptable standards. For financial reasons the Minister for Health has not approved any additional nursing homes since 1980. The possibility exists, therefore, that an

elderly person in need of subvention cannot receive help because, for whatever reason, he or she cannot find a place in an approved home. In contrast, there may be elderly persons in approved homes not in need of subvention but subvented anyway simply because of their good fortune in finding a place in a home designated for approval before 1980.

Health boards, under Section 26 of the Health Act, 1970, may also make a separate arrangement with voluntary or private nursing homes to provide a service for eligible persons. This section is used quite extensively in the Eastern Health Board (EHB) where there is a recognised shortage of long-stay public beds. If the Eastern Health Board had relied only on Section 54 approvals there would have been a major long-stay accommodation crisis in the Dublin region during the last decade. The advantage of Section 26 subventions is that they are not tied to approved homes so that use can be made of the full range of homes available, provided they meet the inspection requirements of the Board. In 1988, the EHB paid out in excess of £2.5 million by way of subvention for patients in private and voluntary nursing homes. For the most part this money was paid at the approved rate to persons seeking assistance (Eastern Health Board, 1989). In some cases rates of subvention higher than the recommended rates were paid. These were based on a means tested assessment of the resources of the applicant. This Board has also entered into contract arrangements with a number of nursing homes which have undertaken to provide care at an agreed level and to a particular patient group on the Board's behalf. In all there are about 40 of these contract beds with access strictly controlled through provider led assessment and allocation procedures. The cost of these beds is negotiated with individual nursing homes in the scheme but it is likely that the strategic and dominant power of the Board has been successful in establishing an average payment for contract beds somewhat below that charged to individual clients. The use of contract beds by the EHB is the *de facto* recognition that the numbers of long-stay public beds in the region are insufficient to meet the residential requirements of the elderly.

Convalescent grants are also available for a small number of mainly private nursing homes, almost exclusively in the Eastern region, which are geared specifically to the care of people recuperating following discharge from acute care. Only a limited number of beds qualify for assistance. Persons referred privately receive £6.50 per day towards fees while persons referred by the health board receive £8.40 (Eastern Health Board, July 1990). To qualify for the award a medical certificate is all that is required. There is no means testing for potential residents.

In some health board areas, capitation grants are paid towards the cost

of long-stay accommodation in specified voluntary nursing homes. These homes are not covered by the 1964 Act and apparently cater for welfare type cases with low incomes. The health boards do not assess eligibility or means and the subvention is quite low, ranging between £7 and £12 per week. Not all beds in listed homes are covered. Some voluntary homes may also receive means tested subvention payments for elderly persons in their care. The number receiving such awards is limited but the subvention paid is approximately £40 per week. Though these homes are exempt under the 1964 legislation they are treated similarly to private nursing homes in most respects.

The Voluntary Health Insurance (VHI) scheme also has a list of nursing homes designated as approved for payment purposes. Once again, no inference about quality can be made about nursing homes not on this list. The approval status has more to do with the general unwillingness of the VHI to engage in financing long-stay care of the elderly than anything else. Generally the VHI will only finance short-term (two weeks) post-acute care convalescence in any approved nursing home. Longer-term care will only be financed if the VHI can be convinced of the medical nature of the care being provided. The likelihood of funding for long-term care does improve if the elderly person or their relatives enlist the help of providers to exert strong pressure on the VHI. Given our earlier discussion on financing options the attempt by the VHI to restrict coverage is not surprising. As the model suggests, insurers worry greatly over problems of adverse selection and moral hazard.

The situation at the moment in public long-stay institutions is not any clearer. The current legislation which empowers health boards to charge for long-term residential care distinguishes two categories of service. Firstly, institutional assistance defined in the Health Act 1953 as shelter and maintenance in a county home or similar institution allows charges to be imposed on all persons with personal means with effect from the date of admission. Secondly, institutional services are defined by the Health Act 1947 as including maintenance, diagnosis, advice and treatment and the supply of appliances and medicines and are intended to deal with patients receiving more medical forms of care. In addition, the Health Act, 1970 provides for further elaboration of institutional services including charges to persons receiving in-patient services in hospital, convalescent homes, or homes for persons suffering from physical or mental disability or in accommodation ancillary thereto. The Act specifically excludes those entitled to a medical card. Moreover, charges may only be levied where the patient has no dependants.

