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Social Policy and Ageing Research Centre

Research Brief No. 1

No Place Like Home:
Domiciliary Care Services for Older People in Ireland

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'Every elderly person you meet their main fear is that they will have to go into nursing home. Remember, these people were the guts of our country; they were the backbone of our country. Give them their due. They should be treated like VIPs.'

Interview with Home Care Worker

No Place Like Home is the first book to provide a comprehensive analysis of policy issues surrounding the care of older persons in their own homes in the contemporary Irish context. The contemporary context includes the operation of public, non-profit and private providers, and the proliferation of home care packages. No Place Like Home is the first book to emerge from the Social Policy and Ageing Research Centre, Trinity College Dublin (est. 2005).

The Centre selected the topic of home care for older persons as its initial flagship project, reflecting the central importance of developing this area of policy and provision in Ireland. The book argues for the importance of putting home care first and creating policies that enable older persons to access high-quality home care services on an equitable and needs-led basis.

The book draws on interviews with 125 individuals involved in the financing and delivery of home care for older persons. These interviews and documentary and historical analysis are used to map the home care system as it has evolved into its current form. The three sectors involved in the financing and provision of home care, namely the public, non-profit and private sectors are compared. The strengths and weaknesses of the current system are outlined, and a number of policy recommendations are put forward.

The book argues that home care must become the centre of care policy for the older population, and that increased investment is necessary in order to ensure that high-quality home care is available even to people with extensive care needs.

Research Methods

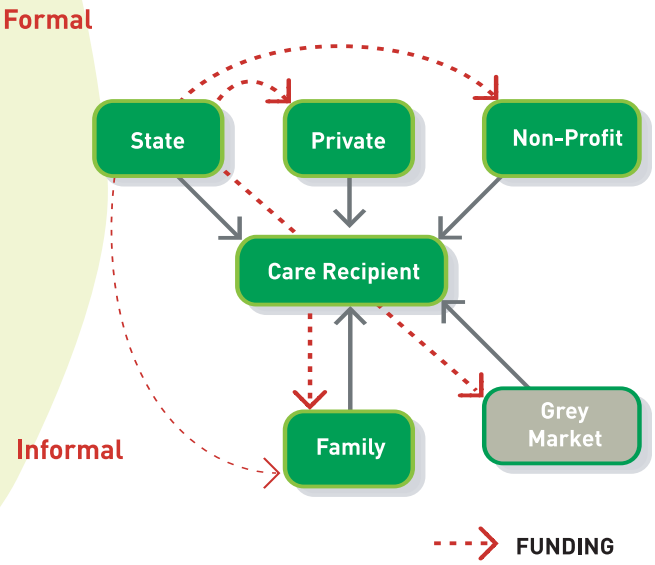
We conducted 125 interviews across the three 'pillars' of public, non-profit and private sectors, and across the three 'layers' of individuals involved in planning and financing services, operational management of services, and direct care provision in the Dublin area. A postal survey of private home care agencies and companies was also carried out, and documentary and administrative sources relating to home care policies were consulted.

Background and Context

The **non-profit** sector is the longest-established of the three home care sectors and continues to be predominant in terms of hours of care provided. This sector has undergone extensive changes in recent years, the most noteworthy being the introduction of the minimum wage in 2000, which resulted in a significant improvement in the careworkers wages. The non-profit sector is under pressure in the face of an increasing non-profit/private sector mix in the provision of care. This mix in turn can be partly traced back to the introduction of cash-for-care (home care packages) that can be used to hire either private or non-profit sector carers, and increasingly the former.

The **private sector** first emerged in the late 1980s. The introduction of home care packages has resulted in an expansion of private home care businesses. For all but two providers interviewed, home care packages are now the main source of their clientele. As a result of funding arrangements for this sector, it operates in a flexible way but in many cases workers in this sector are not within the tax and PRSI system.