It is hardly surprising that the above legislation has given rise to confusion and differences in interpretation within and among health boards. The

main problem stems from the difficulty in distinguishing between non-medical and medical services in care of the elderly. What has happened in practice is that charges have been levied 30 days after the date that elderly people enter into public institutions as long-stay patients (the 30 day rule is to satisfy current regulations in this regard). Charges apply, however, to all those with personal means regardless of category of eligibility. In practice, this has meant that institutions have kept as revenue approximately 75 per cent of the pension of the elderly person. The assets of elderly persons are rarely taken into account. Personal means are usually restricted to income from pensions, contributory or non-contributory.

It is quite obvious that the current arrangements with regard to subvention payments are at times anomalous, inconsistent and far from simple. Awards under section 54 are not means tested, while those under section 26 are subject to stringent examination of income and assets. There are also different rates of payment across schemes which do not appear to relate in any systematic way to means, dependency, or cost of care. Furthermore, there are differences between the public sector and the nursing home sector. An elderly person in a public long-stay institution is exempt from any means tested contribution, except of course that most of their pension is retained by the institution. If the same elderly person were cared for in a private nursing home he/she would be expected to contribute perhaps two thirds of the cost of care and that is assuming he/she qualified for a Section 54 or Section 26 grant. If subvention was paid under the latter scheme the assets of the elderly-person and possibly their relatives would also be taken into account.

Not surprisingly the Commission on Health Funding (1989) warns of the need to specify the circumstances in which charges should be payable in long-stay care. They suggest the standardisation of the amount of personal allowable income above which charges are levied. The Commission are particularly concerned that the rise in contributory and occupational pensions in the future will increase the disposable income of residents thereby rendering more of them capable of making some contribution to the cost of services. The Commission did not consider the possibility of taking the assets (usually housing) of the elderly person into account in assessing eligibility for subvention, either in public long-stay beds or in a private nursing home. Nor did they make any mention of whether the income and assets of the family of the elderly person should be considered before subvention is awarded.

The question of whether assets should be included in means tested arrangements is the subject of much debate. As a result of increased longevity, estates are now being inherited by people in middle life who

are often already better off and in better housing than their parents (Wheeler. 1986). This raises the issue, discussed earlier in Chapter 4. of whether the resources of the elderly person and their immediate family should be included, either prospectively or retrospectively, as part of the eligibility criteria for subvention. If the assets of the elderly person are used to make families richer instead of to pay for long-term care, which as a result must be funded by the exchequer and implicitly those less well off. there is a valid redistributive argument for instigating procedures against families in order to recoup the cost of care. This seems to be the rationale underlying the means testing procedure used by the Eastern Health Board in assessing applications for Section 26 grants. In addition, if it is families who make demands for care on behalf of elderly persons the case for including their income and assets for means testing purposes is made even stronger.

Accepting the principle of means testing (income and assets) in this area is not to deny the problems inherent in the system as currently operated in the country. Existing schemes differ across, and sometimes within, health boards. Assets are included in some schemes, excluded in others. Where assets are included it may be that asset stripping is occurring so as to qualify elderly relatives for greater assistance. Efforts to combat this practice by gathering even more information on total family income and assets creates its own difficulties. For one. the investigation requirement is much greater as the incentive for duplicity and dishonesty grows accordingly.

Proposals for Future Arrangements

The generally unsatisfactory nature of the relationship between the State and the private and voluntary nursing home sector has led to many calls for legislative, regulatory and financing changes (NCA. 1986; *The Years Ahead*. 1988). This has resulted in the enactment of the Health (Nursing Homes) Act 1990 by the Dáil. This Act requires that all nursing homes, with the exception of voluntary homes to which grants are paid by the Minister or the health board, must in future be registered. To qualify for registration homes have to meet regulatory and inspection requirements dealing specifically with the process of care. Under the new regulations the current anomaly of approved and non-approved beds will be removed. Instead, elderly persons who meet income and dependency requirements will be subsidised as long as they choose care in a registered home. There will be more than one rate of subsidy. The Health Board will be able to vary the subvention in accordance with the individual's dependency and income. Currently, the only proposal is that there would

be payments for three categories of dependency — light, moderate and heavy, where the latter is defined to include persons with dementia.

There have been no indications yet on how the financial circumstances of the elderly person will be taken into account in the allocation of subsidy. Means testing is always likely to prove administratively cumbersome and complex. This is exacerbated with respect to some old people who, although income poor, may be asset rich, as noted earlier. In addition, household family income may be sufficient, but not forthcoming, to buy private care for an elderly relative.

Furthermore, the issue of whether decisions on subvention should apply with equal vigour to elderly persons seeking admission to public and nursing home care must be addressed. This raises some difficult issues not least the judgements to be made on the appropriateness and level of subvention.

Our concern with simplicity and uniformity leads us to the view that the new subvention arrangements should be based on the eligibility criteria which are well known to the public. That is why we suggest using the old eligibility criteria for acute health care as a basis for awarding subventions to elderly persons seeking admission into long-stay care. Under this approach only the income of the elderly person would initially affect eligibility for subvention. Elderly persons defined as Category I (the medical card population), would be entitled to full subsidisation either in a long-stay community hospital or in a nursing home. Institutions would, however, be allowed to keep a predetermined proportion of resident's pensions as is currently the practice. More restrictively, elderly people in Category II (those who would have previously qualified for the Hospital Services Card) would have to pay for the cost of accommodation in long-stay care but would be entitled to subvention for nursing and paramedical services. Elderly people in Category III would not, however, be entitled to any subvention and would have to bear the full cost of long-term institutional care (Table 6.1). In contrast if elderly persons (irrespective of category of eligibility) are looked after at home no category would be liable for the cost of community care services, except perhaps for nominal charges designed to counteract frivolous consumption. The implicit assumption is that equal subsidies (at least in a nominal sense) would be available to provide elderly persons on the margin of institutional care with specific integrated packages of care designed to keep them living in their own homes for as long as possible. It would be the responsibility of providers and case managers to ensure that community resources were directed only to those persons who most needed help. The overall objective, therefore, is to encourage and assist families to care for their elderly relatives at

home rather than in long-stay accommodation while at the same time not restricting the option of subvented nursing home care to those elderly who need it.

Table 6.1: Financing Scheme for Continuing Care

Coverage	Category		
	I	II	III
Accommodation	Fully-covered (Net of Pension)	Paid by Client	Paid by Client
Nursing and Paramedical Services	Fully covered	Fully covered	Paid by Client
Community Care	Fully covered (Nominal means- tested charges)	Fully covered (Nominal means- tested charges)	Fully covered (Nominal means- tested charges)

The above scheme has the advantage of simplicity. It is based on well known, and well tried categories of need and is not open to the possibility of inequitable interpretation across regions. It is acknowledged that our proposals on eligibility criteria for long-stay care are different to those for acute hospital care as proposed under the Programme for Economic and Social Progress.¹ However, a system whereby all elderly persons would be entitled to subvention would place an intolerable burden on the exchequer and the assessment services at this time. It may well be that the ongoing development of the latter will, at some time in the future, allow eligibility for long-term care to be brought into line with acute care (as assessment rations demand according to need) but, for the present, different criteria should apply. However, if the subvention system is to work at all then the recommendations of the Commission on Health Funding will have to be implemented in order to overcome problems inherent in the current eligibility criteria for medical cards. The Commission have recommended changes in the present system to ensure that assessment for medical cards is made uniform across regions. Regular review is also required to make sure that awards are made only to those people in genuine need.

The assets of the elderly person should also be taken into account but only on a retrospective posthumous basis. It should be possible to devise imaginative contracts between elderly persons and health boards whereby the latter would be entitled to recoup part of the expense of

¹Under the Programme for Economic and Social Progress the income limit for Category II eligibility (i.e. entitlement to a Hospital Services Card) is to be abolished from 1st June, 1991.

long-term residential care from the estate of the elderly person. This claim could only be exercised, however, after the death of the elderly person. In cases where a spouse was still alive recoupment could not occur until after his/her death. If the total realised value of the estate lay below a certain threshold (say £25,000) all claims by the health board would be forfeited. The moneys due would relate to the number of years spent in subsidised care, operating along the lines of a retrospective deductible payment.

Given the potential difficulties involved in liquidising the assets of living elderly persons, as discussed above and in Chapter 5, this scheme would simplify matters by waiting until the estate of the elderly person was disposed of after their death. It would also avoid an invasive and potentially inefficient and inequitable examination of the assets of elderly persons and their families. There is no doubt that the family make demands for care on behalf of elderly persons. The difficulty, however, is to identify which member of the family should, in turn, bear the major responsibility towards the cost of care in a nursing home. It would hardly be equitable simply to focus on that person within the family who was mostly responsible for initiating the demand for care. If that were the strategy, it could lead to inefficient choices being made within households as some members sought to free ride on the altruism of others. Such behaviour would reduce overall caring within families as some members opt out in order to avoid having to make any contributions towards the cost of care. Our scheme would avoid these problems by ignoring the income and assets of relatives for the purpose of means testing. However, a retrospective deductible would reduce the size of inheritance which uncaring and unhelpful offspring could expect to get. If, for instance, assets were disposed of prior to death the moneys raised would be treated as available income of the elderly person and thereby fall within means test. This would apply even if assets were transferred to another member of the family in an effort to avoid the long-stay care deductible. Any income arising from home annuity schemes would also have to be taken into account for means-testing purposes (although we do realise that such a recommendation is out of line with recent changes under Section 35 of the Social Welfare Act 1990 which exempts income derived from the sale of pensioners' principal residence for means tested purposes). Similarly, any rental income earned by the elderly person while in long-stay care should be included as part of their means and therefore assessed for the purposes of eligibility classification.