In 1994 the role of health care assistant (HCA) was created. Aside from home nursing (although in some areas outside Dublin home help workers are directly employed by the HSE) these were the first **public sector** employees to engage in direct delivery of domiciliary care. There are very few HCAs in the community, staff ceilings restrict additional recruitment, and as a result demand for their services outstrips supply.



In recent decades, domiciliary care has become increasingly complex as the State has extended its functions both in providing (via the health care assistant service), and funding home care. The figure above illustrates this complex care mix; the dotted lines signify the flows of funding from the State to the non-profit sector (home help organisations), the private sector (via home care packages) and, in some instances, the care recipient who is given the freedom to channel the home care grant to an informal provider. (The thinner dotted line signifies carer's allowance/benefit.)

Now is the time to spell out clearly the rules according to which older persons access care, the extent to which care is publicly financed, and to develop the guidelines for ensuring that home care is of highest possible quality.

Summary of Key Findings

A degree of **specialisation** is evident between the three sectors. The public sector focuses on providing personal care. The non-profit sector provides mostly domestic help, although increasingly non-profit organisations are helping their workers to acquire training as personal carers. The private sector offers a combination of personal care and domestic help.

These specialisations are to a large extent the result of the differing ways in which the State channels **funding** to the three sectors. Whereas funding for the non-profit sector is retrospective i.e. largely based on past delivery of a certain number of home help hours, private sector agencies and companies 'bid' for a set of care packages, or for inclusion in a list from which care recipients choose their service providers. The manner in which funding is channelled to the two sectors therefore creates a strong incentive for the private sector to be as flexible as possible, whereas non-profit organisations are constrained by the retrospective nature of the funding arrangement.

Because provider organisations are able to operate in a complete or partial "vacuum" in terms of policy guidelines and regulations, they have diversified and established their own procedures and protocols for areas such as staff qualifications and quality controls, tax compliance, hiring and contractual practices, and insurance.

If the current funding arrangements are maintained, it is likely that the non-profit sector and the private sector will continue to evolve along different paths. In a more consumer-driven alternative (such as those in operation in Denmark and Germany), any provider that meets quality, training and monitoring requirements would be free to offer their services to individuals who are given entitlement to services.

There is **unequal access** to services across different areas. While the availability of home care packages is clearly welcome, it serves to further deepen the disparities in the availability of formal care services between the areas covered and those that are yet to be brought within the remit of these packages.

More individuals with extensive care needs are remaining at or returning home with the help of the home care packages. This is a positive development, but it also has repercussions for the training of home care workers, and further adds to the importance of developing **quality standards.**

Currently there is very little communication and co-ordination between the different home care service providers. In practice, this can mean that an older person has several care providers who do not communicate effectively with each other.

From previous research (Timonen 2004) we know that even among those who receive significant amounts of formal care, informal carers are in most cases the key individuals who underpin and co-ordinate the often complex care arrangements, and indeed continue to make very considerable inputs after the introduction of formal care. Research conducted in other care regimes, too, has shown that the relationship between formal and informal care is not zero-sum in nature: rather than crowding each other out, the two complement each other.

At present, there is no explicit emphasis (in home care for older persons in general or in the context of home care packages specifically) on the social and companionship aspects of care. Whereas home care services for (younger) disabled persons often make allowance for leisure activities and "quality time", this is not the case for older persons. However, in reality care workers are very often involved in this kind of social/companionship work, in many cases to an extent that is clearly beyond the call of duty i.e. unpaid.

While the perception that home care is relatively inexpensive is correct in some cases (especially in comparison with the costs of keeping people in a hospital setting when they are no longer in need of extensive medical care), it is important not to adopt the attitude that care in the home can be provided 'on the cheap'.

Policy Recommendations

The time is now ripe for spelling out more clearly the delineations between public and private responsibility in financing and delivering home care in Ireland, and only when this task has been completed can the ageing population of Ireland plan for the eventuality of their care needs in an informed manner. At present, the task of planning, organising and financing care is often made very difficult due to the lack of clear, transparent and consistently applied guidelines and assessments and the patchiness of service provision across the country.