¹Free riding is where some member(s) would understate their preferences for care thereby avoiding the financial implications in the belief that caring will be provided anyway, paid for, at least partly in this case, by other members of the family.

It could be argued that the system of classification discussed above is not very helpful as most elderly people fall into Category I. That may be currently the case but the retirement income of elderly persons is likely to increase in the future owing to the maturation of contributory pensions and the steady growth in occupational pension rights. When that process is complete the distribution of old people by category will more closely resemble the national picture for all age groups. Hence subsidisation of the sort we propose is likely to become more appropriate. Meanwhile, fears about the regressive nature of the subsidisation should be reduced by the inclusion of household assets albeit in the form of a retrospective deductible payment.

Whatever subvention scheme is chosen there should no longer be a distinction in the application of such a scheme between elderly persons in public beds and those in private or voluntary nursing homes. At the moment care in long-stay public accommodation is free, except for pension contributions, while elderly persons admitted to private nursing homes are expected to pay the full cost or part thereof. Policy proposals contained in *The Years Ahead* report suggest that there is to be little, if any, difference in the standard of care and availability of resources between public and private long-stay care in the future. If that is the case (and at this moment it is only an assumption) there is no logical reason why elderly persons in either regime should be treated differently for subvention purposes. Of course some hospitals or homes may continue to look after more dependent elderly people providing more specialised care and therefore would be entitled to extra resources. This is a separate issue. Our concern here is that public long-stay care providing the same type of services for similar people must be treated the same way for subvention purposes. In the same way, of course, all long-stay units must be subject to similar regulations as the private sector regarding standards and quality of care.

The financing of nursing homes should not, however, occur at the expense of resources for community care. Accepting this principle means that subvention for nursing home care should never be granted unless it is clear that a similar subsidy would not have succeeded in maintaining the elderly person in their own home. The subsidy, if applied to community care, could be used to buy resources like home helps, community nursing and paramedical services, as well as perhaps making some financial contribution to informal carers. It is precisely these services which are vital in slowing down or preventing entry into long-stay care. The subvention could also be used to pay for respite care, or even to improve the housing conditions of the elderly person. The decision on what package of care is more appropriate would be made by an agent

acting on behalf of the elderly person (though respecting as far as possible consumer sovereignty, including that of the family). As discussed earlier the person best placed to fulfil this role is the district liaison nurse as proposed in *The Years Ahead*. It is only if assessment deems it necessary to move the elderly person into residential care that the subsidy should be transferred to long-stay care. The size of the community subsidy could be fixed below the prevailing cost of institutional care as in the Kent experiment but we would require more information on relative costs before making definitive statements in this regard. As we have noted in Chapter 5, the most important requirement is to target the extra resources on marginal elderly persons (who would otherwise be in institutional care). If this is not done it is unlikely that case management will be a cost-effective solution to the problems of care of the elderly.

Level of Subvention by Category of Dependency

In the event of an elderly person having to go into long-term care the level of subvention paid to nursing homes should relate to the dependency characteristics of the elderly person seeking admission. The proposal under the new legislation is that payments would be made for three categories of physical dependency — light, moderate and heavy. Persons with severe forms of dementia are included in the latter. Assessment of this type would serve two purposes. Firstly, it determines whether that person needs nursing home care at all and if some more suitable form of care might not be arranged. Secondly, it serves to establish the level of subvention to be paid to a long-stay home upon admission of that person.

Very few elderly persons, whether receiving public subvention or not, are currently subject to rigorous assessment before admission to nursing homes. There is also evidence that some elderly persons have, in the past, been admitted to long-stay public care without rigorous evaluation or consideration of all possible alternatives (Blackwell *et al*, forthcoming). Such practice is, however, no longer as common as before. Specialist geriatric assessment is now available in some hospitals and admissions committees have been set up in other institutions for the purpose of assessing the eligibility of elderly persons for admission to extended care. However, this does not mean that a homogenous approach to assessment exists across institutions. Usually four criteria are considered: medical, nursing, social and length of time on waiting list (see Chapter 2). Each criterion is assigned a points weighting and the elderly person is scored accordingly. The widely ranging levels of dependency among elderly patients in public long-stay institutions, at least when physical dependency is considered, confirm that there are

differences in admissions procedures among these institutions (see Chapter 3).

As part of the proposals for improvements in care of the elderly *The Years Ahead* (1988) recommends that additional geriatric departments be provided as a matter of urgency. In addition it is recommended that some existing health board geriatric hospitals be developed as community hospitals. The latter are an interesting concept and, if introduced, may radically transform the process of care in the long-stay sector. It is difficult, however, to find a precise definition of them in *The Years Ahead* report. Instead what one gets is a list of services which these hospitals are expected to provide. These services include:

- assessment and rehabilitation of elderly patients
- day hospital and/or day care services
- respite care to support caring relatives
- facilities for nursing highly dependent or terminally ill elderly patients who can no longer be cared for at home
- information, advice and support for those caring for elderly persons at home.

The key recommendation here is that community hospitals be equipped with assessment and rehabilitation facilities. Moreover, it is also proposed that a physician in geriatric medicine should be able to provide specialist advice to the assessment and rehabilitation unit of the community hospital by means of regular visits and/or seeing patients on referral from the unit to the general hospital. Training opportunities for staff from the unit should also be provided in the specialised geriatric departments of larger hospitals.

The philosophy behind the community hospital proposal is that of an active and dynamic approach to care of the elderly. The objective is to keep elderly persons out of institutional care if at all possible. In practice this will require the equipping of some of the existing health board long-stay institutions with the resources necessary to carry out assessment and rehabilitation. However, it may be necessary, in larger urban areas, as is made clear in *The Years Ahead*, to build completely new community hospitals. At the same time it is not proposed that all existing long-stay institutions should be reclassified as community hospitals. Such a proposal would in any case be unwarranted, given the renewed emphasis on community care. However, it should be noted that there is no indication in *The Years Ahead* as to which of the existing institutions are to be upgraded nor the timescale involved. These decisions will, presumably, have to be made by health boards operating within revised budget constraints and taking the distribution of population within their borders into account.

It is our view that elderly persons seeking a subvention to enter private and voluntary homes should also be subject to the same assessment procedures as an elderly person entering a long-stay public bed. In addition, it is suggested, by and large, that similar rehabilitation opportunities should be available to that person. It is not proposed that all nursing homes should have to invest in expensive assessment and rehabilitation facilities. Instead, the resources of the community hospital should be used to determine whether a subvention-seeking elderly person needs long-term care in a private or voluntary nursing home. If, following assessment, an elderly person is placed in a nursing home, rehabilitation facilities, jointly provided by the public sector and the nursing homes, should be made available to that person. In that way some persons may, eventually, be able to return to the community, following a successful rehabilitation programme. It is hard to disagree with Neill *et al.* (1988) when they say, admittedly in the context of the United Kingdom, that the main problem lies not in the (nursing) homes but in the way in which, or circumstances in which, decisions to enter them are taken.

The proposal that subvention payments should be linked to dependency is a novel one in this country. For that reason it is worthwhile to briefly examine policy developments in countries which have some experience of implementing a national geriatric assessment programme linked to the funding of long-term care. Australia is a useful example in this regard. The relationship between the level of funding for a particular institution and the dependency status of its residents has been established in that country through the use of a Resident Classification Instrument (RCI) which allocates each resident to one of five categories of dependency. Under this system nursing homes are given a notional basket of nursing and personal care hours determined by the average care requirements of residents in each category. Final subvention payment to nursing homes is in turn a function of the number of notional hours.

As this scheme has only recently been introduced it is too early to say if, as a method of financing nursing home care, it has been successful. There has been some concern expressed that the RCI does not properly reflect the relative service needs of some groups (Lingwood, 1989). Some of the categories for whom concern has been expressed are those who require therapy, those with sensory defects and ambulant dementia residents. Further concern has been expressed about the optimal life of RCIs. At the moment, an RCI assessment remains valid for one year. Some have argued that a shorter period is more appropriate, especially for particular at risk groups. As discussed in Chapter 2, the dependency profile of some elderly people can change much faster than allowed for in this scheme. What is not disputed, however, is the manner in which

RCIs have succeeded in reducing inequity among regions both in assessment procedures and funding arrangements. The RCI was not intended to, and does not, measure absolute care needs. Its purpose is to measure a resident's need relative to those of the general nursing home population.