The State is accountable for the public resources it spends in (part) financing care delivered by other providers. The pivotal issue in this regard is the **regulation of services** and the creation of a level playing field that draws out the strengths of different providers and ensures a greater degree of consumer direction and quality control.

The issue of **training and monitoring** domiciliary care workers is of fundamental importance. Even if the State ultimately assumes a distant role in the delivery of domiciliary care, it will have to assume responsibility for the enforcement of minimum training and supervisory standards among the service providers it subcontracts care to. *Ignoring the duties of ensuring quality care to care recipients and ensuring good terms and conditions of employment for care workers would be grave errors that would sooner or later result in abuses of various kinds.* New **quality standards and inspection regime** must cover both the institutional and domiciliary sectors, and apply equally to all providers, regardless of whether these are public, non-profit or private.

In a consumer-led model, both private and non-profit organisations can offer their services to older persons, provided that they fulfil quality criteria and are competitive in the sense of meeting the requirements of the care recipients. In order to maximise **choice**, the service users should be able to choose from among the approved providers in their area (where necessary or desirable, with assistance from a family member or a health services employee equipped to give informed and impartial advice).

A national **assessment system** urgently needs to be put in place to ensure that older persons' needs are measured as objectively as possible. In the absence of such a national framework and guidelines on assessment, glaring disparities in access to services and the level of services designated will persist.

Costs of care, whether institutional or domiciliary, should not be financed through the requirement to sell one's primary residence, either upfront or posthumously. Such requirements have been shown to significantly suppress demand for care, even among people who urgently require care.

In the Irish context, the most equitable, realistic and sustainable alternative would be to make a **basic amount** of services and/or financing universal, and to make the remaining services/funding income-dependent. This would ensure that all older persons with care needs (as defined and assessed with the help of national assessment protocols) would be able to access some services/funding, from a basic minima to full coverage, which in turn would help to ensure the popular support and therefore the long-term sustainability of the system.

Currently the majority of home care package recipients originate from a hospital setting i.e. they are awarded the package to facilitate their return home. Community-dwelling individuals are granted care packages, but the number of packages and the funding available to community-dwellers is lower than that available to those returning home from a hospital or other institutional care settings. This creates a perverse incentive for people to seek institutional care in the first instance, since a prior stay in an institutional setting seems to enhance the chances of getting a care package. The funding available through a care package should be based on care needs (and possibly to some extent on the applicant's income), not on the applicant's location in the community or in a hospital.

Home care workers need a **career pathway** with promotion and progression prospects, so that they can look forward to a varied career that can evolve and lead into supervisory and management roles. If home care is to be made more widely available to people with extensive care needs, it will be necessary to equip more home care workers with **para-medical** training. All care workers should be within the tax and PRSI net. This is particularly important considering that the expansion of employment in the care sector is largely driven by public funding, and would serve to ensure that all workers in the sector attain a basic level of social security.

While home care is the preference of the majority of older people, it should not become compulsory in the sense that no other alternatives are available. For varying reasons care in the home may not be the preferred choice for some older persons. In these cases, the stigma associated with assisted living and institutional care settings can cause unnecessary distress for the person who may wish to move away from home. One central aim of care policies for the older population should always be genuine choice, and this can only exist where a range of high quality care options are available.

About the Centre

The Social Policy and Ageing Research Centre (SPARC) provides fresh, rigorous thinking on social policy as it relates to the ageing population in Ireland and internationally. The Centre draws on policy and practice in Ireland and abroad to generate insights into ways in which social policies can better serve older people. The first research centre of its kind in Ireland, SPARC was established in 2005. In addition to generating high-quality research, the Centre hosts graduate students working towards policy-relevant PhDs. Researchers from the Centre are members of an inter-disciplinary team working on the first Irish longitudinal study of the ageing population (TILDA).

If you wish to give us any feedback or advice regarding this and proposed future work, please contact us at:

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