The first task facing policy-makers in this country in establishing meaningful subvention arrangements based on dependency, therefore, is to establish a dependency measure which can be uniformly applied across all long-stay institutions. Choosing a scale that manages to capture all aspects of dependency is not, as we have noted earlier, a simple task (Wright, 1986). But at least there is a range of scales from which to choose, some of which were discussed in Chapter 2. For the purposes of allocating resources a more aggregate measure of disability is most useful: one that is robust enough to incorporate general characteristics and flexible enough to include the multifaceted nature of dependency in elderly persons. One should not be seeking a scale that provides very fine uni-dimensional measurements of disability yet fails to reveal much about overall dependency. For that reason, and for all their disadvantages, cardinal scales, for example the Crichton Royal Behavioural scale, are probably the most useful. Alternatively, the success of the Guttman Cumulative Disability scale used by Blackwell *et al.* (forthcoming), and discussed further below, provides support for following this approach. Whatever scale is chosen, every effort must be made to take account of the social circumstances of the elderly person under consideration.

A major problem in establishing a relationship between subvention levels and cost per category of dependency is the absence of much information about costs. As discussed in Chapter 3, the relationship between costs and charges in nursing homes has never been subjected to close scrutiny, sometimes not even by owners of homes themselves. One should be wary, therefore, of using charges as a proxy for the real costs of care. The only evidence on which to base a discussion of the cost of care by category of dependency in this country consists of data collected by Blackwell *et al.* (forthcoming) on four long-stay public institutions. Two of these can be ignored for the purposes of this report as they provide more complex services than are generally available in public long-stay institutions and most certainly in most existing nursing homes. The other two institutions are, however, more representative of the low technological level of care provided to elderly persons in long-stay homes. As a result, the relationship between dependency and the hours of specified care provided by nursing/attendant staff in these homes may provide some guidelines for potential subvention arrangements in the future. The measure of dependency used to assess elderly people in these institutions was based on the Guttman Scale shown in Table 6.2.

Table 6.2: Guttman Scale of Dependency

Scale Point		Functional Disabilities
A	{ 0	No disability
	1	Cannot bathe without help
B	{ 2	Cannot walk outdoors without help
	3	Cannot walk indoors without help
C	{ 4	Cannot dress without help
	5	Cannot get out of bed without help
	6	Cannot sit/stand without help
D	{ 7	Cannot use the toilet without help
	8	Cannot wash hands and face without help
E	{ 9	Cannot feed without help

Source: Blackwell *et al.* (forthcoming)

As explained earlier, the assumption of the Guttman Scale is that individuals lose functional disabilities in a cumulative manner. For example, if an individual cannot dress without help then neither can they walk indoors or outdoors or bathe without help. The scale proved reliable when used to measure the dependency of old people in the four institutions surveyed and for a randomly selected number of people living in the community. It met the usual conditions of scaleability and had the very desirable property of being highly correlated with non-physical additional measures of dependency, such as incontinence, mental deficiency, uncommunicativeness, uncooperativeness and restlessness.

It was necessary to combine different disabilities in order to increase numbers at each level of dependency. Hence, individuals who were either free from dependency or could do everything except bathe without help were assigned the lowest category of dependency (A). Next came those elderly persons who could not, without help, walk outdoors or walk indoors, or bathe (Category B). Those persons classified as Category C dependency represent those on points 4, 5, 6 or 7 of the original scale. The least dependent of this category cannot, without help, dress, walk indoors, walk outdoors, or bathe. The most dependent of this category cannot, without help, use the toilet, sit or stand, get out of bed, dress, walk indoors, walk outdoors or bathe. Category D is equal to scale point 8 of the original scale while Category E is equal to scale point 9.

Ward sisters in the two institutions were asked to estimate the number of care hours spent by nurses and attendants helping randomly selected elderly residents with specified tasks. Table 6.3 shows the care hours

provided by dependency averaged across the two hospitals relevant to our analysis.

Table 6.3: Hours of nursing/attendant care (aggregated by specified activities*) per week by category of dependency averaged across two public long-stay institutions

Category of Dependency	Hours of specified* Care per Week	Ratio of units of care (relative to Category A)
A	4	1
B	6	1.5
C	10	2.5
D	10	2.5
E	20	5

*Includes the following activities: bathing, washing, toileting, dressing, feeding, mobility assistance, administration of medication, general administration and other.

Source: Blackwell et al: *Comparative Costs of Caring for Elderly Persons in the Community and in Institutions* (forthcoming).

Elderly people in the lowest category of dependency receive an average of four care hours per week. Those elderly in Category E, the most dependent category, receive five times more care hours than those with least dependency. There is no difference in the number of hours provided to elderly in Category C or Category D. The evidence presented here is crude and is meant only to be suggestive. Nevertheless, at the very least, it does not undermine the wisdom of proposals to categorise dependency into low, medium and severe. Neither is the general pattern shown above out of line with evidence from the UK which reports that care hours increase with dependency, although not as dramatically (Wright, 1981). Other findings also suggest that the burden of care on residential staff derives very largely from the demands which a minority of very severely dependent residents make on their time and skills (Booth, 1985).

Even with better information on the relationship between care hours and dependency in long-stay institutions, it is not necessarily the case that judgements about subvention levels would be made any easier. An interesting finding of Judge *et al.* (1986) is that the dependency characteristics of nursing home residents exert no significant effect on charges. Proprietors of homes appeared to take a morbidity cycle view of dependency. They assume that most residents will need varying levels of care at different times. Hence charges are set to reflect expectations about the average level of dependency over time rather than marginal relationships in the shorter term.

The ideal funding arrangements would be to set up universal payment

structures based on the average cost of care by category of dependency, across all long-stay units, much the same as the concept of Diagnostic Related Groups in acute care (Wiley and Fetter. 1990). Under such a scheme long-stay institutions would be rewarded for efficiency with consequent beneficial effect on overall resource use. However, until the cost and outcome data are available to allow this to happen the allocation of subvention to nursing homes by category of dependency will remain an inexact science. In the meantime estimates from long-stay public institutions, albeit a restricted few, will at least inform us as to the credibility of the data provided, in due course, by the nursing home sector.

Regulating the Quality of Care

Nursing homes are regulated because society takes the view that elderly persons and/or their families are not in a position to exercise their usual consumer sovereignty in this area. Regulation incorporates many aspects of care. For example, items covered include accommodation, design, suitability and training of staff, as well as the prevention of financial exploitation. The ultimate objective of regulation, however, is that residents receive high quality care with satisfactory outcomes. The real difficulty, however, is the absence of suitable measures of outcome. Much more effort will have to be made in this country to establish a programme of research to identify the most practical outcome measures for use in care of the elderly, measures that will have as their core the view of the consumer. Until such time as this occurs it is imperative that intermediate measures of performance, such as input and process, are regulated to the highest standard. Codes of practice are currently being developed in this regard dealing specifically with issues of registration and inspection. Consequently, they are not discussed in this report.

The question of who should do the inspections, however, is important. There are many administrative grades and professional groups who would lay claim to the task. It would seem most appropriate that the inspectorate team consist of a medical representative, the community liaison nurse and an administrator with major responsibility in the area. At the moment, health boards vary with respect to the personnel they send to inspect homes. This does not lead to good practice, either from an efficiency or equity point of view. In the future, inspectorate teams should be uniform within and among health boards. In the long run the objective should be to build up expertise within health boards on aspects of registration and inspection. This might prove very valuable should a more legalistic approach creep into regulatory practice whereby nursing

homes would contest, by tribunal or in the courts, the judgement of inspectors.

Nursing home regulation is not confined to registration and inspection. Indirect control is exercised through many of the factors already discussed in this report: the availability of public long-stay alternatives, levels of subsidisation, tax relief and community care options. One major way in which the State can affect quality of care is by rewarding the better nursing homes with more subsidised residents. At the moment, the nursing home sector is a competitive market with many small homes seeking to attract residents. It is known, for example, that homes which are currently providing contract care in the Eastern Health Board welcome the guaranteed income which these beds provide. Under more flexible subsidy arrangements, health boards, as major funders of nursing homes, will be in a stronger position to determine placement on the basis of quality. If nursing home proprietors are aware that poor quality leads to the absence of subsidised residents there is a strong financial incentive to ensure that standards are maintained. Health Boards should therefore be encouraged, under the new legislation, to aggressively seek high quality care at the lowest cost from the homes within their jurisdiction. If private homes are better at providing care than the public sector they should be allocated more subvented elderly persons through a system of contracting out by health boards. This would bring about a competitive long-stay market leading to better quality care for elderly persons.

Conclusions

There are many options for the financing of long-stay care of the elderly. One of the most promising is the introduction of a social insurance scheme which would pay for care over the life cycle thereby avoiding the adverse selection problems inherent in private insurance schemes. Future policy for the financing of long-term care has, however, already been decided for Ireland. A mixture of public and private funding is envisaged. Within that framework, subvention payments should relate to the means and dependency of elderly persons, although no subvention should be paid to nursing homes unless it is first of all established that a subsidy of equal magnitude would not have succeeded in keeping the elderly person in their own homes.

The criteria for eligibility according to means should be based on simplicity and uniformity. To that end it is proposed that the former three tiered eligibility criteria for acute care subsidisation should be used when deciding on subvention for long-term care. In addition, however, the

assets of the elderly person should be considered but only on a retrospective basis. The size of subvention awards should reflect the dependency of the elderly person. Scales that incorporate general characteristics and the multifaceted nature of dependency (including social aspects) should be used to assess disability. Nursing homes which are efficient should be rewarded with more subvented residents even if this is at the expense of directing patients away from more costly, less efficient public sector institutions. Meanwhile, research is required in order to develop consumer oriented outcome measures in this area.

CHAPTER 7

Conclusions

Introduction

The purpose of this chapter is to draw together the wide and disparate set of issues raised in the study. This is done by highlighting the more significant conclusions of our work. In the first instance the role of nursing homes is discussed. The future development of the nursing home sector is addressed from the point of view of policy and practice. Recommendations are made with respect to financing arrangements. The approach to assessing the dependency characteristics of elderly people is also considered. Finally a research agenda is proposed for the nursing home sector. Without more and better information public policy-making in this area is likely to continue to be less than optimal.

The Role of Nursing Homes

It is a major theme running through this report that elderly persons should be looked after, wherever possible, in their own homes. This means that public policy should, first and foremost, be concerned with assisting elderly people and their families to achieve this objective. For this to happen more resources, in line with the recommendations of *The Years Ahead* report, must be devoted to community care. In particular, the role of the informal sector must be acknowledged and supported. The rhetoric of recent years must be transformed into the reality of additional resources for community care if the number of elderly persons entering long-stay care — public, private or voluntary — is to be reduced.

The most promising way to facilitate change is the introduction of integrated packages of care for at-risk elderly persons living in their own homes. Within an agreed budget a designated case manager could use the resources at his or her disposal to ensure appropriate care for the elderly person. For instance, they might use the budget to pay what were formerly unpaid informal carers, if that was considered most useful in a particular case. Alternatively, some of the budget could be used to

subsidise a short-term respite stay in a private nursing home. There is no reason why more formal experimentation with case management cannot begin immediately in this country, particularly as there has been some discussion about the limits of the current programme structure within the health boards and the desirability of area management. Whether anything happens on this front or not, the arguments for case management in care of the elderly are strong. Within such a framework the job of case manager should perhaps fall to the proposed new district liaison nurse. She would be in the best position to determine real need for individual at-risk elderly persons. However, there would have to be more emphasis on management training if such a scheme were to work as intended. There is no point in asking individuals to manage if they have never been taught how to manage.

Nursing homes should be more integrated with both public long-stay institutions and with services in the community. Otherwise it is possible that a dual system of care may develop: an efficient and well financed private sector and a not so efficient, lower standard, public sector. There are particular advantages in treating the public long-stay sector and regulated nursing homes as close substitutes. The main benefit is that it would widen the choice available to the health board when making placement decisions on behalf of subsidised elderly persons. Under the new regulations the state should be able to effect an overall improvement in the quality of care by rewarding the better nursing homes with more subsidised residents. The degree of choice should be extended to allow the health board to place a fully subsidised public patient in a private nursing home if that is where the board believes it gets best value for money. At present the Eastern Health Board has about 40 public patients in contract beds in the private sector. The arrangement seems to work very well. The nursing homes value the guaranteed income which these public patients provide while the Board is in a strong enough bargaining position to ensure high quality care at low cost. Experiments of this nature should be replicated throughout the system.

It is obvious that the role we foresee for the nursing home sector is very different from that which prevailed under the old — pre-Health (Nursing Homes) Act, 1990 — system. In the future it should not matter whether an elderly person receives long-term care in a public, private or voluntary institution. Each type of institution should provide an equal standard of care for all residents. Those institutions which do not provide good care should not receive referrals. Under this scheme all subsidised elderly persons entering nursing home beds would be subject to the same assessment procedures as persons entering public long-stay institutions. In this manner only those elderly persons really in need of long-term

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